Presentation on UHC/ SHP to Stakeholders in Tanzania

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1. **Opening remarks by Deputy Minister MoHSW, Dr Stephen Kebwe:**
   - UHC high on global agenda (WHA, WHR 2010)
   - Developments towards promoting UHC started already in 1961 in Tanzania with its policy on free health care services until 1991
   - Since 1993 introduction of cost sharing policy, with exemption and waver mechanisms for the poor
   - 2012 started the development of long term HF strategy started with creation of the Inter-ministerial Steering Committee to further pursue UHC for Tanzania in line with the global health agenda to avoid detrimental expenditures at the point of accessing health care
   - HSS approach, while ensuring access to HS also ensure adequate supplies, essential medicines, HRH are in place
   - 2014 goal of employing approx 11.000 health staff and enrolling 7000 students annually into health training institutions
   - Good governance stressed as pertinent, a need to focus on accountability on results, with special efforts on governance of CHSB and HFGC

2. **David Evans on HFin and UHC**

1- Definition of UHC, *see presentation*

- UHC as umbrella goal for health sectors post 2015 (suggested by WHO) - UHC as constant journey in an ever changing environment (e.g. increasing demand for NCD – as "epidemic of the new world" where interventions in those areas will become increasingly relevant, changing population structures, urbanization, new technologies and medicines etc.)
- Expansion of the WHO cube (see presentation – services offered, population covered, financial protection) not just through financing but also through mutual service delivery expansion/ improvement

2- Three dimensions of HF: Fund generation / who pays what, pooling of risk and resources / purchasing incl. efficiency and equity concerns

- THE tripled over the last 10 yrs in SSA in line with GDP increases, proportion of OOP fallen a little but actual OOP has gone up per capita (as effect of economic growth)

➔ domestic economic growth (more money available!) should be driver for new resources to health

➔ largely there are still insufficient resources for health: 50-100 USD per capita are required to attain health MDGs, most SSA spend below 50USD per capita, TZ 43USD p.c.

➔ sustainable: health too protected? ODA in general going down, but not health... what does it mean for Tanzania?

-> per capita in Tanzania around usd 41 in 2012, 7% Of GDP, below 3% in GEGDP

. From GE 5% plus of GDP protection of poor possible – no income country has achieved this yet.

- how to argue for more money to health? -> showing results and efficiency will be increasingly important to convince own governments as well as external funders.

- hot issues on pooling: role of CHI, how to cover informal sector, how to minimize fragmentation (linked to efficiency) – best practices show that micro-insurances with small risk pools not they way to reach UHC effectively.
- How best cover the informal sector and who pays and who is subsidized, how to protect the near poor are important questions to tackle
- Purchasing hot issues:
    - common forms of inefficiencies are known, getting the political balance in improving efficiency complicated (More health for money, more money for better health)
    - RBF in this context important tool , as focuses on results (here however attention needs to be placed on the monitoring and verification of results)

3- Governance

- Important when developing HFS to be aware what legal frameworks are in place: analysis crucial to understand how to incentivize the system and the potential limits that exit to implementation

4- Measurement of Progress

- UHC progress CAN be measured: as far as to which level the goals of the "cube" have been reached, outcome of population coverage, services depths, financial protection achieved.

5- MDG post 2015: UHC 100% by 2030 goal suggested by WHO to be measured in two dimensions:

- health intervention coverage: to be measures with basic health indicators (FP, Skilled birth attendance, ART, ITN coverage...)
- financial risk protection coverage: how to capture the impoverished population ? proportion OOP
- (for more information see WHO paper online)

6- Discussion Q/A

- what and how to measure? only coverage? (no, they could be following up on MDG impact indicators too, but might have to be of inter-sectoral nature to capture action items), note: currently two parallel UN processes, i.e. the high level panel and the open WG
- Health expenditure, allocative efficiency in HRH: how about PE which is up to 70%?
- no value for money in the health sector? dilemma
- fungibility of donor aid – allocations away from health
- capture most-pressing health challenges, e.g. road traffic accidents, urbanization, urban slums health, violence...; change line item budget to achieve "make the money follow the patient"
- Increase expenditure in health, how about the negative impact this might have on other sectors, e.g. education which also has benefits for health - currently no answer to this
- economic growth sees fragmentation of insurance companies, what is the role of Government
- indicator setting, how to deal with regional differences? every country to track according to their disease burden
- population dynamics and growth: facture into the debate, contextualize (movement, age structure), equity?
- universal access versus universal coverage, how about the link to poverty and its dimensions (see article in the WHO bulletin)

- What are the big problems over the next 20-30 years that countries want/need to address? national/regional perspective
    - understanding patterns and what will work to address them
    - dynamics of health will shift!
    - intersectoral link (land use, access to water, nutrition, refugee, migration), multisectoral nature, (do we navel gaze?) more integration is required, what is our contribution as the health sector
    - UHC goal post MDG what does it mean for us, approach and direction to move in health!? new approaches / vision required (focus on the poor versus health for ALL)