THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, THE ELDERLY AND CHILDREN

Tanzania Health Financing Strategy 2016-2026
Path towards Universal Health Coverage

Final Draft

Preface

Globally, millions of people fall into poverty each year as a result of paying for health care out of their own pockets. Many more are too poor to even consider seeking care at health facilities. In addition, adequate health care is often not available especially in remote areas, preventing vulnerable population groups in particular from accessing needed health services. This holds true also in Tanzania.

To address these issues, Tanzania, like many other low- and middle income countries, is intending to establish a Social Health Protection (SHP) system which strives towards Universal Health Coverage (UHC) – a goal also to be included in the post-Millennium Development Goals (MDG) agenda, the Sustainable Development Goals (SDG).

This Health Financing Strategy (HFS) outlines the strategic interventions and critical path necessary for Tanzania move closer to UHC through an effective SHP system.

The development of the HFS was included in Health Sector Strategic Plan III, and the process has been overseen by an Inter-Ministerial Steering Committee. The primary aim is to establish a mandatory National Health Insurance (NHIF) under which the entire population of Tanzania will have access to a standard minimum health care benefit package at all levels of care (aligned to the National Essential Health Care Intervention Package 2013). The HFS has identified major country-specific challenges and developed strategic interventions to reform the health sector financing architecture. Over the next ten years, the HFS will guide the MHCGE&C, other implicated line-ministries, and stakeholders, in the way health financing is governed, how the health sector is financed, how it pools resources and purchases health services. Development Partners in the health sector, as part of the Sector-wide Approach (SWAp), are encouraged to align their technical and financial support to the proposed strategies, goals and objectives to ensure that targets are successfully met.

Assessments have been conducted to show the current level of total financing for health care and on how additional funding can be mobilized to provide adequate quality health services. The HFS outlines how resources are currently allocated and spent, taking reference from the latest National Health Accounts (NHA) and Public Expenditure Review (PER). It describes the governance structures to be put in place and the concept of the NHIF institution. It describes the roles of actors both at the national and decentralized levels, and the necessary reforms within public financial and data management systems. Also, it describes how resources can be mobilized through different sources.

Last but not least, the HFS aims at poverty alleviation and aims at empowering the consumers of health care, communities and families whether poor or wealthy. With the mandatory purchase or subsidization of health insurance membership, Tanzanian residents regardless of their socio-economic status, have been given a voice to demand adequate care without the fear of economic hardship due to seeking health care.

Acknowledgement

The Health Financing Strategy document and its implementation plan are results of a well-coordinated effort by various individuals, institutions and stakeholders. The MHCGE&C, under the guidance of the Inter-ministerial Steering Committee and through its Health Financing Technical Working Group, has developed this strategic plan in a broad consultative process. The MHCGE&C would like to express its sincere appreciation to everyone who was involved in the preparation of these documents. While it is not possible to mention all who have contributed to the production of this document, the MHCGE&C would like to acknowledge the following:

We would particularly like to thank all heads of department of the Ministries represented in the Inter-ministerial Steering Committee, department heads, section and program managers in the MHCGE&C, all TWGs of the Ministry and SWAp partners who have worked under the guidance of the MHCGE&C and Directorate of Policy and Planning management to support the development of the HFS.

We would like to express our gratitude to the Providing for Health (P4H) Network partners including African Development Bank, German Development Cooperation (GIZ, KFW), Swiss Development Cooperation (SDC), USAID, World Bank (WB) and World Health Organisation (WHO), together with Danida, for their targeted technical and financial support in the efforts.

Finally, the MHCGE&C acknowledges the contribution and dedication of all who in one way or another have taken part in formulating the health financing strategy, specifically Mariam Ally, Chair of the Health Financing TWG and Assistant Director Policy within the MHCGE&Cand Mr Kuki Tarimo, who coordinated all activities leading to production of this document and its implementation plan.

The MHCGE&Cis committed to the implementation of this strategy and shall use it as guiding document for planning, monitoring and evaluation. We look forward to continuing to work with our partners in the government, non-government organizations, development partners, and the users of services we provide, in order to improve the health and well-being of all Tanzanians.

Acronyms

ANC	Ante Natal Care
BoT	Bank of Tanzania
CAG	Control and Auditor General
CBHI	Community-based health insurance
CCHP	Comprehensive Council Health Plan
CCT	Conditional Cash Transfer
CFS	Consolidated Fund Services
CHF	Community Health Fund
CHMT	Council Health Management Team
D-by-D	Decentralization by Devolution
DED	District Executive Director
DHIS	District Health Information System
DP	Development Partner(s)
FBO	Faith-Based Organization(s)
FY	Financial Year
GBS	General Budget Support
GDP	Gross Domestic Product
GoT	Government of Tanzania
HBF	Health Basket Fund
HC	Health Centre
HDI	Human Development Index
HFS	Health Financing Strategy
HMIS	Health Management information System
HSSP III	Health Sector Strategic Plan III (2009-2015)
ISC	Inter-ministerial Steering Committee
LGA	Local Government Authority (ies)
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MBP	Minimum Benefit Package
MDA	Ministries, departments and Agencies
MHIS	Mutual Health Insurance Scheme
MOF	Ministry of Finance
MHCGE&C	Ministry of Health, Community Development, Gender, Elderly and Children & Social Welfare
MOL	Ministry of Labor
MTR	Mid-Term Review of HSSP III (2013)
MOU	Memorandum of Understanding
NBS	National Bureau of Statistics
NGOs	Non-Government Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund

NIDA	National Identification Authority
NSSF	National Social Security Fund
OC	Other charges
OOP	Out of Pocket
PER	Public Expenditure Review
PFM	Public Financial Management
PHI	Private Health Insurance
PMT	Proxy-Means Testing
RAS	Regional Administrative Secretariat(s)
RBF	Results Based Financing
RHMT	Regional Health Management Team
RITA	Registration, Insolvency, and Trusteeship Agency
SHI	Social Health Insurance
SHIB	Social Health Insurance Benefit
SHP	Social Health Protection
NHIF	National Health Insurance
SSRA	Social Security Regulatory Authority
SWAp	Sector Wide Approach
TACAIDS	Tanzanian Commission for AIDS
TASAF	Tanzanian Social Action Fund
THE	Total Health Expenditure
TIKA	[Tiba kwa Kadi] - urban, informal sector health insurance
TNCHF	Tanzanian Network for Community Health Funds
TIRA	Tanzania Insurance Regulatory Authority
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Program

Glossary

Capitation	A mechanism to pay a provider. Under capitation the unit of payment is defined on a per-person-basis fixed for all services that a person may use in a period of time.
Case-based payment	This form of payment pays the providers a lump sum for a classified case of illness and its associated treatment cost.
Efficiency gains	The experience of financial gain or savings through introduction of more efficient processes.
Gatekeeping	Is a mechanism to rationalize health expenditure. A Gatekeeper is a health care provider at the first contact level who has responsibilities for the provision of primary care as well as for the coordination of specialized care and referral.
General Budget Support	External funds directly contributed to the general government budget (not sector specific).
Fee For Service	Out of pocket payment mechanism, where a fee is charged for a service at the time of use. Currently used by NHIF for reimbursement to providers.
Fragmentation	Refers to the existence of multiple financial and risk pools.
Minimum Benefit Package	Is a minimum package of health services offered within a health protection scheme
Purchaser	"Buys" health or management services, of a specified quality, according to agreement with the service provider. The purchaser is a recipient of services provided under a contract of service.
Purchaser-Provider Split	Separation of provider and purchaser functions
Results-Based Financing	Refers to any system that transfers financial or non-financial incentives either to a patient when they take health-related actions (demand side), or to health care providers when they achieve pre-agreed results (supply side). RBF can also be

	defined as an approach to develop financing based on payments made after results have been delivered and independently verified. A well-designed RBF mechanism motivates staff to deliver quality services and assists them to access the resources needed.
Risk Pooling	Individuals and households share the financing of total healthcare costs. Risks are pooled both between and worse health among beneficiaries, and of higher and lower income groups. The larger the degree of risk pooling in a health financing system, the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have access to the care they need.
Social Health Insurance	A publicly subsidized health insurance scheme which operates under the principles of solidarity, equity and risk pooling.
Social Health Protection	A series of public measures against social distress and economic loss caused by reduction of productivity, stoppage or reduction of earning, or the cost of necessary treatment that can result from ill health (ILO).
National Health Insurance	One single social health insurance scheme.
Universal Health Coverage	All People in Tanzania can use promotive, preventive, curative and rehabilitative health services they need, of sufficient quality to be effective without suffering any financial loss (WHO).

Executive Summary

Introduction

This Health Financing Strategy (HFS) describes the strategic direction of the health sector relating to health financing for the period 2016-2026. The specific implementation steps under the HFS are described in the HFS implementation plan. This document provides a guideline for strategic implementation of national and sub-national health financing reforms and for annual planning in this area.

Policy Rationale

In 2007, the Government of Tanzania (GoT) adopted a Health Policy with the policy vision "to improve the health and well-being of all Tanzanians with a focus on those most at risk […]". This vision remains valid and the GoT is committed to movie towards Universal Health Coverage (UHC) by making sure that everybody has access to required health services of high quality and is protected against financial risks that could arise as a result of paying of health care. As part of the Health Sector Strategic Plan III (2009-2015) (HSSP III), the decision was taken to develop a Health Financing Strategy to ensure that this vision is realized.

Health Financing Strategy Framework

The HFS is organized into 4 pillars of health financing: governance, revenue collection, pooling of funds and purchasing. Ten strategies have been developed according to the principles of equity, solidarity, transparency, accountability, sustainability, acceptability, efficiency and gender sensitivity and are found across the four health financing pillars.

The Health Financing Strategies:

Pillar 1: Governance

1. **Establish National Health Insurance (NHIF) Legal and Regulatory Framework**, with the objective to develop or adapt a clear and executable legal and regulatory framework that clarifies and streamlines health financing policies, ensures stakeholder participation, strengthens accountability and provides clear direction for NHIF implementation.

2. **Establish and operate the NHIF institutional structure, roles and relationships** which reflect the voice of the community/ user of the health system and moves reforms towards mandatory NHIF. This strategy relates to the physical set-up of the health purchaser institution, which will be clearly split from the functions of the provider of health services.

Pillar 2: Revenue Collection

3. **Increase Government and Private Contributions to the Health Sector** with the objective to strengthen revenue collection and mobilization of resources for the health sector. The strategy suggests a rechanneling and increase of government resources to health, next to the insurance contributions that will be collected from the population. Specific government levies are suggested to be earmarked to the NHIF as well as other private sources of contributions to the pool sought a part from efficiency gains in the improvement of services delivery aspects.

4. **Make Health Insurance Mandatory for All** in order to reduce financial access barriers to health services to the whole population of Tanzania. All residents will either contribute to or receive subsidies (those classified as poor) for the NHIF without the possibility to opt out of the system.

Pillar 3: Pooling of Funds

5. **Create one National Financial and Risk Pool for Health** in order to improve financial and risk pooling mechanisms within the health sector. This will imply merging, over time, existing finance pools such as NHIF, NSSF-SHIB, CHF, GoT subsidies for the poor, general revenue budget, parallel funding flows and other funds into the NHIF pool, in order to purchase a standard Minimum Benefit Package for the whole population.

6. **Guarantee Health Insurance Coverage for the Poor and Vulnerable,** through ensuring effective identification and inclusion mechanisms, in order to create a health financing system which is responsive to the needs of the poor and vulnerable, and which leaves no person behind.

Pillar 4: Health Care Purchasing

7. **Establishment of a Standard Minimum Benefit Package** as legal entitlement to the whole population. This package would evolve over time as available funding increases, and the health system is strengthened.

8. **Allocate Health Sector Resources Strategically** with the intention of continuously adapting and shaping the purchasing structure within the health system, placing particular focus on improving incentives for improved services delivery (eg through results-based financing). This strategy aims at developing effective provider payment methods throughout the country with integrated performance structures.

9. **Strengthen the Public Financial Management system in the Health Sector,** given the NHIF's need of strong financial management staff, systems and procedures in order to successfully manage the identification and collection of revenue from multiple

sources, multiple provider contracts and output-based provider payment systems at all levels, and increasingly manage revenues and expenditures at the health facility level.

10. **Develop a Strong Health Information and Data Management System** for the NHIF which is interlinked with the health management information system (HMIS) and with vital national databases. This strategy also aims to ensure evidence-based policy making through the generation of supportive research in the area of health financing and social health protection.

Implementation of the Strategy and Sequencing

Key to HFS implementation success is the articulation of a critical path which ensures that the many and varied tasks ultimately result in a cohesive and functioning NHIF system. Implementation will be clearly sequenced by breaking down the overall task of NHIF implementation into simple and realistic steps. These steps will be ordered in a way that makes each next step inevitable and enables implementation to progress seamlessly.

HFS Costing

The long-term feasibility of the NHIF will depend on ability to pool sufficient funds across sources to finance the provision of the MBP and MBP+ for different groups of citizens. A sustainable NHIF will reduce the burden of out-of-pocket payments for the poor and generate greater equity in how health care is financed at all levels. Assessment of sustainability requires comparing the projected cost of delivering the MBP or MBP+, as per the current HFS Implementation Plan, with the possible size of resources that can be pooled for NHIF.

Monitoring and Evaluation

The overall monitoring structure is based on the UHC results chain Based on the HFS goal, a set of outcome and impact indicators and targets have been developed to allow the GoT and stakeholders to monitor and evaluate HFS success. A system of quarterly, annual and periodic monitoring will use these selected health financing indicators. M&E of the HFS will be undertaken in coherence with the HSSP IV monitoring and requirements and will ensure timely and reliable provision of progress reports on implementation of the proposed strategic interventions and related activities.

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1 Background

1.1 Rationale for the Health Financing Strategy

In 2007, the Government of Tanzania (GoT) adopted a Health Policy with the policy vision *"to improve the health and well-being of all Tanzanians with a focus on those most at risk […]"*. This vision remains valid and the GoT is committed to moving towards Universal Health Coverage (UHC) by making sure that everybody has access to needed health services of high quality and is protected against financial risks that could arise as a result of paying of health care. As part of the Health Sector Strategic Plan III (2009-2015) (HSSP III), a decision was taken to develop a **Health Financing Strategy** to ensure that this vision is realized.

Tanzania is entering a new phase of health financing reforms based on those undertaken since the early 1990's. The first phase of reforms moved the Tanzanian health financing system from a purely budget-financed system to a mixed financing model with the hope of increasing availability and quality of care. In this first phase, user-fees (in 1993), Community Health Funds (CHFs – from 1996 onwards) and the National Health Insurance Fund (NHIF – in 1999) were introduced in order to leverage additional funds, build community ownership, and create stronger accountability of service providers. However, these mechanisms have largely failed to achieve significant population coverage and thus adequate social health protection.

A large body of evidence shows that spending from public sources, especially from domestic sources, is still low hence finance a package of essential health services or minimum benefit package. User-fees are still a barrier to access especially among the poor while coverage of pre-payment schemes is low, funding is not distributed equitably between and within districts, and the limited funds available are not used efficiently to achieve the maximum effect (NHA 2010). Accountability and transparency can also still be improved. The above challenges are to a large extent a result of a highly fragmented health financing system whereby a lot of small risk pools finance health care needs of different small segments of the population.

1.2 The Process of Developing the HFS

The need to develop a Health Financing Strategy was spelt out in HSSP III (p32), and the process started in 2012 with background studies, initial consultations, and efforts to learn from other countries as part of capacity building (Figure 1). In order to ensure high level, multi-sectoral Government ownership and oversight of the process, the Ministry of

Health, Community Development, Gender, Elderly and Children (MHCGE&C) inaugurated an Inter-Ministerial Steering Committee (ISC)[1] In August 2012. The ISC comprises representatives of key ministries, departments and agencies (MDAs) to ensure that proposed reforms are comprehensive, accepted and implemented by all stakeholders. Its role was to provide leadership, ensure national ownership of the process, coordinate technical level activities, provide guidance on policy direction and act as a transmission mechanism between a technical Secretariat and the high-level decision makers.

Figure 1.1 Process of developing the Health Financing Strategy

An early task of the ISC was to identify reform areas, after the identification they commission a number of studies and option papers in order to generate evidence to inform key decisions on these areas. These included papers outlining options for the health insurance market, CHF reform, inclusion of the poor, and the minimum benefit

[1] ISC Comprised of President Office- Regional Administrative, Local Government, Civil Services and Good Governance, Ministry of Finance and , Prime Minister Office, President, Ministry of finance and Planning, Ministry of Industry of Trade and Investments, TACAIDS, , E-Government, NIDA,

package, among others[2]. Study findings were discussed and validated with national stakeholders and form the basis for choosing the proposed social health insurance structure.

The proposed social health insurance structure was again comprehensively discussed by stakeholders at the national and district levels for further inputs before coming up with a refined final structure that is presented in this strategy.

1.3 Demographic trends

According to the 2012 population and housing census Tanzania Mainland where this Health Financing Strategy applies had a population of 43,625,354 (NBS 2013). This is an increase of about 30% compared to the 2002 population census. The population annual growth stands at 2.7 percent which is a small reduction compared to the 2.9 percent growth estimated in 2002. Average household size is about 4.8 with variations between urban (5.3) and rural (1.8). About 29.6 percent of the population lives in urban areas and 70.4 percent in rural localities. About 50.1 percent of the population is below 18 years of age, 16.2 percent of the population aged 5 or under, while 5.6 percent is aged 60 years and above. Life expectancy at birth is estimated at 56 years which is an increase from 51 years in 2002 (NBS 2013).

1.4 Economic Context

GDP and Inflation

In 2012/13 Tanzania realized a total GDP of 33 billion US dollar, an increase from 21 billion in 2009. GDP growth in 2012/13 averaged 7 percent (BoT, 2013). The per capita GDP increased from about $500 in 2009 to about $700 in 2013. The growth in GDP is mainly attributable to services sector which accounted for an average of 43.5 percent of total GDP during 2009-2013. Agriculture and fishing is the second large contributor to the growth with an average of 27.2 percent during this period (WB-http://data.worldbank.org/country/tanzania). Industry and construction is the third largest contributor with an average of 21.35 percent.

There have been fluctuations in inflation rates over the past ten years. In 2005 inflation rate stood at 4 percent but this has been increasing over time with the highest inflation rate of 16 percent observed in 2012. In June 2013 the level of inflation stood at 7.6 percent (BoT, 2013).

[2] All commissioned studies are included in the reference section

Poverty, Inequality and Human Development Index(HDI)

About 28 percent of the population lives below basic needs poverty line and 9.7 percent in extreme poverty (food poverty) (NBS, 2014). There are variations in poverty incidence between urban and rural localities with more poor people located in rural areas compared to urban areas (Table 1).

Table 1 Poverty headcount rates by type of area, 2012

	Dar es Salaam	Other urban areas	Rural areas	Tanzania mainland
Basic needs poverty	4.2%	21.7%	33.3%	28.2%
Food poverty (extreme poverty)	1.0%	8.7%	11.3%	9.7%

Source: NBS (2014) Household Budget Survey 2011/12

There has not been significant change in income inequality in Tanzania since 1990 although the distribution shows significant inequality. The degree of income inequality observed in 2012 as measured by the GINI index was 0.34 same to the level observed in 1990 (NBS 2014). Despite the observed inequality in income distribution, the country has been experiencing and increasing trend in Human Development Index (HDI). In 2012 HDI was 0.48 which is an increase from 0.40 in 2005 (UNDP 2013).

Employment

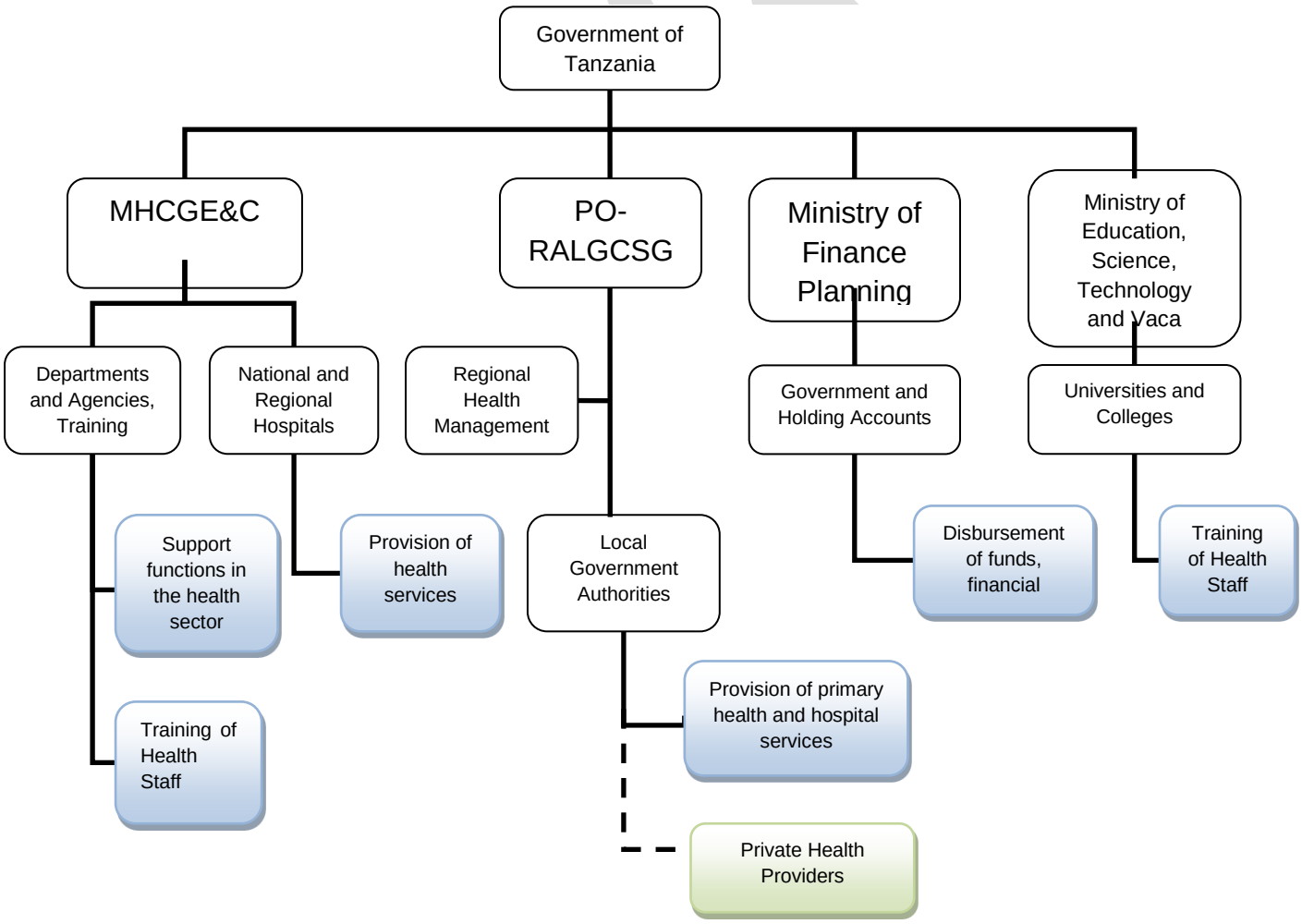
About 40 percent of Tanzania population was employed in the informal sector in 2006, an increase from 35 percent in 2001 (NBS, 2006). The proportion of the population working in the informal sector is higher in urban areas (66 percent) than in rural localities (27 percent). About 75 percent of the population works in the agriculture sector. Only about 12 percent of the population is employed in the formal sector (NBS, 2006).

2 Health Financing Overview

2.1 Governance

The MHCGE&C is mandated with overall stewardship of the health sector. The Ministry is responsible for policy development, strategic planning, resource mobilization, and monitoring and evaluation for the sector as a whole. The relationship and roles of different Ministries, Departments and Agencies (MDAs) in the health sector is shown in Figure 2 below.

Figure 2.1: Ministries, Departments and Agencies, and their responsibility in health sector



Under the GoT policy of devolution, LGAs are responsible for the operation and management of primary level health services, while regions are responsible for LGA supervision, and also management of the regional hospitals. The MHCGE&C plays a major role in policy development and articulating the case of health, and shares

regulatory and accountability functions with other Government MDAs, especially with the President Office for Regional Administration and Local Government, Civil Service and Good Governance (PO-RALGCSG).

At the local level, the MHCGE&C maintains technical relations with the Regional Health Management Team (RHMT) and the Council Health Management Team (CHMT). All Councils produce annual Comprehensive Council Health Plans (CCHPs), which incorporates all activities related to District Health Services, and all sources of funding at the council level (government funds, locally generated funds, local donor funds, etc.).

Since mid-late 1990s there has been improved governance structure and dialogue in the health sector through the use of a Sector Wide Approach (SWAp). The SWAp provides the framework of collaboration among stakeholders including MHCGE&C, PO-RALGCSG, Ministry of Finance&Planning (MoF&P), civil society, private sector and development partners (DPs) including United Nations (UN) agencies active in health. It aims to coordinate financing, planning, and monitoring mechanisms.

Other key stakeholders in the health governance structure include the Tanzania Insurance Regulatory Authority (TIRA) and the Social Security Regulatory Authority (SSRA) which deal with the specifics of (health) insurance regulation.

In 2009 NHIF was tasked to administratively manage CHF. However, its core business focuses on public health insurance administration.

Challenges

The main challenge is the fragmentation of the governance structure in the areas of insurance regulation, services delivery, management of fund etc. The reforms required to support implementation of the HFS will pose challenges to some of the existing governance structure. In the area of insurance regulation, for example, SSRA and TIRA will be challenged by the regulation of a full-blown insurance system covering the entire population (Mtei and Bultman 2013).

3 Health Financing System Overview and Challenges

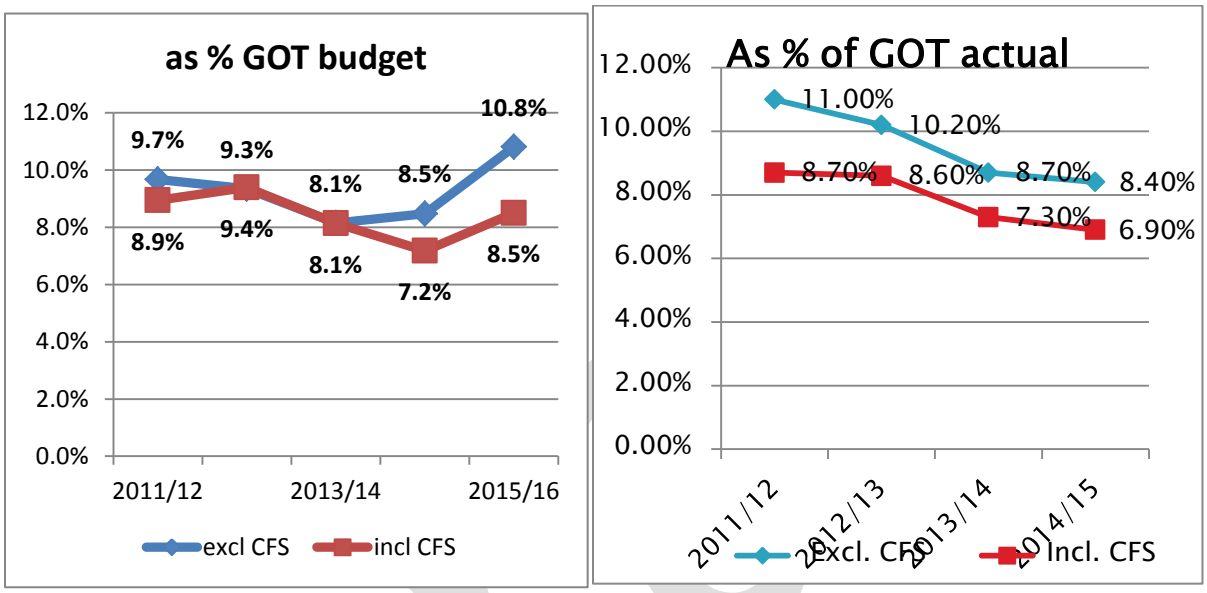
3.1 Revenue collection

3.1.1 Government funding

The health sector government funding is comprised of central tax revenue financed by GoT general tax revenue and DP support. DPs pool funding both through general budget support (GBS), the Health Basket Fund (HBF), a form of sector budget support and direct to project.

The share of public health budget in total government budget, excluding the Consolidated Fund Services (CFS) Increase from 9.7 percent in FY2011/12 to 10.8 percent in FY2015/16. Actual health expenditure as a proportion of actual government spending also declined from 11.00 percent in FY 2011/12 to 8.40 percent in FY 2014/15 (PER 2014/15).

Figure 3.1 Health sector as a share of Total Government Budget



Source: JAHSR PER presentation 2014/15

Per capita expenditure in nominal terms decreases from $15.50 in 2011/12 to $14.69.3 in 2014/15. During the same period the per capita expenditure in real terms decreased from $9.51 to $7.47.

Besides block grants and basket funds, other significant sources of funds at the LGA level were the Global Fund , UNICEF, health insurances (CHF and NHIF), in-kind, cost sharing, own sources and the Primary Health Services Development Program (in Swahili, acronym MMAM).

3.1.2 Prepayment schemes

Health insurance systems in Tanzania are organized into a two tier system, formal and informal sector insurance schemes. The coverage of the contribution based health insurance schemes in the country is about 22% of the whole population of which CHF coverage is 11 percent. This is not close to the objective set in the HSSP III which is to provide health insurance coverage of 30% of the population into CHF by 2015. The health insurance market is composed of five key players, the National Health Insurance Fund (NHIF), National Social Security Fund – Social Health Insurance Benefit (NSSF-

SHIB), Community Health Fund (CHF)/ Tiba Kwa Kadi (TIKA), Private Health Insurance (PHI) and Community Based Health Insurance (CBHI)/Micro insurance.

NHIF members mandatorily contribute 6% of their basic salary. The contribution is equally shared between employees and employers. The scheme was introduced under the NHIF Act no. 1 of 1999. The law has recently been amended to allow contribution of premium from individuals and non-public sector employees on voluntary basis. The SHIB is another form of formal sector health insurance mainly focusing on private employees, parastatals and NGOs. Additionally, SHIB is not a stand-alone health insurance scheme but rather part of benefits provided by the NSSF. Members of NSSF mandatorily contribute 20% to the NSSF. This contribution is also equally shared between employees and employers. Part of the return of investiments of these collections is used to fund health insurance benefits for NSSF members. Private for profit health insurance is a third type of health insurance targeting the formal sector. Contributions to private insurance vary across firms and in most cases it is either community rated as when private employees negotiate for premium or risk rated in case of individual enrolment.

The Community Health Fund (CHF) is the largest informal sector insurance scheme enacted in 2001 under the CHF Act no. 8 after a pilot conducted in 1996 in Igunga district. The scheme mainly targets the rural population and is managed at the council level. Membership is at household level whereby households voluntarily contribute a flat rate. Premium amounts are decided by the district authority after consultation with the community members. Currently, the level of premium contribution across councils vary from 5000 TZS per household per annum to 15,0000 TZS per household per annum. A counterpart scheme, TIKA was also introduced in 2009 (Borghi, Mtei et al. 2012) for urban informal population with the same objectives as CHF except that enrolment to TIKA is on individual basis. In addition to CHF there are a number of other community based health insurance (CBHI) schemes established to insure health care costs across different groups in the informal sector. The commonly known schemes include VIBINDO which brings together workers in small scale industries and petty business. It is estimated that in 2007 there were about 12 CBHI registered by the Tanzania Network of Community Health Funds (TNCHF) (PHRplus 2006). In 2010, these kind of schemes were about 43 in number (Toutant 2010). There are currently moves to harmonize health care benefits provided under VIBINDO network with the NHIF under special arrangements referred to as mutual. With this new initiative the NHIF will be responsible to provide health services to the members of VIBINDO after contribution of a pre agreed premium.

Table 3.1: Description of Health Insurance Schemes in Tanzania

Dimension	NHIF	CHF	NSSF-SHIB	PHI	CBHI
Coverage #	3.12m beneficiaries (616,853phs)	5.06m beneficiaries (843,729)	51,300 beneficiaries (31,000 phs)	450,000 beneficiaries (150,000 phs)	440,000 beneficiaries
Coverage %	7%	12%	0.12%	1.02%	1%
Market segment	Civil servant (+Private)	Informal Low Income H/holds	Formal + Semi formal	Private	Informal Low Income H/holds
Enrollment	Mandatory	Voluntary	Voluntary	Voluntary	Voluntary
Collection meth	Payroll deduction	Remit @ HF	Payroll deduction	Remit to PHIs	Remit to CBHI
Premium range	6% of salary p.m (50/50 for employer/employee)	5,000-15,000 (+Matching grant)p.a	Part of 20% contribution p.m	300,000 – 950,000 p.a	30,000 – 40,000p.a
Benefit package	Medium range1	Primary & some hospital care	Broad range	Full range	Primary & Hospital care
Type of Benefit	In kind	In kind	In kind	In kind + Reimbursement	In kind
Provider payment	Fee for service	Capitation	Capitation	Fee for service	Capitation
Regulator	SSRA	SSRA	SSRA	TIRA	Unregulated

Source:Interviews with Stakeholders, 2013 and FSDT & Cenfri 2012, Insurance Diagnostic Study[3]

3.1.3 Health financing composition

The 2011/12 National Health Accounts (NHA) data shows an increase in donor dependence to fund health care in Tanzania. This source accounted for about 48 percent of the total health sector resources envelop in 2011/12, an increase from 40 percent in 2009/10. The share of out-of-pocket is still on a higher side accounting for about 24.6 percent of total health sector financing. However, there has been a decrease compared to 2009/10 share of total financing (32 percent). Contributions from total general tax revenue remains relatively low accounting for about 20 percent of total health financing; which is on the lower side compared to the 26 percent in 2009/10.

[3] FSDT & Cenfri 2012,Insurance Diagnostic Study for Tanzania, FSDT/Cenfri, Dar es Salaam.

Health insurance schemes contribution is insignificant accounting for about 3 percent of total health sector financing. This low contribution level of prepayment schemes is a result of limited health insurance coverage which is estimated at 22 percent of total population.

Table 3.2 Total Health Expenditures by Source (percent)

	FY2002/03	FY2005/06	FY2009/10	FY2011/12
Households	42 %	25 %	32 %	24.69%
DPs	27 %	44 %	40 %	48.27%
MOF&P	25 %	28 %	26 %	20.71%
Other	5 %	3 %	2 %	5%
TOTAL	**100 %**	**100 %**	**100 %**	**100%**

Source: NHA (2014)

Challenges

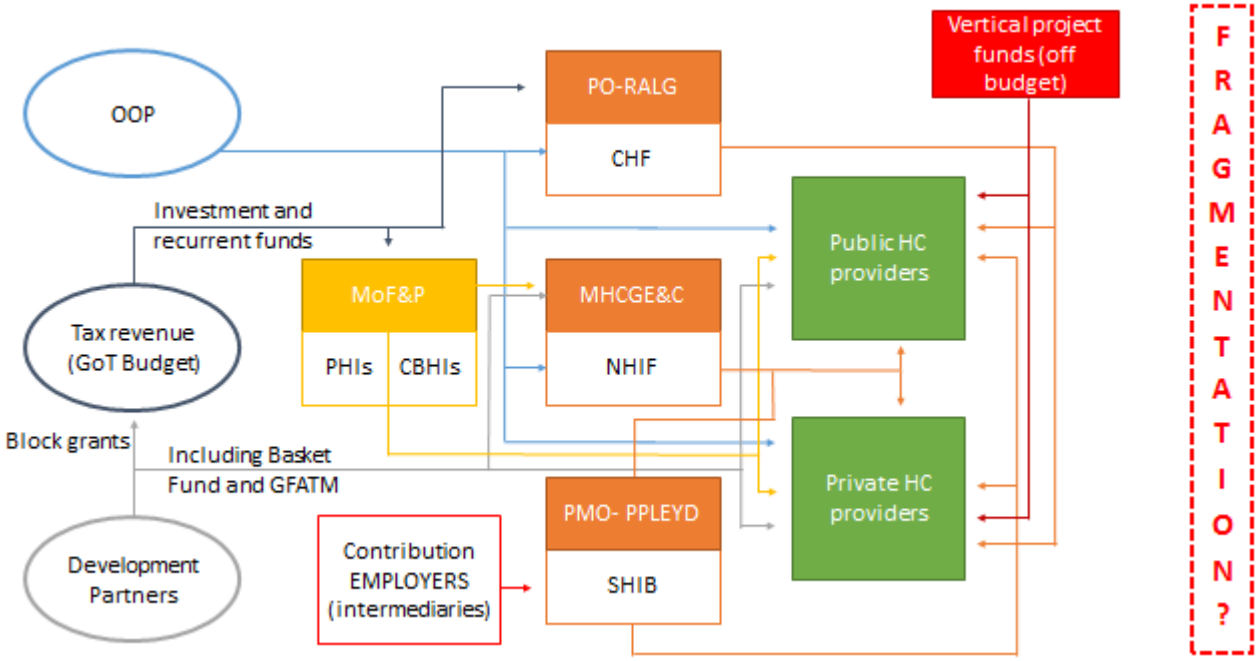
There is still a significant level of dependence on external partners to finance health care while the share of domestic tax sources is still low. A significant proportion of donor funding support goes to vertical programs hence only a small segment of the population benefit leaving broad health system improvement with limited resources. This poses a threat to the sustainability of the system. Further the level of dependence on out-of-pocket payment is still high and it is commonly understood that high dependence on out-of-pocket payments is a major cause of inequities in access to health care and high degree of financial risk for catastrophic health expenditures. With regards to the existing health insurance schemes, enrolment is still low. Studies conducted have identified several reasons for the low enrolment including poor quality of service coupled with frequent drug stock-outs in health facilities, weak design and management, poor understanding of the concept of risk pooling, and unattractive benefits package.[4]

[4] MTR HSSP III Financing Report (2013)

3.2 Pooling

The health financing landscape in Tanzania is heavily fragmented, not only among existing health insurance schemes, but also among different vertical project funds, basket funds and government budgetary funds to central and lower levels. The current funding flows are shown in Figure 4 below.

Figure 3.2: Current health financing structure



CHF premiums are collected from members at health facilities and matched 100 percent by the government (administered by NHIF). With the current fragmented district CHF pools, the richer councils receive higher matching funds (as subsidies) compared to the poor councils. Collected premiums are submitted to the LGA cost-sharing account, where they are pooled with user-fees. At the moment CHF risk pools are relatively small and cover mostly the middle-income groups – the poorer often stay out and the richer are covered by the NHIF or private insurance.

The NHIF has one nation-wide pool into which all premium revenue collected together with returns from investments are deposited. The relatively large pool gives it financial viability. On the contrary, SHIB and the isolated community-based or mutual health insurance schemes (CBHI/MHIS) have small risk pools. In the case of CBHI/MHIS, the small size of the pools makes pooling relatively inefficient due to the low financial stability and sustainability, as well as limits equity effects through redistribution. In the case of private insurance, the risk pool is only balancing risks partially as insurance

contracts are written individually and negotiated between the company or individuals seeking insurance coverage.

Challenges

The main challenge observed is the fragmentation of the health insurance landscape. This fragmentation begins from the governance structures of the schemes, where different ministries are responsible for different health insurances including MHCGE&C, MOF&P, PMO- PPLEYD and PO-RALGCSGG. Fragmentation within the health insurance landscape manifests itself in coordination difficulties in strategy, resources and functions amongst the actors, duplication of activities and processes, not profiting from economies of scale, wastage of resources in the absence of an integrated approach and a strategy to achieve formulated policy goals. Another significant challenge posed by fragmentation is the lack of cross-subsidization from the wealthy to the poor or the healthy to the sick.

3.3 Purchasing, payment, and allocation of resources

3.3.1 Provider payment mechanisms

CHF funds flow back to health facilities through CCHP activities budgeted from cost-sharing funds. There is no clear separation between purchaser of health care services and providers. In the majority of councils CHF cards are not portable across providers and benefit package is limited to one primary facility of household choice. In addition, the limited portability of benefits undermines the risk-pooling potential of CHF/TIKA.

There is currently no single provider payment mechanism in Tanzania and each insurance scheme has its own provider payment system. While CHF, SHIB and CBHI use capitation, NHIF and private insurance use fee-for-service. At the LGA level, budgetary transfer is used for other charges (OC), the non-salary recurrent costs, and for the HBF, whereas other key flows employ other mechanisms such as user fees and NHIF reimbursements.

3.3.2 Resource Allocation

Resources from the HBF are allocated according to a formula based largely on population (60 percent). The formula is designed to improve equity through the inclusion of weights for factors influencing the need for funding in different geographical locations. Currently, these factors are poverty (10 percent); health need, proxy by the under-five mortality rate (10 percent); and the size of the council, to reflect cost differentials, with higher land areas or lower population density resulting in higher costs of supervision, distribution of supplies *etc*. (20 percent). The allocation of the OC follows a broadly

similar formula adjusted by other factors identified by the Ministry of Finance and Planning.

With regard to salaries, health workers based in government health facilities, and some of those in faith-based organizations, are remunerated through monthly salaries which are a separate funding stream directly from MOF&P. For the government sector, this is based on nationally agreed pay scales, determined under the President Office – Reginal Administration, Local Governemnt, Civil Service and Good Governance(PO-RALGCSGG).

3.3.2 User-Fees and Waivers/Exemptions

In FY2010/11 user-fee revenue was reported to be TZS 10.1bn, which was about 1.1 percent of the total health budget in that year. Despite the relatively low contribution to the total resource envelope, it has repeatedly been argued that user-fees are an important source of revenue at the local level, assuring a minimum availability and quality of services and drugs.

The waiver and exemption policy was designed to provide relief for the poor and to facilitate health care seeking behavior for priority population groups and conditions. Under-fives, pregnant women and the elderly are exempted from payment, while exemptions also extend to treatment for diseases of public health importance such as tuberculosis. While exemptions, particularly for children and pregnant women, are largely respected, the implementation of the waiver scheme for the poor has failed most of those it was meant to protect. The process to obtain waivers are not always clearly outlined, criteria not always explicitly set or applied, and poor people find it difficult to make their case in front of health providers and relevant authorities. Moreover, given the nature of health services, there are no incentives for health facilities to offer the waiver/exemption because they know that people will pay for the services if they are charged, and no mechanisms exist for reimbursement of the resources expended. Based on estimates of the pro-poor option paper, it will cost the government about 48.7 billion Tanzania Shillings to pay for the current CHF premium of those individuals below the basic needs poverty line. However, these estimates do not capture the actual costs of services utilization among the poor in order to determine the maximum amount of resources required to fully recover costs.

3.3.3 Service Agreements

Where no equivalent public facility exists, LGAs may enter into a contract, known as a service agreement, with private service providers in order to deliver the priority health services. LGAs agree to pay the service provider per service provided. The price of a service is negotiated between the LGA and the provider. In exchange for the payment

from public funds, the provider offers the contracted services free to the patients. Financing for this arrangement currently comes from the LGA's HBF allocation.

Challenges

Resource allocation is hampered by a myriad of factors. One salient challenge is the ad hoc nature of the allocation of certain resources. Allocation of funds based on DP priorities further complicates the picture. There are delays in disbursement of government funds and health basket funds, due in part to challenges with reporting at all levels, and of CHF matching funds, due to relatively complex administrative requirements compared to staff capacity. Bottlenecks at the district as well as the national level prevent facilities from being adequately reimbursed for service delivery, particularly as regards CHF, exemption and waivers and service agreements. Furthermore, vulnerable groups are insufficiently taken care of by the current system. The CHF does not have a separation between the provider of services and the purchaser. Provide payment is largely input rather than output-based and there's potential for conflicting incentives in the multitude of payment systems used. Together, many of these factors give less incentive to improve efficiency and quality of service.

4 HF Strategy

4.1 Vision

Social Health Protection System that will enable all Tanzanians to access cost effective and affordable health care in time of need without financial barriers.

4.2 Mission

To enable equitable access to affordable and cost-effective quality care and financial protection in case of ill health, according to a nationally defined standard minimum benefit package.

4.3 Objectives

The objectives of the HF Strategy are to:

1. Develop a sound, responsive and adequate health financing legal and regulatory framework;
2. Move health financing reforms towards a mandatory National Health Insurance System;
3. Strengthen revenue collection/mobilization for the health sector;
4. Improve financial and risk pooling mechanisms within the health sector;
5. Develop a health financing system which is responsive to the needs of the poor, by ensure effective identification and inclusion mechanisms of the poor;
6. Ensure appropriate resources allocations and expenditures for health;
7. Continuously adapt and shape the purchasing structure within the health system, placing particular focus on results-based financing for improved services delivery;
8. Strengthen the overall public financial and resource data management systems within the health sector.

4.4 Guiding Principles and Values

Implementation of the Health Financing Strategy will adhere to the following principles:

- Equity

Contribution to health care financing is expected to be progressive whereby those with high income will contribute a relatively higher share of their income to fund health services compared to the poor. Similarly access to health care will be determined by the

needs of the people rather than income. This means that those with similar health care need will get same opportunity to access services.

- Solidarity

Resources collection and pooling will be organized in a harmonized way to make sure that those with higher income and good health conditions cross-subsidize those with less income and poor health conditions

- Transparency and Accountability

Good governance stands at the core of the survival of this financing strategy. Organization of collection, pooling and purchasing will be done in a transparency way making sure that beneficiaries get timely knowledge of what is happening in the NHIF. Responsible stakeholders will be held accountable for all decisions made in relation to collection, pooling and purchasing of health care services.

- Sustainability

Organization of fund collection, pooling and purchasing of health care services will be done in such a way the NHIF will survive for long term. The NHIF will keep on adjusting the level of benefit package according to the ability of the fund.

- Acceptability

Respecting cultural values and norms is an important aspect when it comes to access to health care. It is the objective of this strategy to make sure that cultural values are maintained by making sure that the arrangement of health care service provision respect what the communities have defined to be their standards. This involves being sensitive to opening hours of service provision, interactions between providers and people of different age groups and other societal norms.

- Efficiency and value for money.

The Health Financing Strategy is designed with the value of health as a Human Right in mind. It will be specifically geared towards providing financial protection to the population and will focus its efforts on the inclusion of the poor into the envisaged Social Health Protection System.

- Gender sensitivity

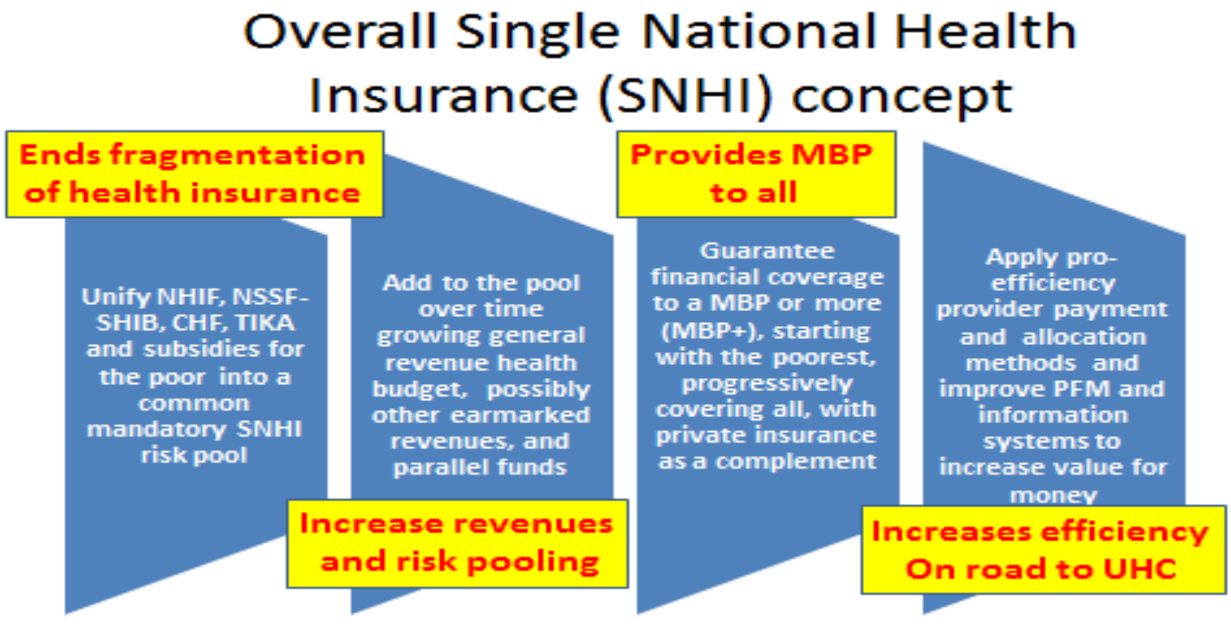
Gender equity stands at the core of this strategy. The strategy will make sure that it responds to the health needs of women and men within their socially accepted roles in society by distributing roles, responsibilities and power between the two groups in order to reduce inequalities that affect health and health seeking behavior.

5 Strategic Interventions

As part of reforming the health financing sector via a comprehensive social health protection system, Tanzania envisages an expansion and consolidation of existing social health insurance schemes into a new **mandatory National Health Insurance (NHIF).** NHIF will purchase a standard minimum benefit package (MBP) for all Tanzanian citizens through performance based financing mechanisms to increase quality outcomes in health services delivery. The new system will aim at reducing fragmentation in health sector resource pooling and increase the size of revenue collectively available to fund health services. It envisaged that the harmonization of health sector funding resources will help to improve efficiency in allocation and use of funds. Introduction of NHIF will not start from scratch but rather build on the current structures and realign with existing health financing interventions. Figure 5 below paints a picture of the overall NHIF concept or the Tanzanian road to UHC from 2015-2025.

The Health Financing Strategy is comprehensive in that it includes both individual health services in the NHIF MBP and population-based public health, education and capital investment programs. It also incorporates both public and private financing. Ten specific strategies are discussed in the following sections organized by governance and health financing functions of revenue collection, pooling and purchasing; HFS objective; specific strategy and strategic intervention.

Figure 5.1: Concept of the UHC development for Tanzania via the NHIF



5.1 Governance

5.1.1 Objective 1: Develop a sound, responsive and adequate health financing legal and regulatory framework.

Strategy 1: Establish NHIF Legal and Regulatory Framework

Strategic intervention: Develop and approve NHIF legal and regulatory framework

This Strategy aims at developing or adapting a clear and executable legal and regulatory framework such that it clarifies and streamlines the health financing policy landscape, ensures stakeholder participation, strengthens accountability, and provides clear direction for NHIF implementation. The legal and regulatory framework will ensure that the vision, values, guiding principles, goals and objectives outlined in HFS are reflected in relevant laws and regulations thus providing the needed legal and regulatory tools to implement, sustain and ensure the proper and transparent functioning of NHIF in Tanzania.

New Laws and Regulations

NHIF proposed in HFS will be mandatory, bringing all existing public and community health insurance together with the view of reducing fragmentation. An adequate legal and regulatory framework for mandatory NHIF will be developed. The legal framework will safeguard the mandatory membership nature of NHIF and protect a standard Minimum Benefit Package (MBP) that will be an entitlement of the entire population.

Development and approval of health insurance laws will move parallel with the review of other health insurance related laws, to complement the imposition of NHIF. The NHIF Act will include mandatory nature of NHIF; consolidation of existing social health insurance schemes; all institutional structure, roles and relationships; initial MBP specification; pooling and purchasing mechanisms, consumer participation, relationship to private insurance; and administrative cost. . The existing SHI laws and acts will have to be amended or annulled (e.g. NHIF Act, CHF Act, SHIB). Other existing laws and regulations relating to insurance, social security and service delivery will have to be reviewed, adapted or changed to suit the new system. As soon as the Strategy enters implementation and the mandatory NHIF is created, appropriate regulations will be put in place to guide its execution.

5.1.2 Objective 2: Establish institutional structure with clearly defined roles and responsibilities which reflects the voice of the community/user of the health system and moves the reforms towards mandatory NHIF.
Strategy 2: Establish and operate NHIF institutional structure, roles and relationships

Strategic intervention: Establish NHIF institutional structure, roles and relationships and develop NHIF purchaser operating capacity

Health Purchaser

NHIF will report to the Ministry of Health, Community Development, Gender, Elderly & Children (Figure 5). Clear functional specifications and roles will be assigned to all relevant entities, and mechanisms for transparent reporting and coordination established. Unified command is necessary to defragment the SHI governance landscape which is currently split among a number of Ministries (MHCGE&C, PORALG, MOF&P, Ministry of Labor etc.).
A clear purchaser-provider split will be introduced within the sector. The NHIF institution/purchaser will become the primary purchaser of health services for the MBP, while the LGAs and their dispensaries, health centers and district hospitals together with regional/referral/national hospitals, accredited for- and not-for-profit private facilities will be the providers. Health service delivery will be also enhanced through public-private partnerships.

NHIF purchaser establishment will be very important for reforming the Tanzanian health financing system. It will be the main institution in the country pooling financial resources and purchasing health care services through MBP for the entire population. NHIF Act will determine whether NHIF purchaser will be a new institution or a substantial evolution of an existing institution (e.g. NHIF). In either case, NHIF purchaser will be built on the foundation of existing systems and human resource capacity. A NHIF Supervisory Board will be established including consumer representatives with its exact representation and roles to be determined in the NHIF Act.

Following approval of NHIF Act, the institutional structure of NHIF purchaser will be established including national organizational structure, regional and district offices as necessary, infrastructure and staffing. Ongoing NHIF purchaser systems and human resources capacity development and ensuring performance and accountability will be a priority throughout HFS implementation. NHIF implementation experience and monitoring and evaluation results will be fed back into policy dialogue and continuous revision of legal and regulatory framework as necessary.

Private health insurance firms will operate in supplementary manner to the NHIF by covering benefits outside MBP. As the private health insurance industry develops, it is envisioned to establish by regulation that they will cover services outside the standard MBP that will be provided by the NHIF.

Parallel to this strategy the Social Security Regulatory Authority (SSRA) will be empowered to regulate all health insurance Schemes and ensure compliance of the NHIF and its single payer with the regulatory environment and thus operate efficiently and with client orientation.

Health Provider

Consistent with the purchaser-provider split, LGAs will focus on service provision and management. The LGAs will focus their engagement on investment in and supervision of health providers as the owners of public district and primary facilities, population-based and community-oriented public health, supervision and monitoring of health policy implementation, and advocacy on behalf of citizens.

Providers of health care in the Tanzanian environment will be given increased autonomy in the public system to allow them to allocate their resources more effectively and efficiently to purchase goods and services for the MBP including drugs. This will facilitate leveling the playing field and competition between public and private providers and thus enhance their quality of care. The creation of primary care networks is envisaged below council level, linking any community or outreach services and dispensaries under a specific health center for improved financial management and services delivery (Fuenzalida and Kuper 2013).

Stakeholder Engagement

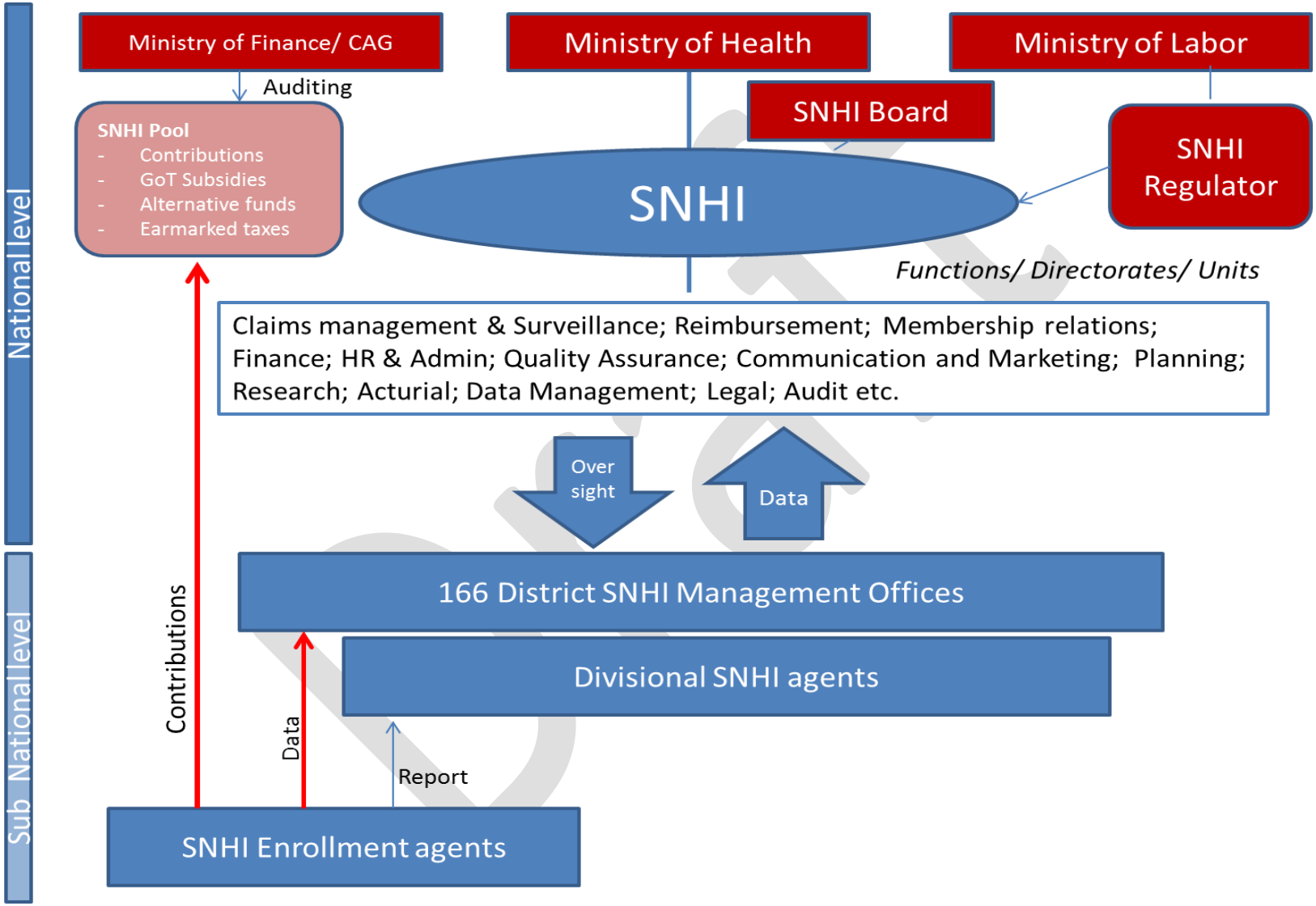
The essence of social solidarity is comprehensive and positive participation of all stakeholders necessary. It is important that this participation is driven from the users of the system. Involvement of the broader population will be fostered through ensuring opportunities for the community to periodically elect multi-sectoral representatives to the health facility governing bodies, and through the creation of structures for participation, linked to the formal sector. This strategy will ensure that health facility governing bodies are representative and multi-sectoral in nature, covering all age groups. These bodies will be involved in the identification of members, prioritization, planning and evaluation of NHIF and health services provided at the facilities, thereby ensuring responsiveness to needs of the user. They will also be involved in health facility management, including recruitment of staff and their evaluation.

Fora for continuously listening and responding to the views of users will be established. A variety of mechanisms will be used possibly including meetings between providers, purchasers and users; consumer associations; consumer complaint mechanisms; hotlines; opinion dropboxes; mobile phone mechanisms; and scorecards, These views will be used to strengthen or change MBP and services provided as needs arise. Specific mechanisms will be developed to ensure responsiveness to consumer complaints. Finally, accessible information will be provided to enable the user to make decisions to promote their own health and that of the environment in which they live, as well as regularly updated information on the NHIF and how it is managed.

Participation of users in setting contribution levels and means of payment will be ensured. Use of existing trusted social groups will be promoted in order to enhance premium collection. Community resources will also be mobilized for support with local infrastructure, both to assist with rehabilitation, and to foster sustainability and local ownership.

Political will is necessary at all levels for the NHIF to be acceptable and for it to thrive. In this context the political constituency will be fully involved at all levels to support NHIF. Politicians' power to influence opinion, allocate resources, and initiate new taxes will be productively directed to help establish and sustain NHIF. Capacity development will be provided for politicians at all levels to enable them to understand the need for social protection through NHIF as a means of attaining UHC, the linkages between catastrophic expenditures and impoverishment, and to support timely implementation of NHIF and the strategy as a whole. Similarly, education will be provided on the critical role that a healthy population plays in building a healthy economy, and the link with NHIF and social protection.

Figure 4.2: Proposed NHIF



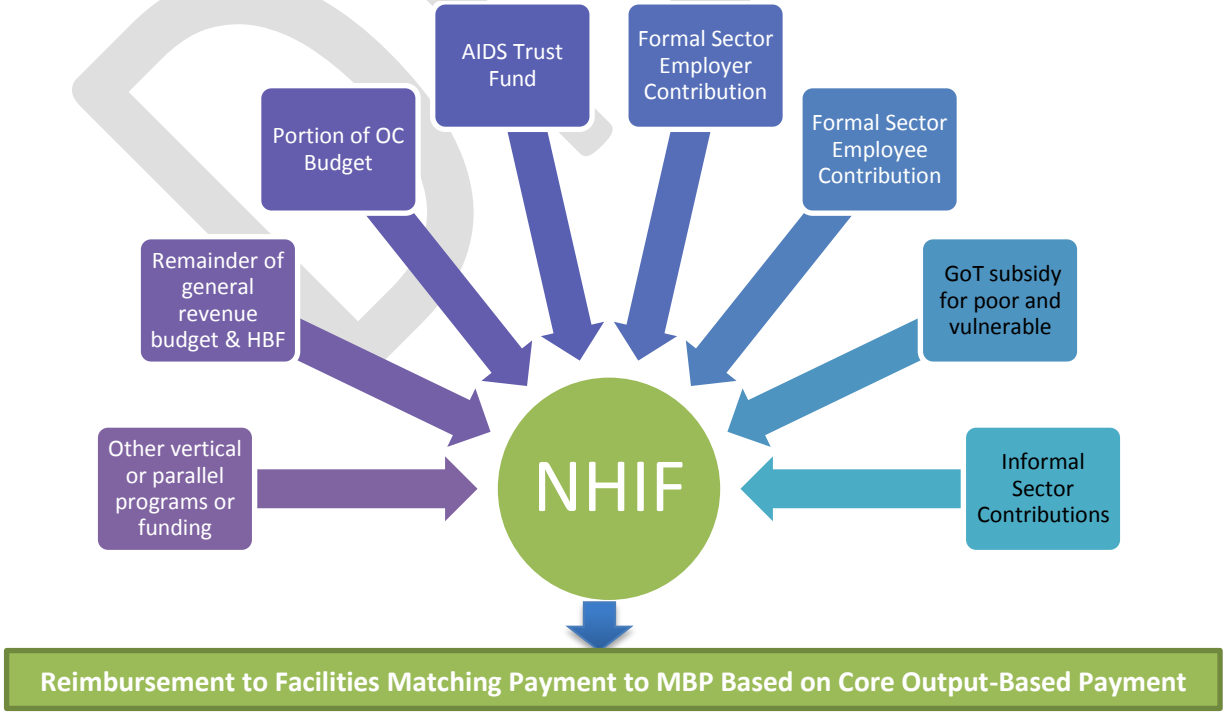
5.2 Revenue Collection

5.2.1 Objective 3: Strengthen Revenue Collection/Mobilization for the Health Sector Strategy 3: Increase Government and Private Contributions to the Health Sector

Strategic intervention: revenues for health

The revenue to pay for the NHIF will have to come from multiple sources in both the public and private sector. Current general government spending on health will have to be rechanneled and, in all likelihood, increased. LGA own-source revenues could also contribute. Government contributions and the matching civil servants' contributions to the NSSF SHIB will have to be rechanneled. Specific government levies might be earmarked for NHIF. The HIV/AIDS Trust Fund and other vertical programs funding could be folded into the NHIF revenue pool. Private contributions by employers and employees through NHIF will be rechanneled. Private contributions to TIKA and CHF will be rechanneled. Some users of services covered by the NHIF will be asked to make small co-payments.The investment earnings of NHIF could be contributed. Other private sources of contributions might be sought. External funds through the Health Basket Fund (HBF) could supplement the domestic resources that must make up the great bulk of the funding for the NHIF pool. Finally, the need for revenue for the pool could be made smaller by making the delivery of health services more efficient.

Figure 5.3: Proposed revenue flows into NHIF



Stakeholder assessment of domestic revenue possibilities

A qualitative assessment of domestic revenue possibilities and efficiency gains to fund the NHIF pool is shown in Table 5.1. The criteria employed in the assessment are: (1) political feasibility, (2) equity, (3) revenue potential, (4) incentive effects of the collection of the revenue, and (5) whether the source is existing or new to the health sector.

Table 5.1: Qualitative analysis of potential revenue sources (++= very positive /large, + = positive/large, - = negative, 0= no effect, ?= undetermined effect)

Source	Political feasibility	Equity implications	Revenue potential	Incentive effects	Existing/new source for health
Government sources					
General government budget	++	+	++	0	Existing
NSSF	++	+	+	0	Existing
LGA own-source revenues	-?	+	+	0	Existing
HIV/AIDS Trust Fund	+?	+	?	0	New
Earmarked taxes	?	+	+	?	New
Private sources					
NHIF employer and employee contributions	++	+	++	0	Existing
TIKA and CHF contributions	++	+	+	0	Existing
Investment revenues from insurance funds	++	+	+	0	New
User co-payments	+	-	+	-	Existing
Private contributions for start-up infrastructure	?	++	+	0	New
Corporate Social Responsibility contributions from sectors such as mining, gas, and tourism	+	++	+	0	New
Efficiency					
Efficiency gains	++	0	+	+	New

The qualitative analysis of the potential sources indicates that the political feasibility is highest for increased general government budget allocations, the rechanneling of both public and private insurance contributions, earnings from investments of insurance funds, and efficiency gains. The largest potential sources of funding are the general government budget, the NHIF insurance premium contributions, NSSF-SHIB Benefits and CHF/TIKA contribution rechanneling. User co-payments are the only source with a negative equity implication and the expected size of the revenue generated from this source is small.

Although their political feasibility is unknown, the following possibilities for earmarked taxes or levies were identified:

- Sin taxes on alcohol and tobacco
- Mobile communication/ airtime levy
- Surplus of public corporations

Many countries decide to raise these additional levies, for example, **sin tax on alcohol and cigarettes** were levied in the Philippines of which 85% went to the health sector, earmarked specifically to promote universal health care access by supporting the national health insurance system (PhilHealth). The health budget was thus increased by USD 657 million from USD 1.2 billion to USD 1.9 billion of which USD 793 million were used to pay PhilHealth premiums. It was estimated to generate USD 6 billion over 5 years and thus lower OOP health expenditures.

The Republic of Korea National Health Promotion Act (1995) foresaw its National Health Promotion Fund to be funded by dedicated tax of USD 0.15 per pack (as of 2005). 33% of funds support health promotion activities this way (health education and anti-smoking campaigns), the remainder is allocated to the National Health Insurance Corporation (NHIC) and to administrative costs.

Nepal implemented special earmarked taxes for health in 1993 (25% of excise tax must be allocated to a health tax fund used for cancer treatment, tobacco control and health education), but due to experience of administrative difficulties in handling the earmark, incorporated it into excise tax in 2003.

Ghana implemented a 2.5% of **VAT** contributions go into National Health Insurance which in 2009 accounted for 60% funding of the National Health Insurance Authority (NHIA). Here the advantages are that funds are expected to grow as formal labor market expands and as effect reduces the size of premium payments from enrollees. On the other hand it has to be noted that even with the VAT funds the NHIA faces financial sustainability challenges. Ghana also introduced a **communication services tax** in

2008 consisting of a 2.5% National Health Insurance levy on mobile phones which was later replaced with a tax on airtime, texting, data, (e.g. USD 0.01 per minute of talk time) to address tax evasion on mobile phone imports. The funds were earmarked to youth unemployment and demonstrated revenue generation potential of a small levy on high frequency transactions. However, this was considered by observers a politically expedient method for increasing tax revenue.

Increase public revenue

The government commitment of more domestic resources will help to meet health services delivery needs among a growing population in a sustainable manner. The cost of health services is rising and can be expected to continue to rise due to increased population, rising costs, and the double burden of communicable and non-communicable diseases, among other factors. The NHIF will ensure that all Tanzanians have access to the standard MBP that now is not the case, so the cost of reaching that objective is higher than current spending. The NHIF will put in place mechanisms to ensure greater equity of access to health services, increased efficiency in the use of health resources, and increase the productive capacity of the population (human capital) by reducing lost labor. The cumulative effect will be to obtain greater value for the money allocated to health. The health sector, like other sectors, expects to benefit from current economic growth and ongoing reforms to strengthen the efficiency of the tax administration system that will expand overall government resources.

While not mobilizing new resources, the need for revenue can be decreased through **efficiency gains** including but not limited to the following:

- Better targeted health care services, effective gate-keeping mechanisms, enforcement of referral mechanisms, and other priority service delivery improvements
- Improved human resource distribution (MTR report 2013) and management
- Productivity gains from a variety of mechanisms (e.g. RBF)
- Implementation of effective and harmonized data management systems (especially related to resources management)
- Lower administrative costs and other efficiency increases especially related to fixed costs and infrastructure
- Enhancing Public Financial Management (PFM) including ensure that full health allocations are spent and per capita allocations of resources across LGAs are improved, improve transfer of funds from central to district level, improve the disbursement of funds by eliminating complicating disbursement procedures, and clarify who is accountable at all levels.

- Increased external aid coordination (e.g. resource tracking, bringing DP funding increasingly on budget).

The Fiscal Space Study analysis of 2013 suggests that if Tanzania puts emphasis on improving efficiency to 82% of international standard in its county peer group by 2015, it could close the fiscal gap in the health sector by 10%.

Private health insurance and strategic public-private partnerships

The strategy envisions enabling and facilitating private health insurance development to fund benefits outside of the standard MBP. In addition, strategic public-private partners will be initiated or expanded. Exemplary public-private partnerships include but are not limited to the following:

- Fostering strategic public-private partnerships in areas such as sharing of diagnostic equipment, supporting tuition fees for prospective students, use of digital and mobile technology, media and communications, and contracting of non-clinical services.
- Fostering collaboration across public and private providers to improve skills, technology, and knowledge
- Private role in training HRH
- Possible role of private pharmaceutical wholesalers as an alternative or competitor to MSD to address the issue of drug and supply availability that is an important source of consumer dissatisfaction. Also leveling the playing field by addressing questions such as whether private providers should/could have access to the lower prices for pharmaceuticals purchased by MSD to help the providers keep their costs down.
- How to stimulate greater participation of the banking sector in health through the provision of credit for: (1) students looking to fund their training to become HRH, (2) providers of services looking to establish or expand services, or (3) those looking to establish new or expand existing pre-service training institutions for HRH.

Strategy 4: Make Health Insurance Mandatory to All

“Reducing the reliance on direct, out-of-pocket payments will lower the financial barriers to access and reduce the impoverishing impact of health payments”.Countries which have made the most progress on access and financial protection objectives have implemented successfully mandated contributions for people who can afford to pay through taxation, and/or compulsory earmarked contributions for health insurance” (WHO-Health Financing for UHC, 2014)

Strategic intervention: enroll every Tanzanian resident into the NHIF

Membership of the NHIF will be mandatory for all Tanzanian residents. All residents will contribute or receive subsidies to contribute meaning no opting out of NHIF. Based on the principle of shared contributions, for those in employment the employer contribution through payroll tax will not be less than that of the employee. For those identified as being without the means to pay a contribution, the NHIF premium will be fully or partially subsidized by Government and cross-subsidies within the single insurance pool.

In line with the purchaser-provider split, the mechanism for ensuring informal sector contributions to the NHIF will be established on the NHIF purchaser side rather than the provider side or outside the LGA/council health delivery system. In order to ensure that everyone is contributing to the scheme, different contribution mechanisms will be used (involving village governments and communities) taking seasonal income into consideration. Beginning to prepare for realignment and transition of CHF into NHIF is an activity that can begin early in NHIF preparation to contribute to visible impact and seamlessly moving to full NHIF implementation (see Section 7 Implementation Plan). Based on international experience, informal sector premiums are notoriously challenging to collect and NHIF may make future system adjustments after the poor are covered. Regular actuarial studies will form the basis for setting and reviewing contribution levels and they will be incorporated into regulation.

5.3 Pooling of Funds

5.3.1 Objective 4: Improve financial and risk pooling mechanisms within the health sector

Strategy 5: Create one National Financial and Risk Pool for Health

"Organizing compulsory prepaid revenues in fewer pools enables more redistribution than the same level of total funds organized in many fragmented pools. Increasing the level and share of revenues channeled through prepaid and pooled mechanisms, reducing fragmentation to increase the redistribution capacity of the pooled funds, and using the pooled funds to cover the health care costs for those in need, are key elements of the broad strategy that countries need to rely on in order to move towards universal coverage." (WHO 2014)

Strategic intervention: Decrease the fragmentation of risk pools

NHIF envisions the creation of a single risk pool merging NHIF, CHF, NSSF-SHIB, GoT subsidies for the poor, general revenue health budget, parallel funding flows and other funds into the NHIF pool purchasing MBP for the entire population.– The single risk pool for MBP will increase the redistributive capacity of prepaid funds and align different

revenue sources to enhance cross-subsidization across beneficiaries with different risks and socio-economic status. It will reduce insurance risk and increase efficiency associated with economies of scale and reduction of duplicative or excess costs inherent in fragmented risk pools.

At the start of implementation when NHIF becomes fully operational, at least NHIF, CHF, NSSF-SHIB, and GoT subsidies for the poor will be pooled in the single risk pool for purchasing the MBP. The importance of risk pooling and cross-subsidization of the poor is such a critical block of the NHIF foundation that including GoT subsidies for the poor in the pool at the start is a pre-condition for moving towards UHC. Some general revenue health budget or Health Basket Funds, earmarked taxes, and parallel funding flows may be pooled as well. Over time, remaining health budget funds including Health Basket Funds, any additional earmarked taxes, selected parallel funding flows, and other funds will be transferred into the NHIF single risk pool for the MBP. This will include part or all of certain external funding flows which are intended to support disease-specific interventions and/or commodities which fall within the MBP (e.g. Global Fund). In the long-term, PE budget of health workers may also be pooled to increase equity and productivity and equate public and private provider payment rates.

A basic assumption of the HFS overall strategic intervention and NHIF is that pooling and purchasing arrangements will differ for MBP and non-MBP services. Funding for non-MBP services will not be pooled in NHIF. LGAs will continue to fund population-based public health services and capital investments to improve the health delivery system structure (vitally important particularly at the dispensary and health center level to increase consumer demand for these cost-effective services). LGAs can also contribute to subsidies for the poor. The differential poverty rates and thus revenue-raising potential of LGAs may necessitate development of an equalization mechanism to ensure that those LGAs with a higher proportion of fully-subsidized poor NHIF beneficiaries are not unduly penalized financially. Cross-subsidization is expected both at the level of the individual and geographic area. Mechanisms will need to be developed to pool or otherwise encompass in NHIF any LGA subsidies for the poor.

5.3.2 Objective 5: Develop a health financing system which is responsive to the needs of the poor, by ensuring effective identification and inclusion mechanisms of the poor

Strategy 6: Guarantee Health Insurance Coverage for the Poor and Vulnerable

Strategic Intervention: adapt TASAF system to identifying the poor in the health sector

UHC inherently implies (eventual) coverage of the entire population, and Tanzanian health policies and strategies emphasis inclusion of the poor and most vulnerable, in terms of ability to pay and health need. Strategy 6 will ensure the poor are accurately and appropriately identified to obtain the GoT subsidies for the poor in Strategy 2 and pool them using the mechanisms established in Strategy 5.

International and country evidence on identification of the poor suggests that a combination of methods is desirable, specifically combining geographical targeting, community identification, and some form of proxy means testing (PMT) in order to have some national benchmarking (Stoermer et al 2013). This approach is cross-sectoral, and is currently being used by the Tanzanian Social Action Fund (TASAF) for the purposes of identifying beneficiaries of conditional cash transfers (CCT) (targeted at 1 million poor households).

At the start identification and inclusion of the poor will prioritize the 16% and then over time move to identify 28.2 basic needs poor. The target population of the very poor for the purpose of full government subsidy of health costs currently differs from that for CCTs, and will depend both on political priorities and budget constraints. The 28.2 percent of the population defined as “basic needs” poor according to the 2012 Household Budget Survey will be fully subsidized by Government (including all the “food poor”). These will be identified using the combination of methods outlined above, in particular the PMT. This will require extending the TASAF approach to a larger segment of the population. To speed up the process of identification, additional agencies/ organizations will be required to undertake this exercise, and it may be necessary to simplify the PMT instrument to reduce costs and facilitate wider application (TBD). As stated in Strategy 5 pooling of funds strategic intervention, LGAs can contribute own source revenues to the NHIF pool to support the subsidies of very poor members identified in this strategic intervention.

5.4 Health Care Purchasing

There are two elements of health care purchasing – what to purchase or the benefit package and how to purchase or provider payment systems. Strategy 7 is MBP and Strategy 8 is provider payment systems.

5.4.1 Objective 6: Ensure appropriate resource allocation and expenditures for health

Strategy 7: Establishment of a Standard Minimum Benefit Package

No country in the world, including Tanzania, can provide health services to meet all the possible needs of the population. For this reason, countries have to select which services to provide, and many have taken the approach of defining a minimum package of services that can sustainably be funded based on the available resource envelope. The standard MBP is intended to be a guaranteed minimum for all. Because the MBP generally identifies cost-effective interventions, it increases value for money – for a given level of health spending, the impact on health status should improve.

Strategic intervention: implementing the MBP

A, simple, clear, affordable and portable standard Minimum Benefit Package (MBP) is clearly defined to serve as a legal entitlement to the whole population. In the short-medium-term there will be two types of MBP, standard MBP and MBP plus which is currently covered under NHIF. The intention of this strategy is to first provide standard MBP to all Tanzanian citizens and then over time move standard MBP to MBP plus for all Tanzanian citizens. Specification of MBP will evolve through NHIF implementation but it will initially be established based on levels of care.

The standard MBP which will be accessible to everyone will include all individualized preventive and curative services at dispensary, health center district hospital and regional Hospital. It will exclude public health services such as water and sanitation programs and education and promotion campaigns. Access to regional Hospital and district hospital will be granted upon receipt of referral letter from dispensary or health center. Where members of NHIF walk-in to the district hospital without referral letter the person will bear full cost of health services provided. Enforcing referral system is crucial for the sustainability of the NHIF especially at the initial years of its introduction where we expected high increase in utilization of formal health care. However, the main challenge in enforcing referral system is availability of services at primary facilities (dispensaries and health centers). Without effective availability of services members will continue to bypass to higher level and the objective of financial protection will not be guaranteed as many NHIF members will be paying out-of-pocket. This HFS has been written under the assumption that the focus on strengthened primary healthcare services delivery will remain during the strategic period. Further with initiatives such as the Result Based Financing (RBF) it is expected that quality of services in primary facilities will be improved and the challenge of drug availability will be resolved, hence reducing unnecessary needs of bypassing to higher level facilities. And also over time

efficiency gains from utilization at lower and more cost-effective levels of care can be used to extend coverage.

Public and accredited private facilities will be contracted to provide the standard MBP for NHIF members. In areas where there will be no public primary facility, special arrangements will be made to ensure that there is an accredited private facility within that area in order to guarantee availability of care to everybody in need. The NHIF card will be portable across all contracted providers within Tanzania.

MBP plus will include in addition to what is provided under standard MBP, access to regional referral, zonal referral and national hospital as is currently covered under NHIF. It is not the intention of the NHIF to reduce the size of health care benefit package that is currently consumed by the members of the NHIF. Such members together with employees in the formal non-public sectors will be accessing the current NHIF package (referred to as MBP plus) but this package will be ‘”frozen” until the time when the NHIF is sustainable enough to raise the standard MBP up to the MBP plus level equivalent to the current NHIF package. Again, the long-term goal is to ensure that every NHIF member has access to the level of benefit package that is currently provided by the NHIF. And this is the long term definition of the NHIF MBP. Individuals who are currently not employed in the formal sector but would wish to enjoy MBP plus straight away can do so upon contributing additional premium top-up to standard premium contribution rates.

As regards public health interventions (e.g. for water, sanitation, and health education and promotion activities) and capital investments, it is envisioned that purchasing of these services will be outside the MBP and continue to be both financed and managed directly by the LGAs. Corresponding national public health interventions (e.g. surveillance), health professions education and capital investment will also remain outside of the individual health services MBP and continue to be financed and managed by the Government.

5.4.2 Objective 7: Continuously adapt and shape the purchasing structure within the health system, placing particular focus on results-based financing for improved services delivery

Strategy 8: Allocate Health Sector Resources Strategically

Strategic intervention: develop effective provider payment methods throughout the country integrated performance structures

“All countries can look to improve efficiency by taking a more strategic approach when allocating resources to providers and services by linking such decisions, in whole or in

part, to information on either/both the health needs of the population and the performance (cost and quality) of the providers. Reducing fragmentation in the pooling of funds but also in the purchasing of health services can reduce the administrative costs of the system while also enabling creation of a coherent incentive environment aimed at steering health service providers towards greater efficiency".

Efficiency gains and high quality health services will not be obtained if there are conflicting financial incentives in different types of provider payment systems purchasing the MBP. MHCGEC and NHIF will develop a unified provider payment framework stating clearly how different types of provider payment systems will align to purchase MBP services. Specifically, it will include how line item budget payment system, core output-based payment systems, and results-based financing (RBF) are aligned and leverage each other to purchase MBP, obtain efficiency gains and improve performance and quality. Alignment of existing provider payment systems can be started before NHIF is fully operational to prepare for seamless transition to NHIF, use RBF as a driver of realignment and the shift to output-based payment, and produce visible impact (See Section 7 Implementation),

Payment of providers

NHIF envisions a gradual shift from input-based to output-based provider payment systems purchasing the MBP. A combination of provider payment systems is envisaged under the new NHIF, combining some form of capitation payment blending some elements of RBF at the PHC facility level (dispensaries and health centers) and case-based or fee-for-service at district hospital and above. Payments will be made by the NHIF directly to the facility responsible for providing services. It is anticipated that some degree of autonomy will be introduced at all levels of health care provision in order to allow flexibility of facilities in determining the best mix of resources to provide services and spending their own resources for health care quality improvement, especially in primary level facilities. Flexibility will be important, and the agreed provider payment system must be flexible enough to incentivize good performance and dis-incentivize inappropriate care. Lessons will be learned from other countries, and a reference group established for the unified provider payment framework and regular review of the appropriateness of provider payment systems.

A RBF mechanism is currently being rolled-out nationwide. The RBF concept is closely aligned with the approach of NHIF in terms of payment for results or outputs and in seeking to empower providers to be more responsive to users by providing quality care efficiently. Initially, Tanzania's RBF may run ahead of and also drive realignment toward NHIF purchasing for MBP but in the long run many, if not all, of the outputs that RBF pays for are likely to be purchased by the NHIF through integration or close linkage between RBF and PHC capitation payment system. NHIF will learn lessons from the

RBF experience as it selects services within the MBP for which to make incentive payments to health providers in order to stimulate increased utilization so that national targets are reached.

The incentivized service range at dispensary and health center level will cover both essential maternal, newborn, and child health services for which uptake remains relatively low, and also general outpatient attendance, screening for hypertension and diabetes, and priority interventions for malaria, tuberculosis and HIV & AIDS, among others. Priority services for RBF will be subject to regular review and will evolve as NHIF develops to ensure they are targeted at gaps in services and performance. The level of financial incentives for a given output will vary geographically, according to factors such as poverty levels and remoteness, in order to provide additional incentives for health workers to work in currently under-served areas. Certain minimum conditions will be met for a health facility to participate in RBF, thereby ensuring general improvement in effective access and quality (e.g. placement of minimum qualified staff, clean water, basic equipment). The use of mainstream HMIS indicators, establishment of independent verification mechanisms, and harmonization with ongoing quality improvement initiatives are expected to strengthen the overall monitoring, supervisory and management systems.

Improve public resource allocation and expenditures

The move towards NHIF as the primary mechanism for funding individual health services will reduce the flow of Other Charges (OC) funding through Councils and Regional Administrations as funds will be re-channeled as output-based payment directly to health providers for MBP services. Some input-based payment will remain in the short- to medium-term for management and operations offered by CHMTs and RHMTs, though with an increasing share of such funding being channeled according to outputs and performance.

The role and structure of existing allocation formulae for non-salary recurrent funding of LGAs (specifically through the Health Basket Fund and the government OC block grant) will be reviewed in order to better support the revised context. Consultation with MOF and PMO-RALG will be necessary to align with the broader context of inter-governmental transfers where appropriate, while the health sector specific reforms will necessitate a particular approach. In particular, continuous adjustment will be required as population coverage with NHIF expands, and as preventive services not initially included in the MBP are incorporated. Some form of formula will continue to be required at least at the LGA/CHMT level to cover non-individual services such as public health interventions, supervision and monitoring and at the RHMT level also for management and support to LGAs.

Effective UHC requires access to qualified health workers throughout the country. Mechanisms for rapidly improving the distribution of health personnel both between and within districts will be developed in consultation with MOF, PMO-RALG, PO-PSM and LGAs, building on the existing pay and incentive strategies, and successful local initiatives. LGA own funding sources could be used for human resource incentives to attract and retain health workers in underserved areas. In addition, the potential for future channeling of PE funding through the RBF pool, and ultimately through the NHIF pool, will be explored with PO-PSM. This is necessary in order to reduce fragmentation of funding, improve health worker productivity, reduce conflicting incentives, obtain efficiency gains, and to level the playing field between different providers of the NHIF benefit packages.

5.4.3 Objective 8: Strengthen the overall public financial and resource data management systems within the health sector

Strategy 9: Strengthen the public financial management system in the Health Sector

Sound public financial management (PFM) is an important component of any health financing system. Resources need to be well managed and efficiency and value for money are priorities. The focus of PFM within the context of Tanzania's health financing strategy is to ensure that resources are both mobilized and spent efficiently and cost-effectively to maximize the provision of quality health services.

Strategic Intervention: improve the current PFM system

The NHIF will need strong financial management staff, systems and procedures in order to successfully manage the identification and collection of revenue from multiple sources, manage multiple provider contracts and output-based provider payment systems through its regional network, and to make payments down to the facility level including payments related to activity and, potentially, performance. In addition, accounting systems, financial reporting, internal controls and internal and external audit will need to be realigned and strengthened to ensure good and transparent management. This will require a degree of integration between financial and non-financial information, and improved accuracy and reliability in both sets of data.

Providers will need to implement effective billing systems to ensure receipt of all funds due, and to improve the arrangements and systems for financial management of those funds possibly through use of provider networks that enable cost effective management and oversight. Policies, procedures and systems will need to be developed to give effect to the envisaged provider autonomy in expenditure management whilst ensuring compliance with existing legislation and PFM rules and procedures. Providers will also

need to strengthen their forecasting capability to model expected future funding flows, patient demand and resource requirements.

Strategy 10: Develop a Strong Health Information and Data Management System

Strategic Intervention: Improve use of information for evidence-based policy

Development of a interlinked data management system for NHIF

In order to ensure evidence-based policy making the NHIF data management system will have to be linked to the health management information systems (HMIS). The linking process will input into the HMIS features of the NHIF data management and information systems and possibly vice versa as well as strengthening linkages between the two over time. The users of the NHIF data management system will need training to be able to use it effectively. Special attention will be given to building capacity at lower level health facilities. A high priority will be enhancing use of information for implementation, monitoring and system refinement. Resource tracking systems (e.g. PER, NHA) will also need to be improved and used in monitoring, forecasting, and ongoing policy dialogue and system refinement.

Link vital national databases to the NHIF

Linkage of key national databases to that of the NHIF is intended to encourage those who have not joined the system to join it, as receiving certain services will become conditional on being a member of the system. Important national databases that should be linked to NHIF include NIDA, RITA and Tanzania Revenue Authority. In the rural areas, where these databases are not very commonly used, enrolment in school databases will be an alternative.

Solid social health insurance database

A solid social health insurance database is an invaluable strategic input for the scheme's performance. This is a critical input in the day to day management of the scheme. Such database will show client behavior, premium conformity, provider needs, quality aspects and areas which need attention to sustain the scheme.

MoHSW will take lead responsibility for analyzing, consolidating and distributing financial and performance reporting for the sector. As steward of the entire health sector, the MoHSW uses the NHIF databases to provider financial report datasets, to ensure overall monitoring of health policy implementation and value for money, to develop nationally set provider tariffs, and to inform further policy development. Clear and transparent reporting of resource use will be critical to enabling the health sector to

demonstrate value for money and to ensure that any additional resources can be most effectively and efficiently targeted.

PMO-RALG, Regional Administrative Secretariats, and LGAs will also require access to appropriate NHIF data sets, in order to monitor implementation of health policy in the regions/ districts, and to assist in identification and management of service delivery risks. In particular it is anticipated that RASs will need strengthened financial management capacity dedicated to the health sector.

Regular supportive research

Evidence-based policies are best derived from daily practice and observations. In this context information generated from supportive research is an important strategy for the NHIF to implement required refinements and perform better. Such research will investigate reasons for population joining rates and drop-out coverage of the poor and satisfaction with services. Supportive research strategy will also investigate extent of risk pooling, effectiveness of provider payment systems, provider performance, ability to pay premiums, extent of desired service delivery improvements especially at the PHC level, and conformity to essential drugs lists. Other important issues to study include equity, social inclusion, organizational performance, actuarial aspects, and alternative sources of complementary funds.

As part of open governance partnership policy the MoHSW to the extent possible and consistent with privacy and confidentiality considerations, will make accessible and publicly available data on the performance of the NHIF so that: (1) operational research and analysis may be performed using it to help generate insights on how the system performs and as a part of the accountability for use of public resources and the achievement of results and (2) civil society organizations can use performance data to hold the NHIF system accountable and advocate for change when desired.

6 Health Financing Strategy Implementation

The HFS is actually realized in practice through the activities defined in its implementation plan. HFS implementation plan is described in the following sections.

6.1 Implementation Strategy and Sequencing

Key to HFS implementation success is an implementation strategy that creates dynamic action driving implementation and helps to ensure the many and varied tasks meld into a cohesive and functioning NHIF system. In addition, implementation will be sequenced clearly by breaking down the task of NHIF implementation into simple and realistic steps. The steps will be ordered in a way that makes each next step inevitable and enables implementation to progress seamlessly.

NHIF is a new and large government program. It will require significant time to develop and approve NHIF legal and regulatory framework and establish and operationalize institutional structure, roles and relationships. In Strategies 1 and 2, it is planned that NHIF Act and receive stakeholder validation in Year 1, discussed and approved by Parliament in Year 2, NHIF institutional structure including purchaser-provider split established in Year 3, and NHIF fully operational in Year 4. This is a realistic timeframe but the importance of producing visible impact relatively quickly is also recognized.

The HFS implementation strategy portrayed in Figure 6.1 represents a two-pronged approach to realizing the HFS. One prong called establish NHIF path proceeds to accomplish NHIF and institutional set-up as described above and in the Implementation Plan. The second prong called the visible impact path focuses on realigning and further developing existing health financing programs, systems and processes to the greatest extent possible immediately after the HFS is approved in order to best prepare for NHIF and produce visible impact in the shortest time possible. The two prongs or paths come together to deepen NHIF in Year 4 when it becomes fully operational. At this point, the visible impact path will have positioned Tanzania to seamlessly and inevitably enter full NHIF operation. NHIF implementation will quickly pick up operations in Years 5-10 on the road to UHC as the systems and capacity foundation has been laid and is already beginning to show visible impact.

Achieving relatively short-term NHIF visible impact is generally envisioned as reducing financial barriers for the poor to access priority services at dispensary level. Current implementation of results-based financing (RBF) can play a key role in driving the visible impact path. Its contribution to visible impact as envisioned above and demonstration of the shift from input-based to output-based provider payment systems is critical to NHIF implementation and ensuring that government funding is better targeted in the future towards the standard MBP for all Tanzanian citizens. MoHSW will

develop short-term plans to realign, build the foundation and produce early visible impact in NHIF implementation with exemplary activities including:

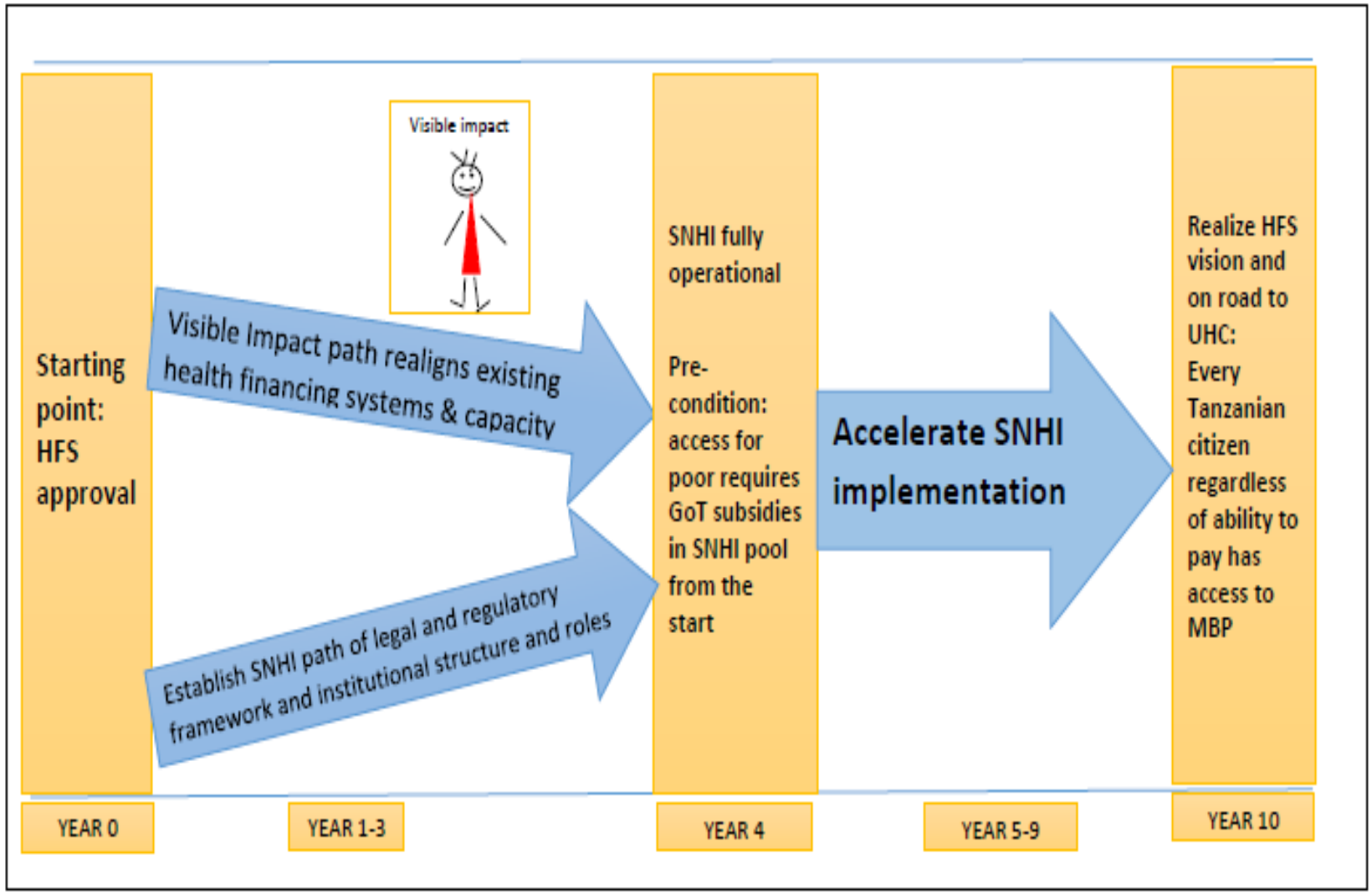
- Re-formulate CHF by-laws to accommodate making CHF membership compulsory when the NHIF is implemented, contributions, MBP and payment reforms in preparation for NHIF
- Learn lessons from regions with higher CHF membership and disseminate those lessons to other lower-membership regions to help increase membership before NHIF is implemented
- Phased integration of NHIF, NSSF, and CHF structures in selected LGAs
- Build systems and human capacity in existing institutions (e.g. NHIF) that can be transferred to new or evolved institutional structure when NHIF becomes fully operational
- Finalize specification of MBP and help ensure that all facilities are prepared to be able to deliver it
- Begin to identify the poor to be 100% subsidized under NHIF throughout the country before NHIF implementation; the identification will be performed using the adapted TASAF proxy means test so that these populations are clearly identified at the time of NHIF launch
- Position RBF and Performance Star Rating as a driver of NHIF preparation and full operation. Early adoption of RBF by regions or LGAs. Per the unified purchasing framework discussed in Strategy 7, begin to integrate RBF and establish linkages between RBF, PHC capitation, health budget other charges (OCs), and Health Basket Fund (HBF).
- Design or refine output-based provider payment systems. Review regularly whether the PHC capitated rate payment system can be refined to improve payment adjustments such as for age and sex and remote rural areas. Also review fee-for-service for hospitals be used or should a more bundled output-based hospital payment system such as case-based or DRGs be implemented to control costs, improve MBP production and provider management? Selected Regions/LGAs beginning to implement new provider payment methods ahead of full implementation including assistance to build systems and capacity to do so.
- Develop plans for PFM changes needed to move to full NHIF operation
- Further develop and link information systems enabling NHIF operation and producing the information needed to manage, monitor, evaluate and refine NHIF.
- Pursue public-private partnerships that would help to efficiently develop MBP services, such as the sharing of diagnostic equipment

In summary, it is expected that this overall implementation strategy and sequencing and the dynamics it will establish will enable productive realization of the detailed HFS Implementation Plan described below.

6.2 Implementation Plan

The purpose of this Health Financing Strategy document is to outline “WHAT” strategic interventions will be realized to strengthen the health financing system of the country. The accompanying HFS Implementation Plan focuses more on the “HOW” in the context of the dynamic implementation strategy and sequencing portrayed above. Implementation aspects do not feature in detail in the Strategy document as they are prone to evolve according to environmental and political changes, together with challenges and experiences collected along the way. Nevertheless, the HFS Implementation Plan describes in more detail the planned activities, processes and mechanisms that will ensure the vision, goals and objectives of this Strategy are met. The accompanying HFS Implementation Plan tables prioritize and sequence planned interventions including matching objectives and strategies/targets to detailed activities, timeframe, indicators, roles and responsibilities of each involved institution, and resources needed to realize the envisaged plan (see attached Implementation Plan tables).

Figure 6.1: HFS Implementation Strategy and Sequencing



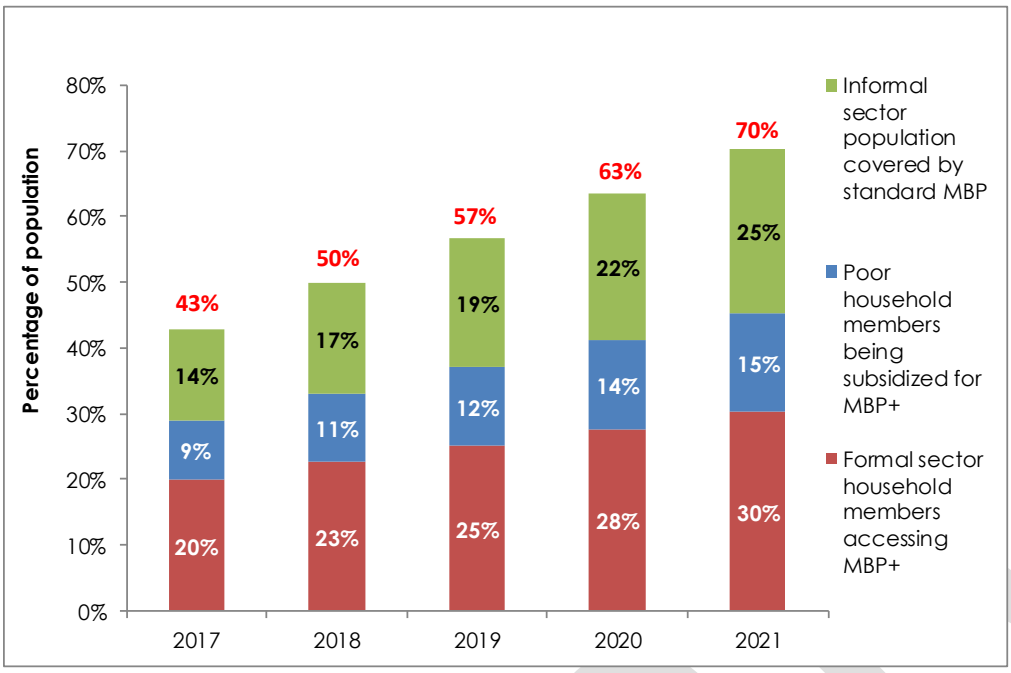
7 HFS Costing and Fiscal Space

The long-term feasibility of the NHIF will depend on ability to pool sufficient funds across sources as discussed in section 5.2 to finance the provision of the MBP and MBP+ for different groups of citizens. Provision of services must be at a desirable level of quality and accompanied by system strengthening to ensure availability of inputs and the continuation of incentives for efficiency and performance. A sustainable NHIF would reduce the burden of out-of-pocket payments for the poor and generate greater equity in how healthcare is financed at all levels. Assessment of sustainability requires comparing the projected cost of delivering the MBP or MBP+, as per the current HFS Implementation Plan, with the possible size of resources that can be pooled for NHIF. Cost analysis for the HFS, given a purchasing mechanism, will require detailed actuarial analysis at a future date. Efficiency gains should also be regularly quantified and monitored.

7.1 Methods and Key Assumptions

The central assumption used for costing is the scale-up path for NHIF coverage, deriving from the Implementation Plan and the overall vision and mission of the HFS. Figure 7.1 shows the five year scale-up path, assuming a start to the NHIF from year 2016. Assumptions on scale-up in the subsidized population follow section 5.3, while scale-up in the informal sector is assumed, with first year equivalent to current CHF/TIKA coverage. The formal sector covered is as per the Integrated Labor Force Survey (ILFS) 2014 estimate of the size of the formal employed sector, plus the families. The growth path for formal sector employment was estimated using recent surveys, including the Employment and Earnings Surveys (2012, 2013, and 2014) and the ILFS. With mandatory enrolment in the formal sector, a growing contributory base for the NHIF is expected. Assuming the NHIF can begin operations in FY 2017/18, an optimistic scale-up pathway could lead to 70 percent coverage of the population in five years, i.e., by the end of the FY 2020/21. This capitalizes on the approaches discussed for identifying and targeting the poor and vulnerable, and innovative mechanisms, including enrolment agents, to attract informal sector participants who can contribute premiums.

Figure 7.1 NHIF rollout as per HFS implementation plan by fiscal year



As per the HFS, we assume all people access the standard MBP except the formal sector participants who access the current NHIF package in frozen form as the MBP+. An alternative scenario was also modeled where the poor and vulnerable access the MBP+, for discussion. For cost purposes, the definition of the MBP follows the principles outlined in section 5.4, and includes individualized preventive and curative services up to inpatient care at the regional hospital level, with an emphasis on primary ambulatory care accessed at the dispensary and health center. Services include reproductive, maternal, neonatal, and child health services, including complete immunization and obstetric care, malaria treatment, injuries/burns, minor surgeries, and certain non-communicable disease interventions such as outpatient diabetes care. The effect of the referral system is assumed, reducing the proportion of outpatient care at higher levels over the analysis period. The MBP+ includes services up to the national referral hospital level, and adds higher complexity inpatient and outpatient care, including cancer care, and surgeries. The benchmark for the MBP+ is the package accessible to NHIF members.

Unit cost data were sourced from the 2012 costing study for the National Essential Package of Health Interventions, and current utilization data from the Tanzanian national HMIS were used alongside population-level studies of per capita outpatient and inpatient care utilization. Two unit cost scenarios were analyzed for the standard MBP and MBP+, which relate to a higher or lower package of included services and the likely cost structure of provider facilities. The MBP+ will likely be provided by public, FBO/NGO, and private facilities, while for the standard MBP, private facilities will not be

included in the initial stage of the NHIF. It was assumed that the outpatient costs for the MBP and MBP+ will be purchased on a capitation basis, while the inpatient costs are purchased based on alignment with current or best practice purchasing mechanisms. For the MBP+, current NHIF practices for purchasing hospital-level inpatient care, including all non-ambulatory surgeries and procedures were expected to continue in the initial phase till later harmonization towards a unified purchasing model. For the MBP, different models were reviewed, including existing systems used for the "Improved CHF" (iCHF) pilots in Kilimanjaro region. In the end, for this analysis, pending future revision, hospital-based inpatient care was modeled as being reimbursed using bundled or package pricing payments. In this context, unit costs were summarized to groups of conditions (five for outpatient and four case types for inpatient). Administrative costs of the NHIF were subtracted from contributions as a proportion, declining from 15% in the first year to 10% by the last year. For the revenue projections, we analyzed several scenarios across the potential sources from section 5.2. These are discussed in further detail below.

Contributory scheme

Final premium rates will be set after comprehensive consultations. For this analysis, we assumed that informal sector participants contribute an annual premium of TZS 180,000 per annum per household in the urban areas and TZS 60,000 per annum per household in rural areas, which are close to rates being proposed under CHF reform in the short term. Formal sector participants will continue to contribute 6 percent of income as under current NHIF provisions, shared equally with their employer. This average about 85,190 per beneficiary per year based on FY 2014/15 data.

Other sources

As discussed in section 5.2, several existing sources across GoT and on-budget support can be pooled for the NHIF to supplement the contributions from individuals and households. Additional resources are required in order to provide for the subsidy, to cover the cost of purchasing the MBP and MBP+, and to increase NHIF coverage over time. As NHIF coverage increases (Figure 7.1), proportionately greater resources should be pooled to ensure the NHIF can be financially sustainable. At the lower end of the fiscal space, pooling of GoT domestic development vote funds, and LGA own source funds would be only be on the basis of the proportion of the population being subsidized for NHIF. The rest would not be pooled for NHIF. A similar principle was applied to the HBF. It was also assumed that in this scenario, GOT PE (salary) and other recurrent funds would not be pooled. Also, it was assumed that on-budget vertical disease program funds and off-budget development partner funds were not pooled. At the higher end of the fiscal space, a scenario not shown below, the proportion of government and other resources considered would be the entire population covered by

the NHIF, GOT recurrent sources would be available, and the on- and off-budget vertical disease programs and other bilateral donors would also participate in the pool.

In addition to these sources, innovative financing, mostly based on proportions of existing taxes, were considered. The allocation to health and the size of this source is shown in Table 7.1.

Table 7.1 Innovative sources of financing that can be pooled for NHIF

Source	**Allocation to health sector**	**Size of potential resource for NHIF** (based on FY 2014/15 data)
"Sin taxes" - Alcohol and tobacco excise and VAT	33%*	TZS 209 bn. ~ **0.248**% of GDP

* Based on allocation to health from sin taxes in South Korea. Source: HPP analysis.

A macroeconomic model was constructed in order to implement the fiscal space calculations, including assumptions on increasing GoT domestic funding for health across votes and with current contributions from all external sources on- and off-budget (based on a survey of partners in March 2016). Based on current trends as well as expert opinion, we also projected flows from such development partners for the health sector including all on-budget and off-budget sources for which data were available. These assumptions involve modest declines in the HBF (from FY 2017), as well as projected allocations from certain bilateral partners, etc.

7.2 Results

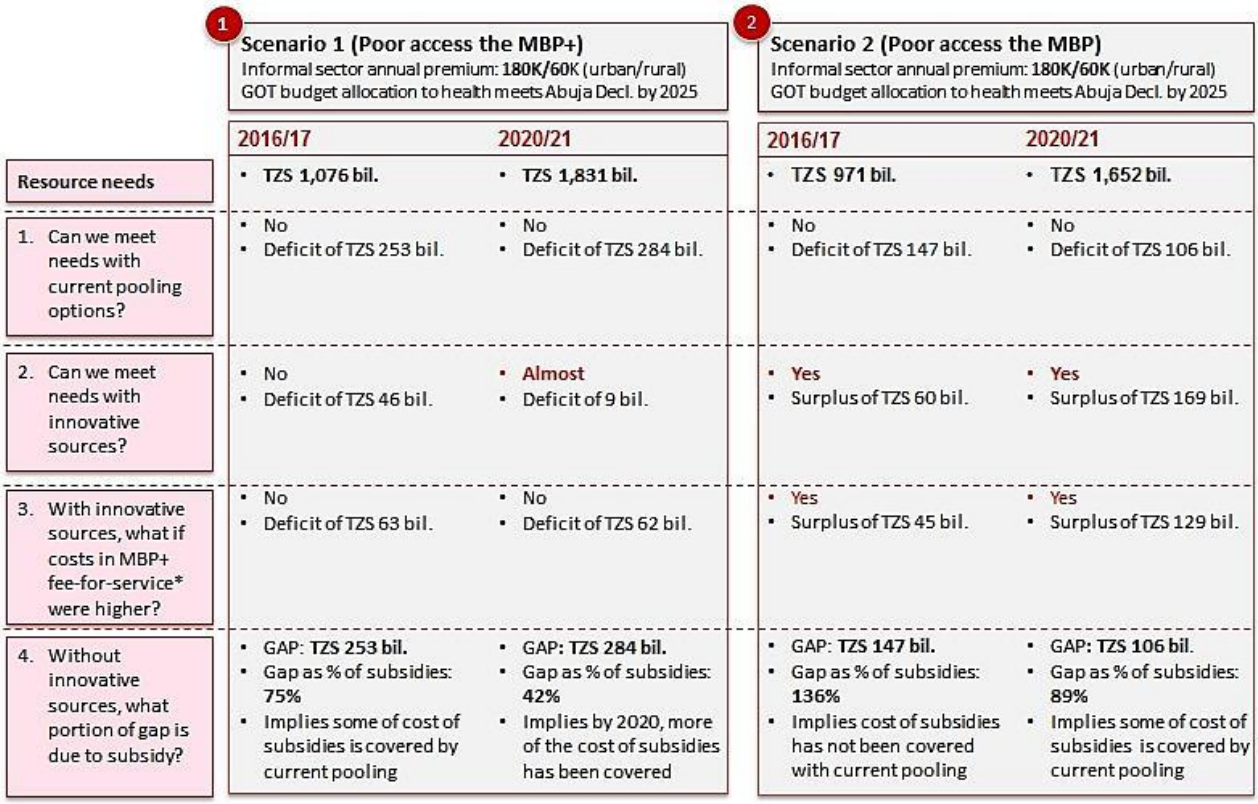
Total NHIF coverage as per the assumptions rises from 33 percent in the first year to 80 percent by the fifth year. Results of fiscal space scenarios are shown in Figure 7.2. The analysis supporting this figure suggests that the subsidized provision of the MBP to the poor and vulnerable, scaling up to reach the 15 percent of the population, a substantial proportion of the group that are basic needs poor, could be fiscally sustainable by 2020/21 with the innovative financing option (pooling of an earmark related to sin taxes). Deficits accumulated in prior years could potentially be eliminated with some additional contribution from the GOT, e.g., from its recurrent budget that was not pooled in the analysis at the start. A substantial portion of the subsidies for the poor are covered through existing sources (i.e., not innovative financing) within the pool: 58% by 2020/21, which suggests a strong element of cross-subsidy.

Table 7.2 Value of subsidies for the poor: the poor access the MBP+ (2012 TZS billions)

2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
335	411	494	584	685

* Based on NHIF coverage scale-up. Value of foregone contribution from the poor is valued at levels for the formal sector. Source: HPP analysis.

Figure 7.2 Summary of cost and fiscal space analyses

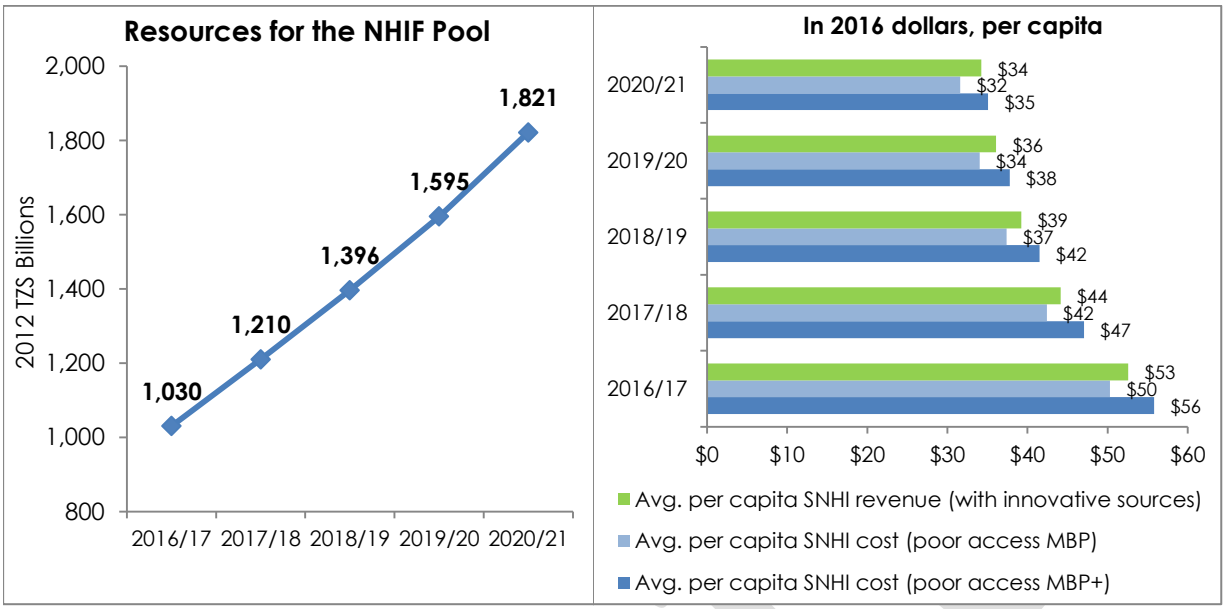


	1 Scenario 1 (Poor access the MBP+) Informal sector annual premium: 180K/60K (urban/rural) GOT budget allocation to health meets Abuja Decl. by 2025		2 Scenario 2 (Poor access the MBP) Informal sector annual premium: 180K/60K (urban/rural) GOT budget allocation to health meets Abuja Decl. by 2025	
	2016/17	2020/21	2016/17	2020/21
Resource needs	• TZS 1,076 bil.	• TZS 1,831 bil.	• TZS 971 bil.	• TZS 1,652 bil.
1. Can we meet needs with current pooling options?	• No • Deficit of TZS 253 bil.	• No • Deficit of TZS 284 bil.	• No • Deficit of TZS 147 bil.	• No • Deficit of TZS 106 bil.
2. Can we meet needs with innovative sources?	• No • Deficit of TZS 46 bil.	• Almost • Deficit of 9 bil.	• Yes • Surplus of TZS 60 bil.	• Yes • Surplus of TZS 169 bil.
3. With innovative sources, what if costs in MBP+ fee-for-service* were higher?	• No • Deficit of TZS 63 bil.	• No • Deficit of TZS 62 bil.	• Yes • Surplus of TZS 45 bil.	• Yes • Surplus of TZS 129 bil.
4. Without innovative sources, what portion of gap is due to subsidy?	• GAP: TZS 253 bil. • Gap as % of subsidies: 75% • Implies some of cost of subsidies is covered by current pooling	• GAP: TZS 284 bil. • Gap as % of subsidies: 42% • Implies by 2020, more of the cost of subsidies has been covered	• GAP: TZS 147 bil. • Gap as % of subsidies: 136% • Implies cost of subsidies has not been covered with current pooling	• GAP: TZS 106 bil. • Gap as % of subsidies: 89% • Implies some of cost of subsidies is covered by current pooling

Source: HPP analysis (2016). * Scenario 1: subsidies for the poor and vulnerable are valued at the premium rate collected from the formal sector. Scenario 2: valued at the rate for the informal sector.

Average annual per capita costs of the NHIF for the scenario where the poor access the MBP+ increase from US$35 to $56 (2016 dollars) over the period, as more people access the MBP+. In the same period, average revenue per capita increases from US$34 in the first year to US$53 in the final year (Figure 7.3). This suggests that as analyzed, increase in revenue is leading towards greater fiscal sustainability in the long-term, especially with increased formalization of the labor force and increases in GOT contributions to the health sector, a portion of which is pooled. It also suggests that initially, greater contributions will be required to meet NHIF costs, including administrative for the payor, before the system achieves overall fiscal stability. Other aspects of actuarial sustainability were also examined.

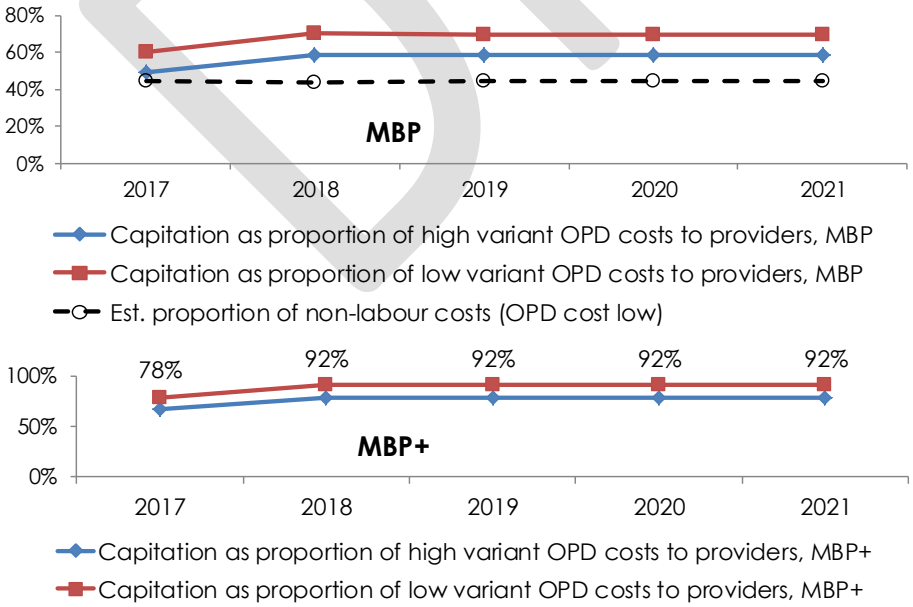
Figure 7.3 Costs and revenue for the NHIF Pool: Scenarios



Source: HPP analysis (2016).

Based on analyzing the OPD capitation reimbursements through the provider payment mechanisms assumed for the NHIF against the underlying cost structure in real Tanzanian shillings, provision of the MBP also appears actuarially sustainable for non-labor costs, given that personal emoluments (PE) will still be covered through existing GOT flows via LGAs. The MBP+, which is provided through a mix of public and private facilities covers full costs, though there is still an incentive for efficiency.

Figure 7.4 Actuarial sustainability, provider perspective



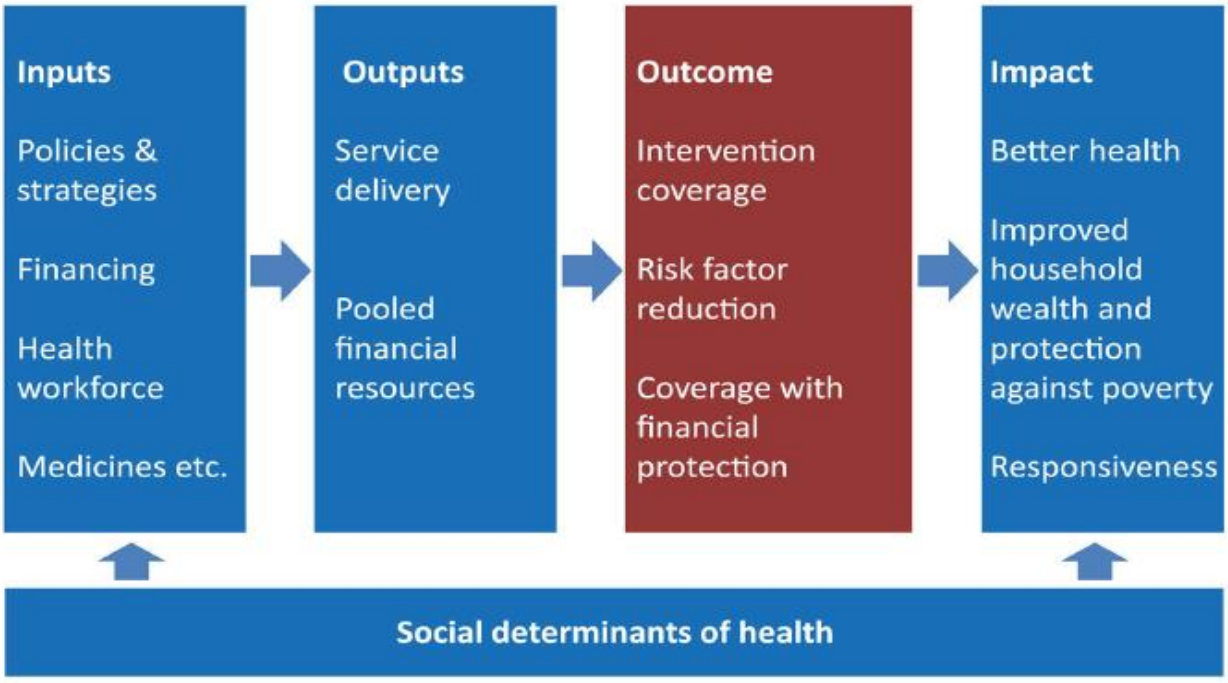
Source: HPP analysis (2016). Note that for MBP+, admissions & procedures are fee-for-service.

8 Results Framework: Priority Interventions, Results and Indicators

8.1 Health Financing Strategy Monitoring Structure

The overall monitoring structure is based on the Universal Health Coverage results chain framework shown in Figure 8.2 which closely reflects the Tanzania Health Financing Strategy. The Health Financing Strategy goal is to enable equitable access to affordable and cost-effective quality care and financial protection in case of ill health, according to nationally defined standard minimum benefits package. The achievement of this goal is supported by eight objectives. Each objective has one or two strategies and corresponding targets for a total of ten strategies and targets. The overarching HFS monitoring structure is shown in Figure 8.1. Furthermore, under each strategy there is a set of activities and activity indicators. The HFS Implementation Plan table has columns for both activity level indicators and strategy level indicators/targets that will be monitored throughout HFS implementation.

Figure 8.1 Universal Health Coverage Results Chain Framework



8.2 Outcome and Impact Indicators and Targets

Based on the HFS goal, a set of outcome and impact indicators and their targets have been developed to allow the Government and stakeholders to monitor and evaluate HFS success. The indicators, rationale, source, baseline and targets of these outcome and impact indicators are shown in Table 8.1 below.

Table 8.1: Outcome and Impact Indicators and Targets

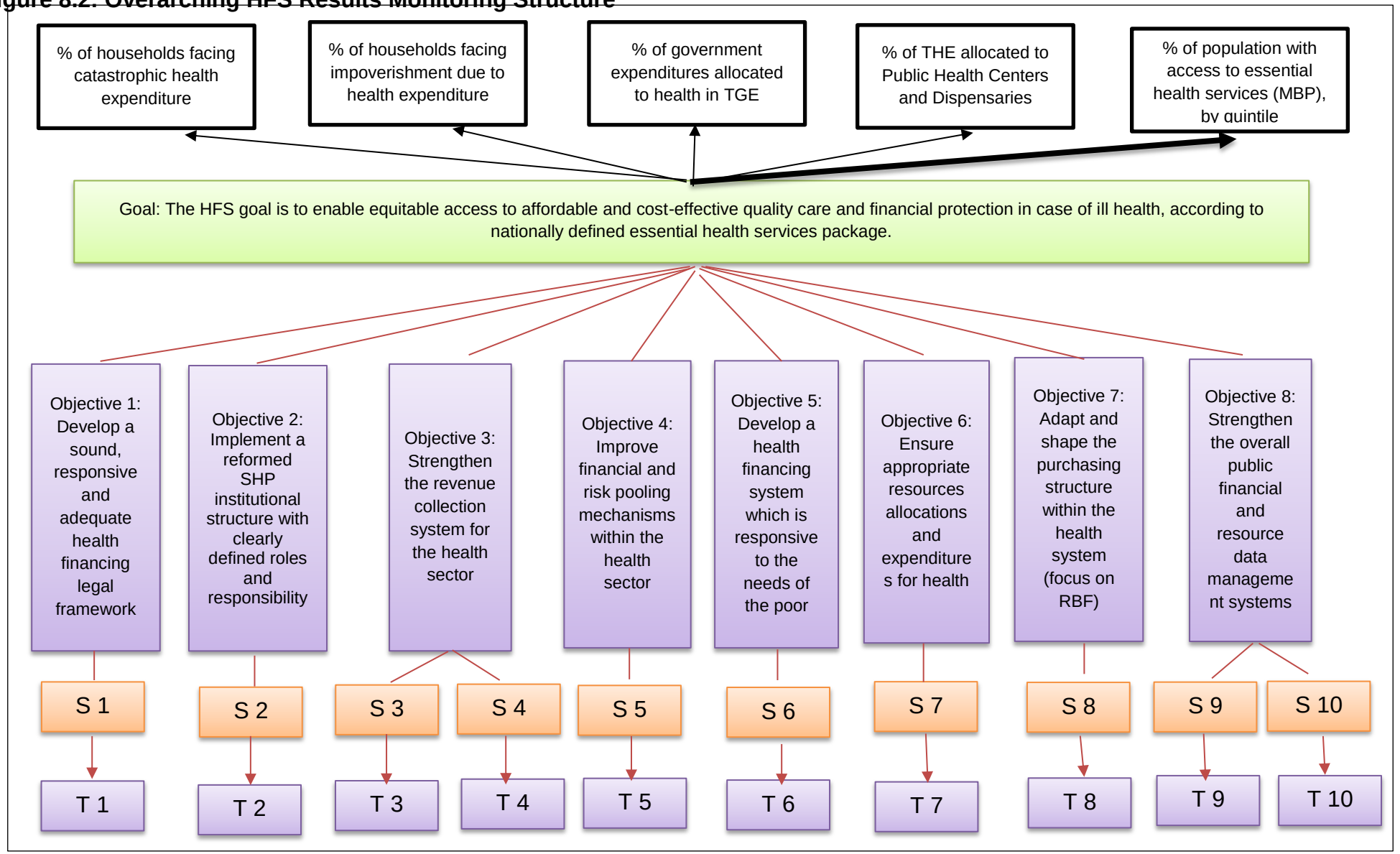
Indicator	Why we need it?	Source	Baseline	Target
1. Percentage of households facing impoverishment due to health expenditure	One of the key UHC indicators, shows financial protection - Impact	HBS	1.0%	0.0%
2. Percentage of households facing catastrophic health expenditure	One of the key UHC indicators, shows financial protection - Impact	HBS	2.0%	0.0%
3. Percentage of government expenditures allocated to health in total government expenditures	Indicates Gov commitment to health.	NHA	6.5%	13.0%
4. Expenditures on Public Health Centers and Dispensaries as a percentage of total health expenditures	Indicates allocative efficiency: strengthening primary/lower level care	NHA	18.1%	30.0%
5. Outpatient visits by quintile (disaggregated by public and private providers)	Indicates equity in coverage	HFS		
6. Proportion of population that has access to essential health services as outlined in standard MBP, by quintile (and also disaggregated by public and private providers)	Indicates equity in coverage by MBP	HBS	0.0%	50.0%

8.3 Evaluation Plan

HFS evaluation is expected to have two types of processes. The first process is done to ensure that key stakeholders and policy-makers can assess the "visible impact" as quickly as possible. It would allow examining policy relevant issues within a relatively short period of time at relatively low cost. It could be done using Participatory Rural Appraisal (PRA) methods based on three tiers: 1) beneficiaries; 2) health providers; and (3) LGAs. One of the questions suggested for such a study even before the start of the NHIF was: What are the factors that promote high enrollment in CHF among the well performing LGAs as compared to those that are lagging behind? This would allow other LGAs to learn and inform the enrollment process and campaign when the NHIF starts. Other questions closely related to shorter-term realignment and start-up will also be elaborated when HFS implementation begins.

A more rigorous evaluation study that will look at causal relationship and provide stronger evidence of the impact of the reforms envisioned in the HFS will also be conducted. The primary questions that will be explored are: Has the NHIF improved removed financial barriers and increased access to services among the poor? Has the NHIF improved access to health services among those working in the informal sector? Has NHIF improved financial risk protection for the entire population of Tanzania? Has efficiency been increased? Has health service utilization changed and are there differences among those insured as compared those uninsured in the health service utilization? What is NHIF impact on service delivery and quality of care at facility level, including drug availability? Has consumer satisfaction increased and related system responsiveness measures? The evaluation study will be designed when HFS implementation begins.

Figure 8.2: Overarching HFS Results Monitoring Structure



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