AN ASSESSMENT OF THE HEALTH FINANCING SYSTEM IN TANZANIA

REPORT ON SHIELD WORK PACKAGE 1

Gemini Mtei[1], Jo Mulligan[3], Mariam Ally[2], Natasha Palmer[3], Anne Mills[3]

[1] Ifakara Health Research and Development Centre; [2] Ministry of Health and Social Welfare, Tanzania; [3] London School of Hygiene and Tropical Medicine

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Acronyms

AGO	Accountant General's Office
AIDS	Acquired Immune Deficiency Syndrome
CBHF	Community Based Health Financing
CCM	Chama Cha Mapinduzi Party
CFS	Consolidated Fund Services
CHF	Community Health Fund
CHSB	Council Health Services Board
CUF	Civic United Front
ESRF	Economic and Social Research Foundation
GDP	Gross Domestic Product
GTZ	Germany Technical Assistance
HIV	Human Immune Virus
HSF	Health Service Fund
LAPF	Local Authorities Provident Fund
MHIS	Micro Health Insurance Schemes
MOF	Ministry of Finance
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MPEE	Ministry of Planning, Economy and Empowerment
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NHP	National Health Policy
NPES	National Poverty Eradication Strategy
NSGRP	National Strategy for Growth and Reduction of Poverty
NSSF	National Social Security Fund
OOP	Out-of-pocket expenditures
PER	Public Expenditure Reviews
PMORALG	Prime Minister's Office – Regional and Local Government
PSPF	Public Servants Pension Fund
RAWG	Research and Analysis Working Group
REPOA	Research on Poverty Alleviation
SHIB	Social Health Insurance Benefit
TDHS	Tanzania Demographic and Health Surveys
TFDA	Tanzanian Food and Drugs Agency
TIKA	Tiba Kwa Kadi
TNCHF	Tanzania Network of Community Health Funds
TRA	Tanzania Revenue Authority
URT	United Republic of Tanzania
WDC	Ward Development Committee
WHC	Ward Health Committee

Executive Summary

The overall aim of the SHIELD project is to identify and evaluate alternative approaches to health insurance in three African countries (Ghana, Tanzania and South Africa) as a mechanism for addressing health system equity challenges. This project hopes to make a key contribution to the understanding of health insurance mechanisms in promoting health system equity and addressing the needs of vulnerable groups.

This report presents the findings from Work Package 1 in Tanzania. The aim of this work package is to provide a critical evaluation of the current health system, document existing health financing initiatives and map the flows of funds within the current arrangements of the financing system. The objective is to identify existing inequities and the main factors driving these inequities in such initiatives. The evaluation involved an extensive document review (including Government reports, policy and regulatory documents, statistical releases and household survey data sets, annual reports of relevant organisations in the health system, academic and related research findings whether published in peer-reviewed publications or grey literature). The intention was to identify and quantify funding flows, together with the key equity, sustainability and related challenges in the health system and to identify key issues of relevance to financing and benefit incidence in Tanzania.

Background

Tanzania introduced cost sharing policy in early 1990's with the introduction of user fees in 1993. The scope of commercial health insurance is very limited and there is a growing experience of community-based pre-payment schemes. In particular, Tanzania is known for its Community Health Fund (CHF) schemes, the first of which was introduced in 1996. Tanzania has also decided to develop a mandatory health insurance system. The first phase, initiated in mid-2001, made it compulsory for all public servants to become a member of the National Health Insurance Fund (NHIF). The NHIF is funded by a 6% payroll contribution, split evenly between the employer and employee, and covers the public servant, spouse and up to 4 other dependants. Benefits include inpatient and outpatient care up to a predetermined maximum amount, generic medicines on the Essential Drug List and basic diagnostic tests. It is envisaged that mandatory health insurance will be extended to formal sector employees in the private sector, via health insurance contributions to the National

Social Security Fund (NSSF), in the next phase. The main policy objectives of the NHIF (and NSSF) are to establish a reliable method of enabling formal sector employees to contribute towards their own health and that of their families, and to institute a permanent and reliable system for the provision of health services to this group. It also intends to improve the accessibility and quality of health services by introducing competition among the full range of public and private health care providers.

Findings

Our review found that, the level of out-of-pocket payments is high compared to other sources of health care financing. Households contribute about 47 percent into health care financing through out-of-pocket-expenditures, while the level of public (government) financing is small and the rate of its increase is still very low. It is estimated that, the level of public financing (including government budget and donors support) account for about 43% whereby the distribution between the two is approximately half-half. Total public health financing as a percentage of total public financing is approximately 10% which is still below the Abuja target of 15%. The per capita public health financing is approximately 9 USD.

Enrolment in voluntary prepayment schemes for the informal sector, such as the Community Health Fund (CHF), remains one the biggest challenges for Tanzania. Some councils are struggling with enrolment rates of less than 2%. Various factors have contributed to low enrolment including perceived poor service provision in public facilities, poverty in rural settlements and limited package of benefit and access to referral facilities. Efforts are now made to motivate councils to establish and strengthen CHF, since this is seen as a better alternative of reaching the large number of people and ensure universal coverage.

A wide regulatory framework for the health sector in Tanzania has been established ranging from health sector human resources, service provision and health care financing. Public financing initiatives are well guided by various acts accompanying their establishment. However there are notable weaknesses in the regulation of the informal health care financing schemes since the majority have been established from various society initiatives but with no proper monitoring or coordination. In addition, there is no a specific regulation that governs for profit health insurance apart from the general insurance act which regulates all kinds of insurance businesses in Tanzania.

From the analysis, various equity challenges can be cited. Although much efforts have been made to sensitise individuals on the role of pre-payment in health care financing and at the same time many prepayment mechanism are already in place, the current arrangements favour those who are employed in the formal sector. Comparing those who covered by NHIF or NSSF with those who are covered with the CHF, it is clear that those in formal schemes have wider range of choice in treatment and they are assured of income to access better care. In addition, formal schemes are well equipped financially, demonstrated by the fact that they are able to provide more a comprehensive health care package.

There is currently only limited scope for cross-subsidization between financing schemes in Tanzania. Cross-subsidisation is only evident within the formal schemes themselves. Members of NHIF and NSSF cross-subsidize in the lump-sum final contribution between those with higher income and those with low income, although all contribute the same proportion of income as premium. However, very little cross-subsidisation exists within the CHF since all members pay the same contribution and the degree of income differential is very minimal since the scheme is mainly in rural settings. In addition, poor CHF members are not cross-subsidised by the formal employees in NHIF and NSSF since these are totally different financing arrangements.

User fees payment in public facilities has an adverse effect to the poor. Although user fees guidelines make provision for the poor to be identified and waived from paying user fees, implementation of the policy has been weak. Communities are not identifying the poor and the process of waiver is cumbersome.

On access to health care, much effort has been in place to ensure that as many people as possible are close to health facilities. This has been a success with respect to access of primary facilities, since a large number of the population now live within 5kms from a dispensary or health centre. However, more effort is needed on hospital allocation, given that there is substantial variation between rural and urban areas. The latter is more favoured.

More disparities have been noted in the use of health facilities. Available information on the use of maternal services shows that, those from richer households have more probability of accessing skilled assistance at delivery and use of modern contraception, compared to women from poor households. However, there are no

disparities in access to other public services like vaccines between the poor and the rich.

Conclusions and next steps

The information and analyses collated as part of this initial work package of the SHIELD project provide a good basis for the next phase of the research. In particular, it has outlined the key health care financing flows and their magnitude, and identified the key equity challenges facing the Tanzanian health system.

The next phase of SHIELD will synthesise and analyse primary data to provide insights into the precise extent and nature of financing and benefit incidence and related health system cross-subsidies. In addition, the factors that influence financing and benefit incidence will be explored in detail. Strategies for addressing equity, sustainability and other health system challenges, particularly through the CHF, will be explored in detail in relation to their ability to address the equity, sustainability and other health system challenges. Given the importance for the successful implementation of any possible changes in the health system of the acceptability of such changes to key stakeholders, extensive stakeholder analyses will also be undertaken in future SHIELD work. It is hoped that this work will contribute to informing policy development towards achieving a more equitable and sustainable health system in Tanzania.

1. INTRODUCTION

1.1 The SHIELD Project

The main aim of the SHIELD project is to identify and evaluate alternative approaches to health insurance in Tanzania, as a mechanism for addressing health system equity challenges. This project hopes to make a key contribution to the understanding of health insurance mechanisms in promoting health system equity and addressing the needs of vulnerable groups.

Overall the SHIELD project is critically evaluating existing inequities in health care financing in Ghana, South Africa and Tanzania and the extent to which health insurance mechanisms could address equity challenges. The work includes a mix of macro-level analysis and case studies of specific financing mechanisms. Firstly, a ‘map’ of the health system is being developed, identifying all the major sources of finance and financing mechanisms, key categories of health care providers and user groups (Work Package 1). This is based on literature review, analyses of secondary data and key informant interviews. Secondly, financing incidence analysis will be used to evaluate the distribution of the current health care financing burden between socio-economic groups, and a benefit incidence analysis will evaluate the distribution of health care benefits across socio-economic groups (Work Packages 2 and 3). Information will be drawn from existing analyses combined with analysis of secondary data sources, such as the databases of existing insurance organisations and household surveys, facility exit interviews, focus group discussions with community members and key informant interviews. A stakeholder analysis will be undertaken to determine the interests, role and relative influence of different stakeholders over insurance policies (Work Package 4). This will involve in-depth interviews with key informants. An overall equity and financial sustainability assessment for the set of feasible health insurance design options in each country will be conducted, using a spreadsheet model (Work Package 5). Finally, the innovative methodological tools developed for certain aspects of the research will be documented in a ‘toolkit’ to ensure accessibility for researchers in other contexts wishing to undertake similar analyses (Work Package 6). The overarching aim is to develop options for redesigning health insurance, which address key equity challenges and ensure universal coverage for all.

1.2 Purpose of this report

The aim of this document is to report on Work Package 1 and provide a descriptive overview of the components of the existing health system, the funding and benefit flows and key issues relating to the factors influencing financing and benefit incidence. It provides both the background and the starting point for the more detailed critical evaluation of the existing health system. We also consider proposed developments for future health insurance. The main way in which universal coverage is hoped to be achieved in Tanzania is via the Community Health Fund (CHF). Therefore this paper also examines the development of the CHF and considers the potential opportunities and challenges posed by its planned expansion.

The next part of this section explains in brief the methods and sources of information used in this report while section two gives the study context, the geography and the economy of the country, governance and gives an overview of selected health indicators. Section three gives an overview of the health system in Tanzania, while the discussion of the health financing system is dealt with in section four of the report. Section five discusses the regulatory framework and highlights the main strategies and policies driving the health sector. Equity implications of the health system are discussed in section six, and include a discussion of issues relevant to financing and benefit incidence and finishes with some conclusions.

1.3 Methods and sources of information

Much of the information presented here is derived from government documents, unpublished or ‘grey’ literature and published materials. Documents were identified in a number of ways including requests from government officials, hand searching of references and the use of the internet. Actual sources of data included equity studies, both in Tanzania and other countries, review of government documents such as the National Health Accounts (NHA), Public Expenditure Reviews (PER), policy documents and other relevant publications and papers. A notable deficit was recognised in the literature on equity in health financing in Tanzania. Not much has been written in this area apart from partial reviews on user fees. In addition, the last NHA in Tanzania was conducted in 2001, so information sourced from there is not up to date, especially as various other financing arrangements have recently been put in place. This makes it difficult to have comprehensive information on the volume of

health financing in Tanzania, especially on private insurance and other micro-insurance schemes or CHF initiatives.

The criteria for the equity evaluation of different health financing initiatives included the contribution mechanisms of each financing mechanism and benefit package together with distribution, coverage, and accessibility.

2. STUDY CONTEXT

2.1 Geography and economy of Tanzania

Tanzania is located in East Africa, a region comprised of three countries, others being Kenya and Uganda. Tanzania includes Tanzania Mainland and Zanzibar. Each has a separate ministry of health. This document refers to Tanzania Mainland (referred to as Tanzania for short). Tanzania Mainland is divided into 21 administrative regions, 121 districts and 121 council authorities. Each District is further sub-divided into Divisions, Wards, Villages and 'Vitongoji/Mitaa'. The National Census of 2002 shows a country population of about 34 million but it is currently estimated to be about 37 million. About 40 per cent (%) of the total population is within the age group 15 to 59 years. Population is unevenly distributed with a density varying from 1 person per square kilometre in arid regions to 51 persons per square kilometre in well-watered highlands of Tanzania.

About 80 %% of the population lives in rural areas and depends primarily on agriculture for their basic needs. The size of the formal sector is small (around 6 % of total employed persons), whereas the public sector employs about 3 % of the total population. GDP is growing by an annual average of 6.7 % and the agriculture sector, which contributes about 45 % of GDP is growing by 6 %. Per capita income is estimated at US$270 per year.

2.2 Governance and politics

Tanzania is a result of a union in 1964 between Tanganyika and Zanzibar. Tanganyika got its independence in 1961 under President Julius Kambarage Nyerere, while Zanzibar revolted in 1963 under President Abeid Aman Karume and a year later the two countries formed a union: the United Republic of Tanzania. The country is led by a constitution with three governing bodies namely the *Executive,* (consisting of the President who is the Chief of State and Commander in Chief, a Vice-President and a Prime Minister); *Legislative* (consisting of the National

Assembly for the Union and the House of Representatives in Zanzibar), *Judicial* (In mainland consisting of courts of appeals, high courts, resident magistrate courts, district courts, and primary courts while in Zanzibar it consists of the High Court, people's district courts, kadhis court/islamic courts). Since independence in 1961 and until the early 1990s, Tanzania was under a one party system with a socialist model of economic development under the governance of "Chama Cha Mapinduzi" (CCM) which was the ruling party. In 1992, the Government decision to adopt a multi-party democracy was accompanied by legal and constitutional changes. The first multi-party democratic election was in 1994 the and ruling party, CCM, won the election. The President is democratically elected through a voting system of citizens over 18 years old and the elections are held every five years. Presidential tenure for any one individual is a maximum of ten years. Currently, there are about 17 parties and the CCM still holds the presidential seat and makes up about 84 % of the parliamentary representatives, of which there are 317 in total. The Civic United Front (CUF) is the second leading party and occupies 9 % of the parliamentary seats. Other parties that have representatives in the parliament are CHADEMA, TLP, and UDP. Women comprise about 30 % of all representatives in the parliament. (http://www.parliament.go.tz, http://www.state.gov)

2.3 Health indicators

The total fertility rate shows little variation over the past eight years. In 2005 it was an average of 5.7 children per woman in 2005, compared to 5.6 children in 1999. However, there is variation between rural and urban: in rural areas, the fertility rate is 6.5 children per woman compared to 3.6 in urban districts. Life expectancy for both sexes was 48 years in 2004, a decrease from 52 years in 1996. There has been a reduction in infant mortality from 147 deaths/1000 live births in 1999 to 112 deaths/1000 live births in 2005 as shown in Table 1.

Table 1: Basic Health Indicators in Tanzania

Total fertility rate (children/woman)		Life expectancy (Years)		Under-5 mortality rate (Per 1,000 Live births)		Adult mortality rate (per 100,000 Adults)		Maternal Mortality ratio (per 100,000 live births)	
1999	2005	1996	2004	1999	2005	2001	2004	1996	2005
5.6	5.7	52	48	147	112	551	524	529	578

Source: (URT 2005; The World Bank 2006)

2.3.1 Infant and child mortality

Analysis of data from the 2002 population census and more recent surveys point to a reduction in infant mortality, with a particularly sharp drop in most recent years. Indirect estimates from census data show a decline in infant and under-five mortality rates during the period 1978 to 2002. Infant mortality fell from 137 to 95 per 1,000 live births, and under-five mortality from 231 to 162 per 1,000 live births. The declining trend in child mortality is thought to be the result of improved malaria control – both the increased use of mosquito nets and improved curative care through more effective drug treatment. However, census data from 2002 suggest considerable geographic variation in mortality rates. Regionally, infant and under-five mortality ranged from 41 and 58 deaths per 1,000 live births in Arusha, to 129 and 217 in Lindi.

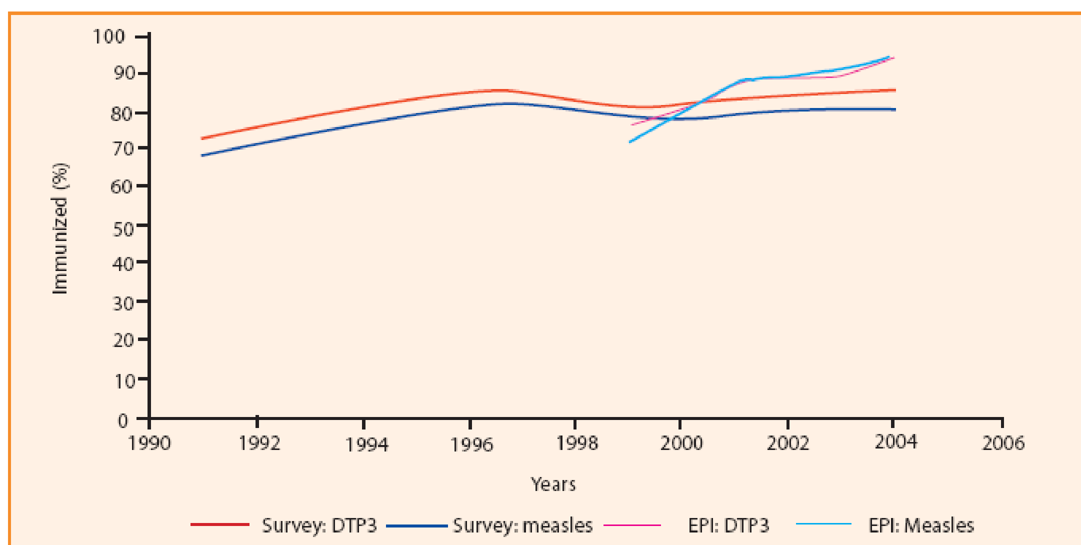
2.3.2 Malaria

Malaria, along with anaemia, is still the main cause of mortality for children under five. In 2004, malaria and anaemia accounted for 48 and 10 % of deaths respectively, for children under five. Malaria is also the leading disease for out patient diagnoses and hospital admission, for both under-fives and those aged five and above. In 2004, malaria accounted for about 39 % of outpatient diagnoses for under five years and 48 % for those age five and above; while for inpatient cases it accounted for about 33 % and 42 % for patients under five years and those age five and above respectively (MOHSW 2006).

2.3.3 Child immunisation

Tanzania has high levels of child immunisation compared to other sub-Saharan countries. As shown below, survey data indicate that the coverage of both the combined DPT3 and measles vaccinations have returned to 1996 levels after a slight decline in 1999. The 2004 coverage rates are 80 % for measles and 86 % for DPT3, exceeding the 85 % DPT3 target that was set for 2003. In general, compared to the rural areas, coverage levels for both vaccinations is higher by about 10 percentage points in the urban areas.

Figure 1: Immunisation coverage, 1991-2004



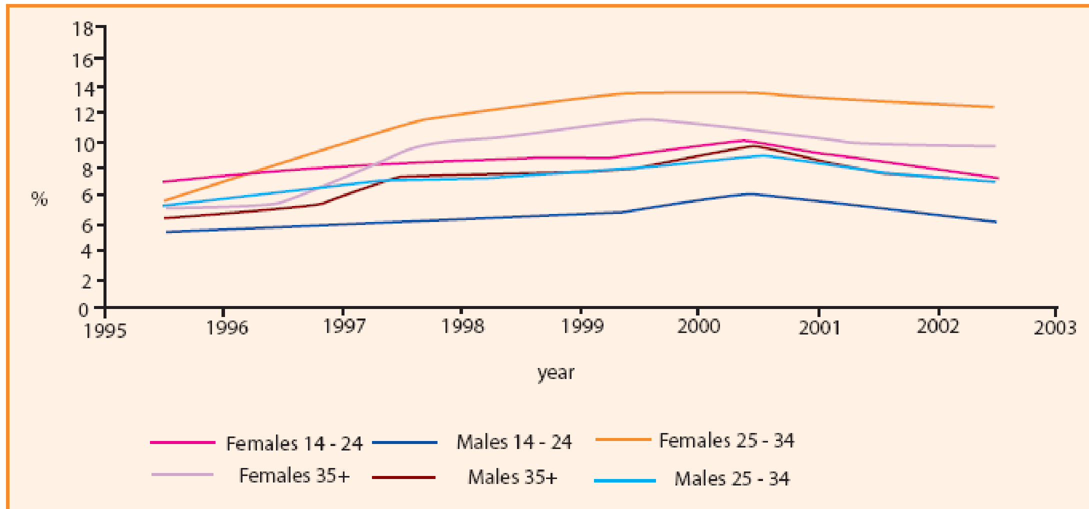
Source: Poverty and Human Development Report, 2005

2.3.4 HIV/AIDs

HIV/AIDS is considered to be one of the most impoverishing forces facing Tanzanians, mainly affecting individuals in the prime of their productive and childbearing years with consequent repercussions for their families (RAWG 2004). Recent projections from the Economic and Research foundation (ESRF) (2003) show that by 2015, the economy will be 8.3 % smaller and the per capita GDP will be around 4 % lower as a result of HIV/AIDS. The Tanzania HIV/AIDS indicator survey shows that 7 % of Tanzania mainland adults are infected with HIV and the prevalence rate is higher among women compared to men (MOHSW 2006) (TACAIDS, NBS et al. 2005). The estimate implies that roughly 1,070,000 people between 15-59 years are currently HIV positive: 610,000 women and 460,000 men.

According to blood donor data, the percentage of the 14-24 year age group which is HIV positive has been on the decline since 2001, implying a decrease in new infections in both males and females (see Figure 2.2 below). The overall reported prevalence rate in 2003 was 8.8 %, 8.2 % for male blood donors, compared to 11.9 % in female blood donors.

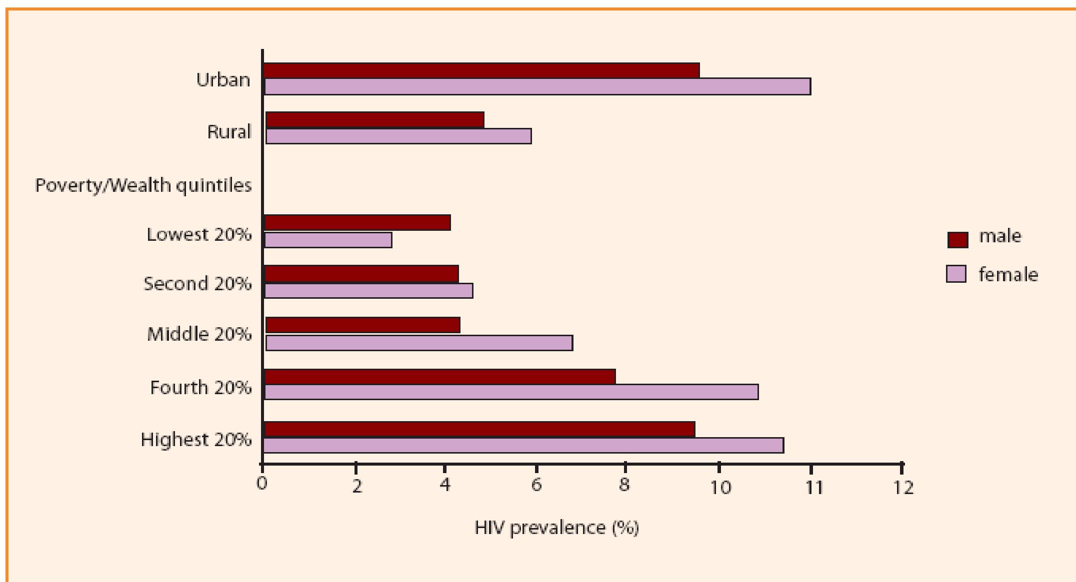
Figure 2: Blood donor data: age and sex specific HIV prevalence, 1996-2003



Source: Poverty and Human Development Report, 2005

Urban residents have significantly higher HIV infection risk for both sexes compared to rural dwellers (Figure 3). Prevalence of HIV for urban women and men was 12 and 10 % respectively compared to 6 and 5 % in rural women and men. The infection difference in wealth quintiles is skewed to the highest wealth quintile of which 11 % of the tested individuals were HIV positive compared to 3 % in the lowest quintile.

Figure 3: HIV prevalence rates by residence and poverty/wealth status



Source: Poverty and Human Development Report, 2005

2.3.5 Maternal health

Data from the 2004/05 demographic and health survey show that pregnancy related mortality has not improved over the last two decades. The maternal mortality ratio for the period 1995 to 2004 was 578 per 100,000 live births, not significantly different from the 1987 to 1996 ratio of 529 per 100,000 live births. Surveillance of maternal mortality is being undertaken in some sites, but conclusions from the data so far are compromised by the small number of deaths in pregnant women and random fluctuations in both pregnancy-related mortality and childbirth. The data which are available from surveillance suggest a substantial decline in the maternal mortality ratio, from 295 per 100,000 live births in 2000, to 160 in 2003 (REPOA 2005). Because of the difficulties in obtaining precise estimates of maternal mortality, a proxy indicator: of assisted deliveries is monitored by health professionals. Nationally, between 1999 and 2004, there was a slight increase in the proportion of births assisted by health professionals, from 41 % in 1999 to 46 % in 2004.

3. THE HEALTH SYSTEM

3.1 Historical policy background

Following Independence in 1961, Tanzania, in common with many other countries in Africa, adopted free health care provision by abolishing user charges in government health facilities (Nyonator and Kutzin 1999). The Arusha Declaration in 1967 heralded the start of a series of health sector reforms with the intention of ensuring universal access to social services to the poor and those living in marginalized rural areas. The Government banned private-for-profit medical practice in 1977[1] and took on the task of providing health services free of charge, (funded through public taxation) to all individuals attending public health facilities.

However, by the early 1990s, the strain of providing free health care for all became apparent in the face of rising health care costs and a struggling economy. In 1993, Central Government started the health sector reform process in an effort to better utilise health resources, improve primary care, increase user access, and cut rising costs. These reforms represented significant organisational, managerial, and financial changes to health care planning and services.

[1] Private, for-profit medical services were re-legalised in 1991.

3.1.1 Financing arrangements

Over the last decade, the main elements of the reforms have included: cost-sharing, the introduction of user fees, introduction of a National Health Insurance Fund (NHIF) for all civil servants in 1999 and the introduction of the Community Health Fund (targeted at the poor and those living in rural areas) in 2001 (Quijada and Comfort 2002). Other more recent financing initiatives include TIKKA (the urban equivalent of the CHF), Social Health Insurance Benefit (SHIB) under the National Social Security Fund (NSSF), private insurance and other Micro Insurance Schemes (MIS) such as UMASITA (the Swahili abbreviation for Tanzania Informal Sector Community Health Fund) and VIBINDO (Swahili abbreviation for association of small industries and small business owners). A chronology of the main health financing reforms is shown in Table 2 below.

Table 2: Key events in health financing reform

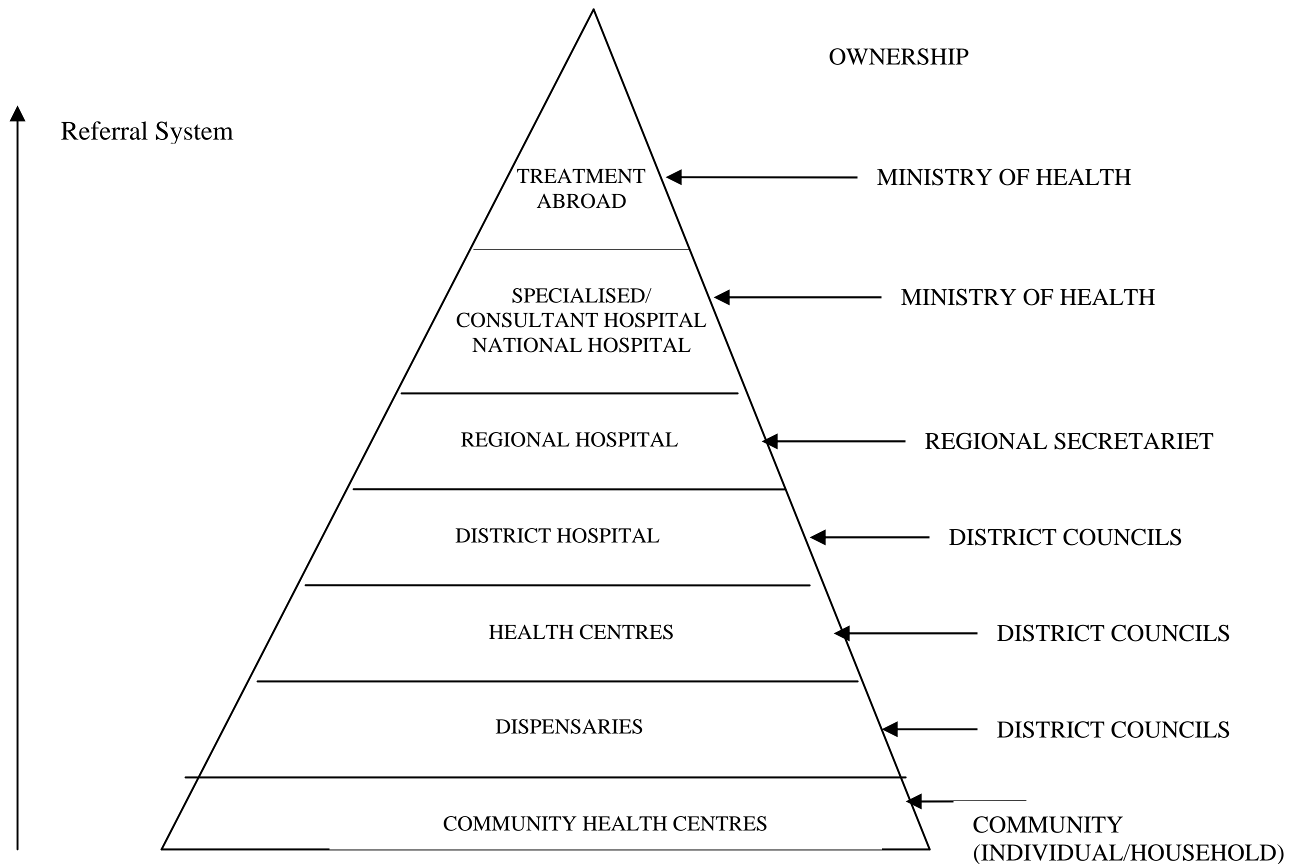
Year	Health Financing Initiative
1967 - 1993	• Free health care provision for all health facilities • Arusha Declaration 1967 • Decentralization 1972 • Abolition of private-for-profit medical practice 1977
1993	• Free Health Care Provision in primary facilities • Introduction of User fees in Grade I and II facilities (Secondary and Tertiary facilities)
1994	• Cost sharing in all facilities • Introduction of user fees in Grade III facilities
1996	• Revision of user fees scheme. • Differentiation of user fees at Grades, I,II and III
1996	• Introduction of Community Health Fund (CHF) in Igunga district as a pilot area
1999	• Formulation of the NHIF for all civil servants
2001	• Official implementation of CHF aimed at informal rural sector

3.2 Public health sector

Government remains the main provider of health services in Tanzania and owns about 64 % of all total health facilities. About 87 % of all facilities are dispensaries; health centres and hospitals account for about 9 and 4 %, respectively. The total number of health facilities is 5379. About 45 % of the population live within 1 km of a health facility, 72 % within 5 km and 93.1 % within 10km of a health facility (MOHSW 2006). Administratively, the provision of health services is divided into 3 levels: national, regional and district. The referral system assumes a pyramid pattern starting from the village level, where there are village health posts; ward level, where

there are community dispensaries; divisional level, where there are rural health centres; district level, where there are district or district designated hospitals; regional level, where there are regional hospitals; zonal level, where there are referral hospitals and national level, where there are national and specialised hospitals.

Figure 4: Tanzania Referral System Arrangements



Source: www.moh.go.tz

At the national level, the Ministry of Health and Social Welfare (MOHSW) administers and supervises the National Hospitals, Consultant Referral Hospitals, Special Hospitals, Training Institutions, Executive Agencies and Regulatory Authorities; while at the Regional level, provision of health services is vested in the Regional Administrative Secretary with technical guidance from the Regional Health Management Team. At the district level, management and administration of health services has been devolved to districts through their respective Council Authorities, Health Service Boards, Facility Committees, and Health Management Teams.

Tanzania is in the process of decentralising government health functions. The roots of the decentralisation process can be found in the rapid growth of the public health sector between 1972 and 1980, with its emphasis on rural development and expanded services in education, health, water and other social services in the rural areas. During this period, there was an elaborate programme to provide health facilities and train health auxiliaries across the country. However, in the 1980s, the country found itself in an economic slump, the demands of an expanded health sector could not be met, and shortages, dilapidated structures and inadequate services became the norm. In response, the Government decided that the focus should be to strengthen district health services, which required devolution of power from the centre to the district. Such shifts of power, of course had to be accompanied by the strengthening of management capacity at each level.

3.3 The private sector

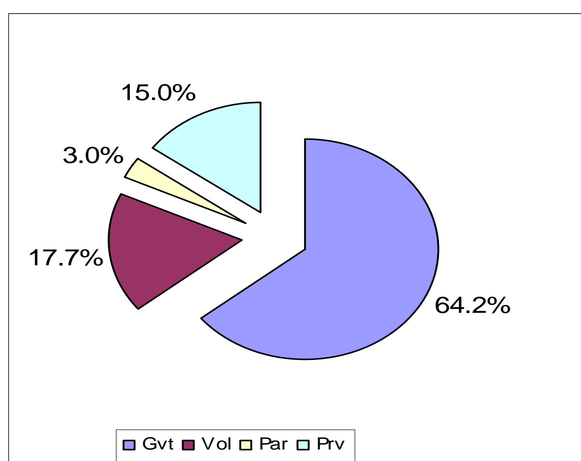
The prohibition of private practice in the health sector in 1977, merely masked private sector activity, rather than eliminating it. The Government lifted the ban in 1991 as part of a broader set of government policy reforms to encourage private activity. Private individuals were allowed to establish, own and manage health care facilities and services. Following this initiative, private health sector activity increased dramatically. Munishi estimates that between 1991 and 1996 there was a 36-fold increase in the number of private-for-profit dispensaries and that the number of for-profit hospitals increased five-fold (Munishi 2001). The private sector is now seen as a crucial partner in providing health services, complementing government provision and widening consumer choice. Non-government organizations and private-for-profit providers now own about 18 and 15 % of total health facilities respectively (table 3 and figure 5).

Table 3: Health Facilities in Tanzania

	Health Centres	Dispensaries	Hospitals	Total
Government	331	3038	87	**3456**
Voluntary	101	763	87	**951**
Parastatal	10	145	8	**163**
Private	39	733	37	**809**
Total	**481**	**4679**	**219**	**5379**

Source: Annual Health Statistical Abstract, 2006

Figure 5: Ownership Distribution of health facilities

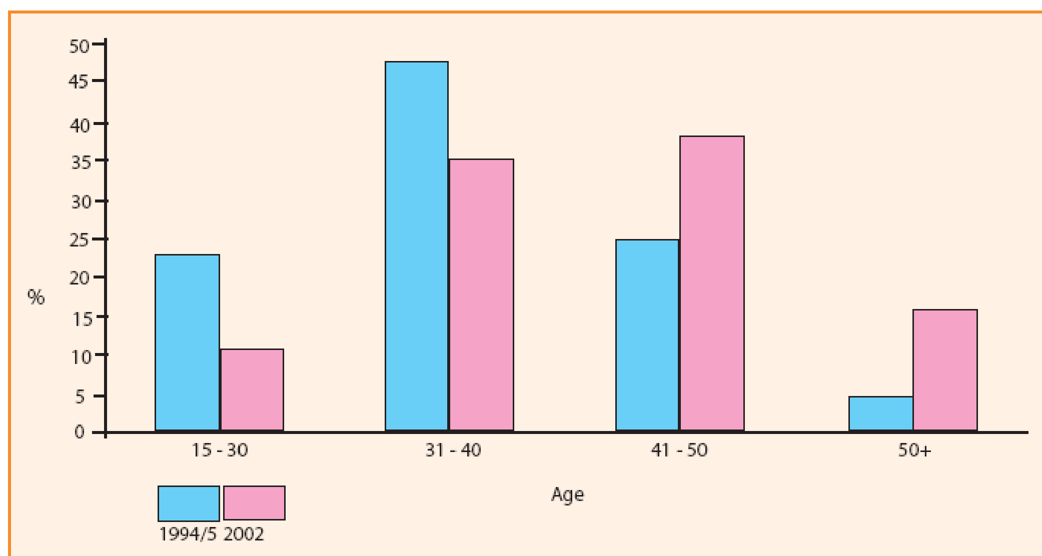


Key: Gvt = Government, Vol = Voluntary organizations, Par = Parastatals, Prv = Private
Source: Data from Annual Health Statistical Abstract, 2006

3.4 Human resources

Government is the main employer of health workers, employing about 74 % of all health staff. Overall, 65 % of the 54,200 health workers in 2002 were located in the public sector, 22 % in private not-for-profit and 14 % in private-for-profit. Faith based organisations employ 22 %; while private sector and parastatal owned facilities respectively employ 3 and 1 % of total manpower (MOHSW 2006). Tanzania, as elsewhere in Africa, has a significant problem in retaining health workers, particularly medical doctors. The total number of active health workers in 2001/02 was estimated at 54,200, with unskilled workers forming the largest group (31 %), followed by the professional group of nurses and midwives (24 %) (Kurowski, Wyss et al. 2003). Between 1994/5 and 2001/02, the number of active health workers per 100,000 population, decreased by 35 %: from the observed 249.4 to an estimated 162.1 per 100,000 population (REPOA, 2005). The shortage of health staff is even more acute when differentiated by cadres, with significant deficits among skilled health professionals. The estimated ratios of currently active professionals per 100,000 population, are 38.9 for nurses, 2.5 for physicians and 25.3 for all medical cadres (i.e. medical officers, assistant medical officers and clinical officers). The decline in human resources followed a freeze in civil service employment adopted by the Government in1993. It is also responsible for the ageing cohort that will need to be replaced within the very near future (see Figure 6).

Figure 6: Age composition of health sector employees, 1994/5 – 2002



Source: Kurowski, reproduced in Poverty and Human Development Report, 2005.

Deployment of available health workers is highly imbalanced (Kurowski, Wyss et al. 2003). Roughly, 84 % of the health workers, mainly the lower skilled cadres, were employed in the rural areas. The 16 % who are employed in urban areas represent a disproportionate share of the higher skilled cadres. Even after corrections for infrastructure distribution, regional variation in staff per head of population remains significant, and the disparities are even greater at the district level. The number of nursing staff per 10,000 population for example, varied between 1.6 in Mkuranga and 16.2 in Ilala.

The 2005 Poverty and Human Development Report argues that poor health worker motivation and performance is commonly manifested in many of the documented issues faced by patients: in lack of courtesy to patients, illegitimate charging for drugs and equipment, high levels of absenteeism, "dual practice", and poor task performance, such as, failure to conduct proper patient examinations (REPOA, 2005). These problems among health staff have a negative affect on quality of care, as well as reducing the utilisation of health services and ultimately impacting negatively on health outcomes. Existing constraints in staffing are likely to be further aggravated by the impact of the HIV epidemic in increased mortality and morbidity of the work force.Additionally, there are increasing demands placed on the health sector, for the additional care of those infected.

4. HEALTH FINANCING AND EXPENDITURE

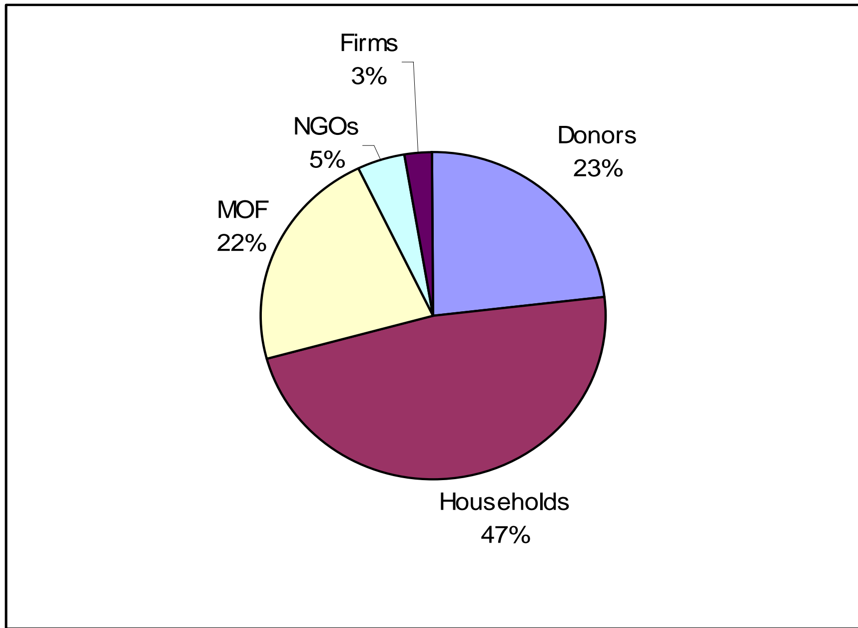
The aim of this section is to consider how and where money is spent by the health system. Unfortunately the latest available comprehensive data for Tanzania is from the National Health Accounts (NHA) of 2001. Therefore, these data are combined with more recent data from the public expenditure reviews to provide as up to date a picture as possible on the flow of funds in and around the health system.

4.1 Overview of health financing

The NHA records the flow of funds from various sources through the various financing agents or intermediaries up to the payment of service delivery. The NHA shows how much is contributed by each financing source and shows the flow of the contributed funds to the health system. In this section we use the information of the 2001 NHA, to depict the general picture of the health sector contributions. The MOHSW is in the process of preparing another NHA which is expected to be out in the latter half of 2007, and we expect to update the figures immediately after their release.

In common with many countries in Africa, nearly half of health system financing comes from households (Pearson 2004) (Figure 4.1). In Tanzania, the Government including donor funding, contributes about 45 % of total health system financing, with donors contributing about half of the total health sector government budget. The Government and donors in total contributed about 126 billion Tanzanian shillings for the year 2000 (MOH 2001). Contributions by firms, in the form of contributions to private health insurance, accounted for only 3 % of total health sector financing. Individual purchase of private health insurance forms a very small proportion of overall health financing in Tanzania.

Figure 7: Sources of health system financing contributions

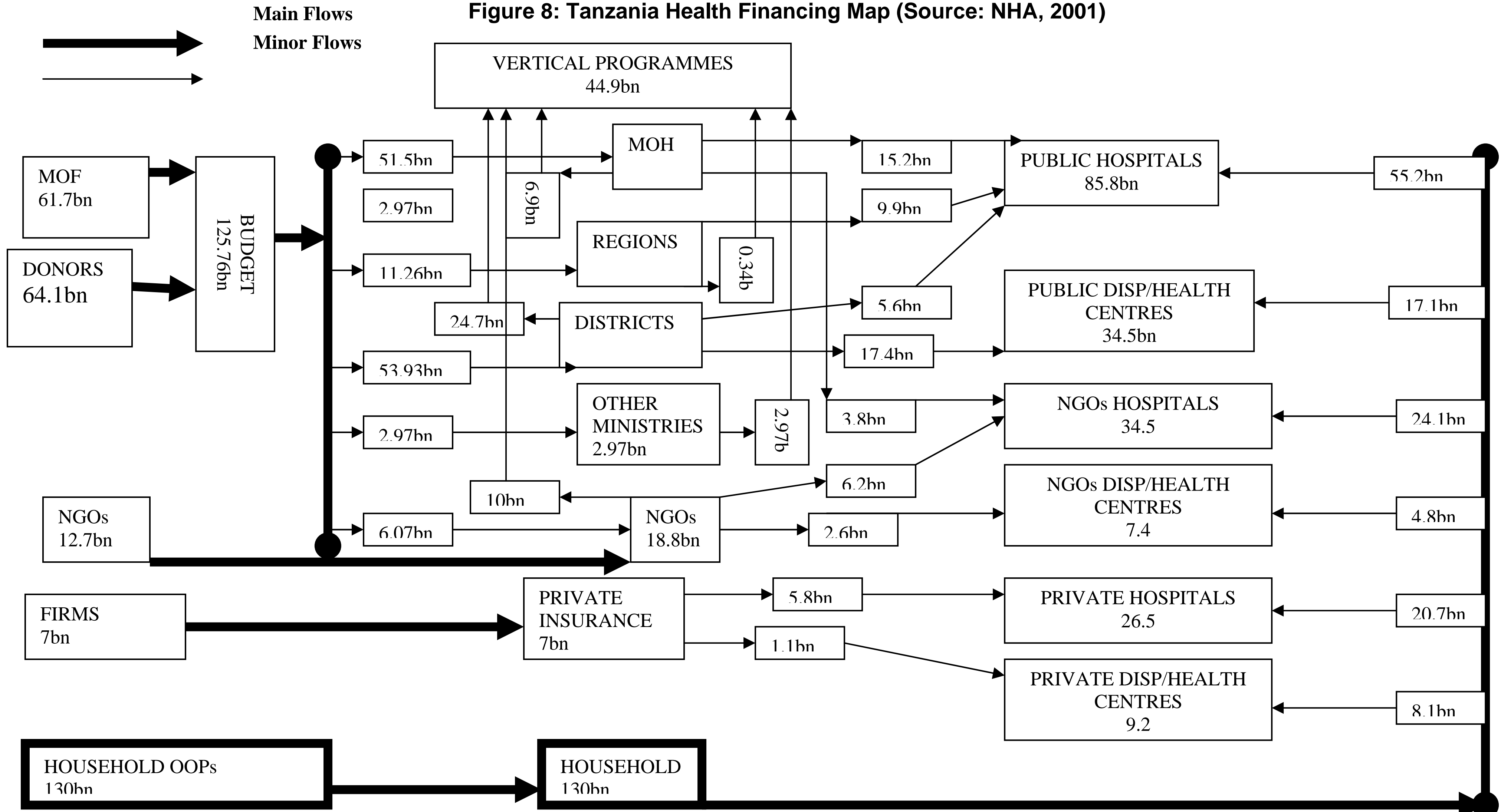


Source: NHA 2001

Figure 8 provides an outline of the health financing map in Tanzania. It depicts the flow of funds from the main sources of financing through the various financing agents to health providers. The total flow of funds into the health sector for the year 2000 was approximately 275.5billion Tsh. This amount includes money spent on administration (32.8bn Tsh) and vertical programmes (44.9bn Tsh). The main sources of health financing in Tanzania are: the Government through taxes; development partners through basket funding and other project funding; households through prepayment schemes or user fees; NGOs and firms. These financing sources contribute to health care in a variety of ways through the various financing agents as shown in the financing map.

The rest of this section provides further detail on the various contributions to overall financing on health, namely: government contributions, contributions from external or donor sources, health insurance schemes and household contributions in the form of user fees and out-of-pocket payments.

Figure 8: Tanzania Health Financing Map (Source: NHA, 2001)

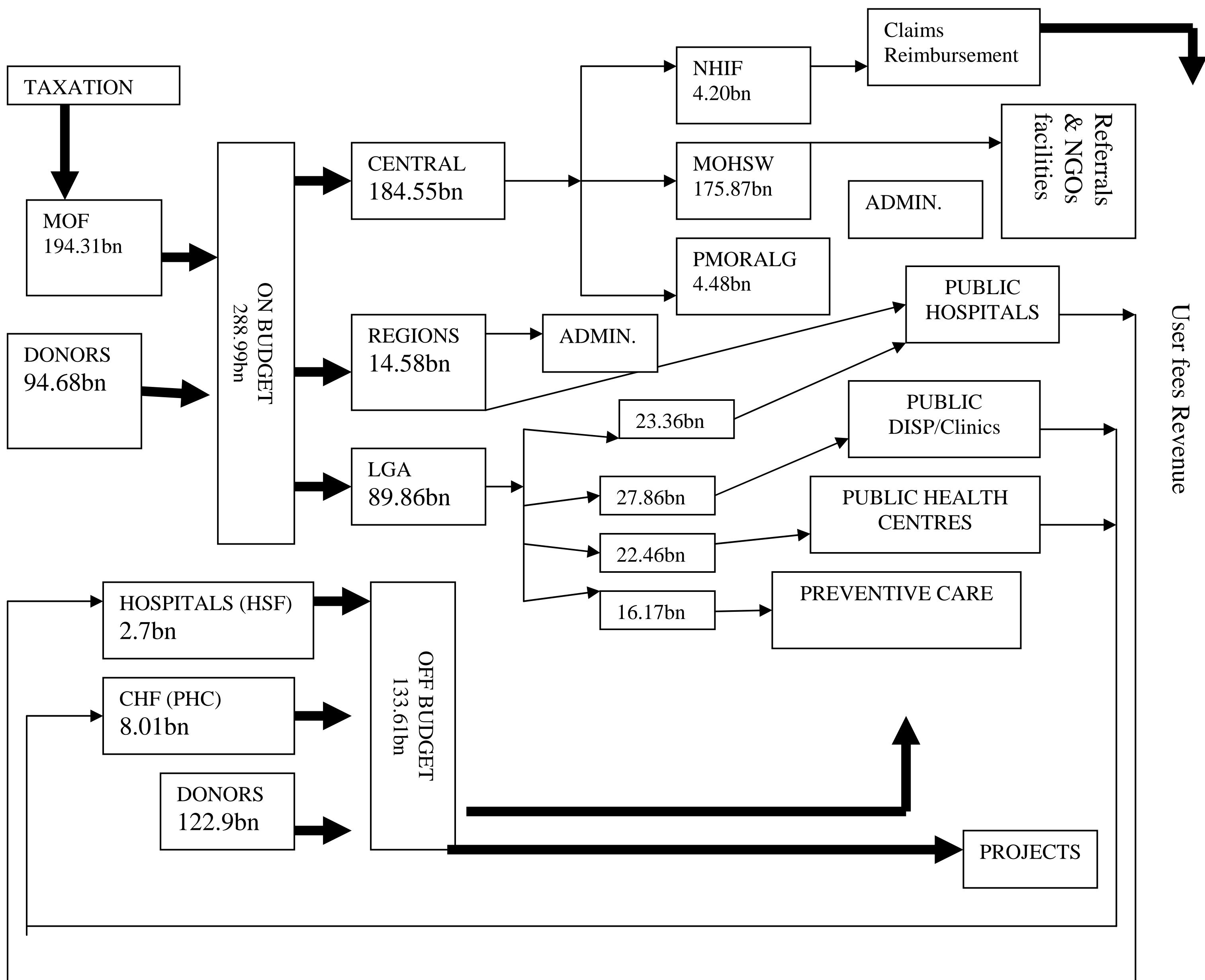


4.2 Government expenditure on health

As shown in the financing map, public spending in the health sector, including the Ministry of Finance (MOF) budget allocation and development partners support, amounted to 126 billion Tsh. The government budget allocation from tax was 22 % of total health care expenditure (MOH 2001). These data are from the NHA, however more recent public expenditure on health can be obtained from the Public Expenditure Review report, which is prepared each year.

The Public Expenditure Framework in Tanzania is divided into two components: 'on-budget' expenditure includes the budget allocated from the Ministry of Finance including donors' basket funding. This is broken down into recorded allocations (recurrent and development, domestic and foreign) to the MOH, Regions, Local Government subventions through the Prime Ministers' Office – Regional and Local Government (PMORALG), and the government contribution to the National Health Insurance Fund (NHIF). The latter is done through the Accountant General's Office (AGO). The second component is the 'off budget' sector which includes revenues from cost-sharing within public (health) facilities, i.e. hospitals and primary facilities, and additional foreign revenues not captured within the official development budget, but recorded in a database maintained by the External Finance department at the MOF.

Figure 9: Public Health Care Expenditure for the Financial Year 2005



Source: Health Sector Public Expenditure Review Update FY06

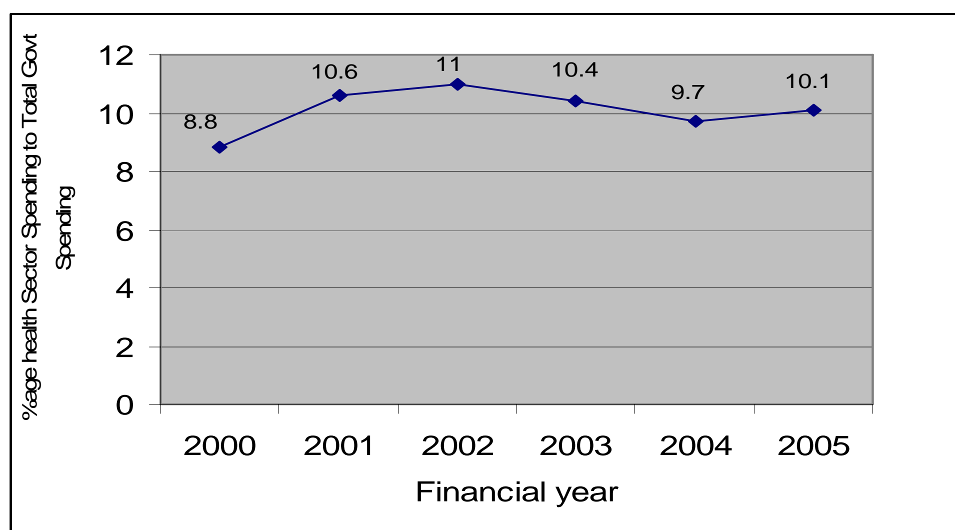
Figure 9 shows the flow of public health expenditure financing from source to various agents and providers for the year 2005. According to this figure, government on-budget actual expenditure was about 289billion Tanzania shillings for the year 2005. This is about a 36 % increase from the previous year's expenditure. Total public health care expenditure including revenue from hospitals and primary health facilities'

user fees and other direct donor support to the projects, amounted to approximately, 423 billion Tanzania shillings.

Further analysis shows that a large share of public expenditure is centrally spent: the Ministry of Health (MOH) spent about 60 % of the total on-budget allocation or 43 % of total public health expenditure. Allocation to local government was about 31 % of on-budget allocations.

Figure 10 shows that over time there has not been a substantial increase in the proportion of on-budget government expenditure devoted to the health sector. In 2005, on-budget allocation on health care expenditure was about 10.1 % (excluding consolidated fund services (CFS) or debt servicing) of total government spending (MOH 2005). This amount is below the recommended target of 15 % in the Abuja declaration. However, the Government is making efforts to increase its share of health expenditure to total government expenditure compared to previous years. For instance, prior to 2004, government expenditure on health was about 9.7 % of total government spending, indicating a slight increase in the government allocation to the health sector.

Figure 10: On-budget health spending as a percentage of total government budget for the years 2000 - 2005



Source: Health sector PER update FY 05

The government budget to the health sector for the FY2006 was estimated at 425 billion Tsh (MOHSW 2006), making the proportion of the government budget on

health approximately 11.6 % of total government spending. This figure assumes that expenditure for HIV/AIDS is captured under the MOHSW rather than the TACAIDS.

In line with the increasing trend of the government budget allocation to the health sector, per capita government spending is also rising. There has been an increase in per capita expenditure from 5000 Tsh (5 USD) in 2004 to 7995 Tsh (7 USD) in 2005 and it is estimated to be 11,447 Tsh (9 USD) in 2006, (MOHSW 2006).

4.3 External Financing

A substantial proportion of the government budget for the health sector comes from development partners' support to the basket funding. The basket funding to the health sector is normally shown in the on-budget government health sector financing. For the FYs 04 and 05, development partners' support to the on-budget health sector spending was approximately 27 and 33 % respectively. In monetary terms, these were about 59.5bn Tsh and 94.68bn Tsh for the two years respectively. For the FY06, the share of development partners to total on-budget spending is about 30 %, which is about 129 bn Tsh.

A significant amount of development partners' support to the health sector is not captured under the basket funding but is captured in the External Finance Department of the MOF. Estimates for FY06 combining all of these sources, shows that donor support to public total expenditure on health makes up about 42 % of public health expenditure, equivalent to 224bn Tsh, while the total public spending is approximately 531bn Tsh (on-budget and off-budget), (MOHSW 2006).

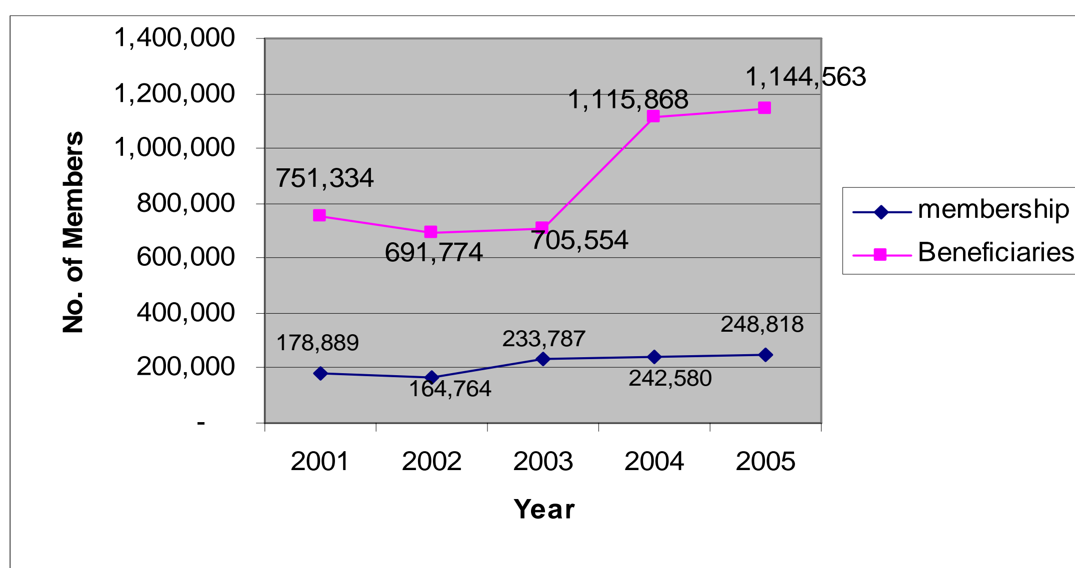
4.4 Health insurance schemes in Tanzania

A move towards universal coverage and social health insurance (SHI) is a core element of the government's health financing policy. To this end, the Government has initiated and encouraged the proliferation of a number of prepayment schemes. These are outlined below.

4.4.1 National Health Insurance Fund

The National Health Insurance Fund (NHIF) was established in 1999, began its operations in 2001. To date, the NHIF covers all public servants at both central and local government levels, together with up to 5 family members.[2] Since its establishment, the NHIF has seen a continuous increase in membership (see Figure 11) from 164,708 in 2001/02 to 248,818 in 2005 (NHIF 2004; Kiwara, Minja et al. 2006).

Figure 11: NHIF membership trends 2001 - 2005



Sources: (NHIF 2004; Kiwara, Minja et al. 2006)

The NHIF offers both inpatient and outpatient care as part of its benefits package. However, it has specific limits of spending granted to the beneficiaries. Any amount in excess of the fixed expenditure is paid by the beneficiary in an attempt to counter consumer moral hazard[3]. The main source of NHIF revenue is members' contributions. The members compulsorily contribute 6% of personal salaries per month. Employees pay three % and the employer tops up the remaining three % of the employee's salary per month. Total NHIF contribution to the health sector for the

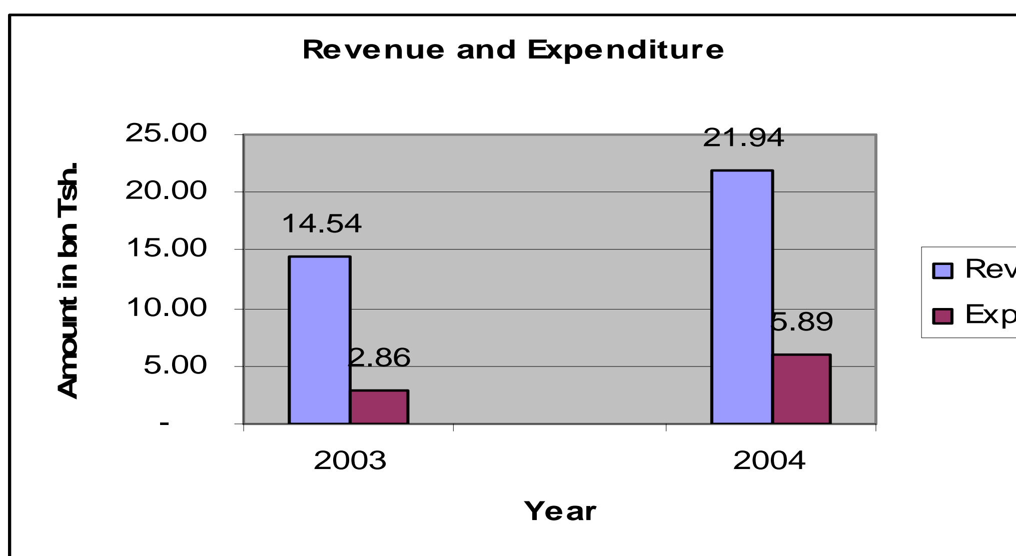
[2] Membership in the NHIF is not a lifetime entitlement and ceases three months after the member leaves employment.

[3] "A tendency of entitlement to the benefits of health insurance to act as a strong incentive for people to consume more and better health care and a weak incentive for them to maintain a health lifestyle". McIntyre, D. 2007

FY06 is approximated to be 20.4bn (MOHSW 2006). This is equivalent to about 5 % on-budget spending and 4 % of total public spending on health.

The NHIF income and expenditure statement shows an increase of about 51 % in total revenue from the year 2003 to 2004, whereas members' contributions to total revenue account for about 95.4 and 92.6 % in years 2003 and 2004 respectively. Total expenditure to total revenue for the years 2003 and 2004 were about 20 and 27 % respectively. This implies that the spending level is still very low and much of the fund remains unutilised. Total revenue in nominal terms for the years 2003 and 2004 is shown in Figure 12. The main spending area is benefit payments which account for 47 % of total expenditure in 2003 and 64 % in 2004.

Figure 12: Nominal Revenue and Expenditure for 2003 and 2004

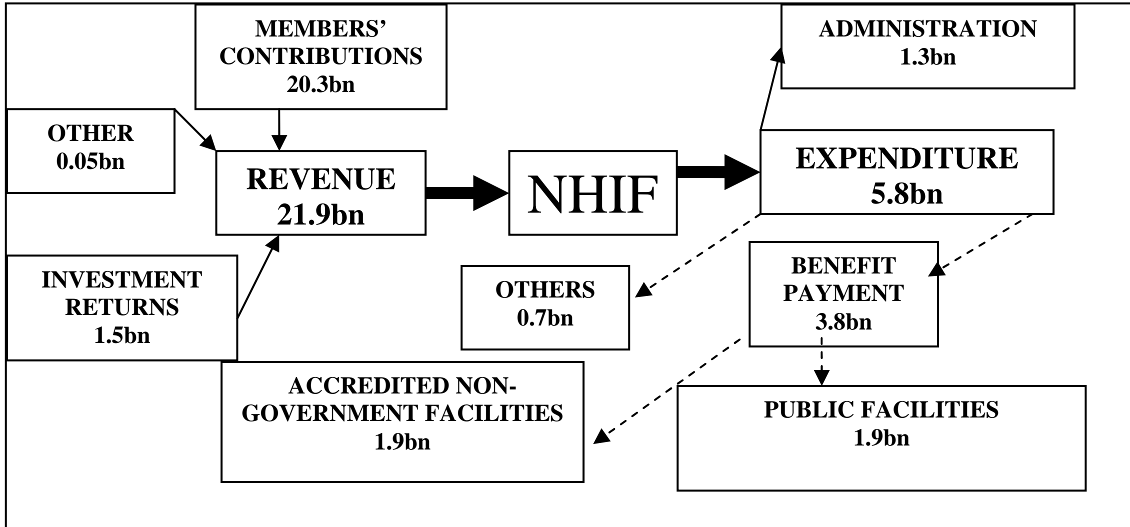


Source: NHIF Income and Expenditure, June 2004

Upon, commencement in 2001, about 91 % of total expenditure went to accredited government facilities, since very few non-governmental facilities had been accredited. In the second and third year of NHIF operation, the proportion of benefit payments as a percentage of total expenditure for government and non-government accredited facilities was about 49 and 51 % respectively. Within this period, more non-government facilities including mission facilities, have been accredited. In 2004, about 39 % of total reimbursements was spent on outpatient care while inpatient care accounted for about 28 %. Other reimbursements were for registration fees (12 %), investigations (8 %), surgical services (7 %) and pharmacies (6 %) (Kiwara, Minja et

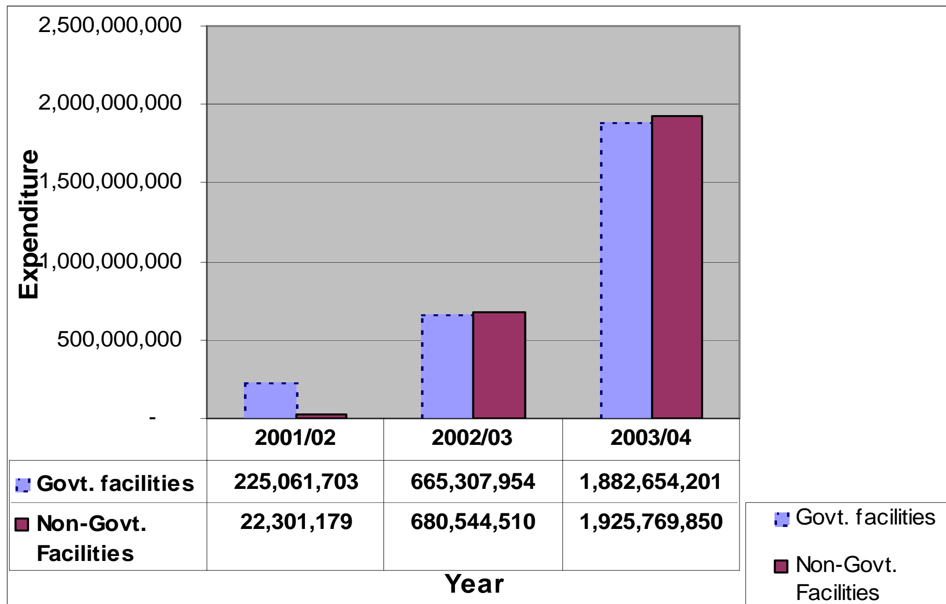
al. 2006). Figure 13 illustrates the flow of funds from sources to services for NHIF. The distribution of benefits is as shown in figure 14.

Figure 13: NHIF Revenue and Expenditure Flow for the year 2003/04 (Tsh)



Source: Author compilation

Figure 14: NHIF Benefit Payment Categorized by Facilities



Source: 2003-04 NHIF Actuarial and Statistical Bulletin

Payment to providers is through fee for service, whereby providers submit their claims for payment to NHIF and the Fund pays the provider within a period of sixty days. The money paid to public hospitals is deposited into the Health Service Fund

(URT 1999), while the amount that is reimbursed to primary facilities (dispensaries and health centres) enters into the Community Health Fund and is used according to the direction of the district health plan (Kiwara, Minja et al. 2006).

The main providers of services of NHIF are government public facilities, which comprise about 86 % of total accredited health facilities. In total, 3574 facilities have received accreditation and of these 514 belong to non government providers. While blanket accreditation has been provided to all public health facilities, private facilities need to apply separately. Lack of clarity in the procedures for accreditation is suggested as one reason for the small number of private facilities participating in the scheme (Kiwara, Minja et al. 2006). Although government accredited facilities occupy about 86 % of total providers, they account for only 50% of the benefit payments. This reflects the fact that many members prefer to go to private health facilities where there is a perception of higher quality of care and less likelihood of drug stock-outs compared to government facilities (Kiwara, Minja et al. 2006). Mtei (2005), reported that many members said they would prefer out-of-pocket payments rather than NHIF if the latter was not compulsory. Delays in processing claims in government facilities may also account for the lower level of reimbursement compared to private facilities.

Overall, there have been few analyses of the impact of NHIF in financing and service provision. Although membership has increased, this may reflect the compulsory nature of its membership rather than its efficiency given the many complaints from members on quality of services provided (Mtei 2005). Furthermore, despite the apparent surplus, authors have raised doubts concerning the long term sustainability of the Fund (Msimbe 2005). More than 95 % of members contribute less than 10,000 Tanzanian shillings per month.

4.4.2 Community Health Fund (CHF)

The CHF is a voluntary scheme, which enables a household to pay when they have funds rather than at the time of illness, and members are entitled to access services at the primary health facilities. The CHF started in 1996 in Igunga district as a pilot scheme and later expanded to other councils with the expectation of covering the whole country (MOH 1999). The scheme was identified as a possible mechanism granting access to basic health care services to populations in the rural areas and

the informal sector in the country. Its aim was not primarily to raise additional funds but rather, to improve access to health care for the poor and vulnerable groups. According to the Community Health Fund Act of 2001 the objectives of the CHF are to:

- mobilise financial resources from the community in order to provide health care services for members;
- provide quality and affordable health care services through sustainable financial mechanisms: and
- improve health care services management in the communities through decentralisation by empowering the communities in making decisions and by contributing on matters affecting their health (URT 2001).

Currently the CHF is operating in 69 of the 92 councils (URT 2006). Membership contributions are decided at the council level, and each household contributes the same amount of fee, which varies between councils from 5000 to 10,000 Tanzania shillings per year (MOH 2005). Households are given a card that allows that household to access care for the whole year before renewing the membership. Revenues from members' contributions are matched by a 100 % grant from the government. Households that do not participate in the CHF scheme are required to pay a user fee at the health facilities at the point of use.

The CHF Act gives provision for user fees paid at public health centres and dispensaries to be used as a source of funding to the CHF (CHF Act 2001:68). Other sources of funds include the government matching grant (commonly known as "tele kwa tele") which tops up by 100 % the amount thatcouncils have collected as members' contributions to the CHF, grants from councils, organisations or any other donor and any other monies lawfully acquired from any other source.

It is difficult to obtain consistent information on how much is generated as revenue and how much is spent through the CHF ((MOHSW 2004; MOH 2005; MOHSW 2006). Information on the CHF's contribution to the health sector can be estimated in a number of ways. Data on the matching grants offered for a particular year can be seen as a proxy for membership premiums. The assumption is that membership contributions account for about 15 % of total revenue, while user fees at primary facilities account for 85 % (MOHSW 2006). CHF contribution to the health sector is also captured in the public expenditure review under the off-budget expenditure section.

Review of CHF performance

One of the most pressing issues for the CHF is the low enrolment rate and early drop outs in membership (Chee, Smith et al. 2002; Shaw 2002; Msuya, Jutting et al. 2004; Musau 2004; Mhina 2005). Furthermore, in many schemes, enrolment has been found to go down where it was once relatively high. Shaw (2002), found that enrolment of community members in the scheme in Igunga and Singida rural districts was 6 and 4 % respectively compared to the expectation of 30 %. Chee et al, (2002) in their assessment of the CHF in Hanang district found that membership in 2001 was around 3 % of total households. More recent data indicate this fell further to 2.2 % in 2003 (Musau 2004). This is an alarming finding given that CHF membership in the same district had reached a peak of 23 % in 1999, yet within just a few years had fallen dramatically to less than 3 %. Shaw (2002) argues that one of the reasons for low enrolment rates could be the small user fees set in public facilities since they give little incentive for community members to join an alternative financing system like the CHF. User fees in some councils are set at 1000 Tsh. per visit at health centre level and many community members are more willing to pay the user fee rather than pay the higher CHF premium (Mhina 2005). Similarly, high CHF membership fees set by some councils is also likely to be a barrier to enrolment.

Kamuzora and Gilson (2007) investigated the causes of low enrolment. They found that for the poor inability to pay membership contributions was the most important barrier, whereas poor quality of care, non-acceptance of the need to protect themselves against the risk of sickness and lack of trust in CHF managers mattered more to average and wealthy community members. They also showed that district managers responsible for implementing the CHF often had a direct influence over the factors explaining low enrolment. For example, mangers failed to give adequate information regarding entitlements to exemptions to possible beneficiaries. Yet their behaviour (and lack of action) might be seen as the coping strategy of ‘street level bureaucrats’ reacting to pressure from above and adapting the practices of policy implementation, with negative consequences for policy goals. The authors concluded that successfully extending enrolment to all groups is likely to require a range of participatory policy and managerial responses and rely less on top down pressure from the Ministry of Health.

Msuya et al. (2004) cited low income and income un-reliability as other reasons for low enrolment. They found that 60% of richer households in Igunga district joined the

scheme compared to 33% of the poorest households. Other reasons cited include: lack of information due to insufficient sensitisation/education of the community; introduction of NHIF which took out public servants who were previously members of CHF; non-coverage of referral care; perceived poor quality of health care services at public facilities (drug stock-outs and inadequate service provision); poor staff attitudes; and broad exemption policies which leave a limited number of people contributing to the CHF (Mwendo 2001; MOH 2003; Mhina 2005; MOH 2006). Bonu et al. (2003), argued that the poor enrolment rates in many CHF may be linked to a perception of poor quality of care. Thus, those who register initially into the scheme may drop out quickly if the quality of care does not reach expectations.

Access to health facilities is another important issue for improving enrolment rates to the CHF. Msuya et al. (2004) argued that CHF had improved access to health facilities for the poor because being a member improved the chance of seeking health care from formal health care providers, compared to non-members and membership also reduces the use of alternative medical care such as self medication and traditional healers especially for the poor. Membership in the CHF reduces the risk of households selling their assets for the sake of getting money for treatment during a disease outbreak. Yet, despite the claimed evidence showing improvement of access for members, it is important to return to the question of persistently low enrolment rates. If the scheme only reaches a small proportion of the population then it will be difficult to impact on improving equity of access for the health system more generally. CHF schemes have great potential to improve access for poorer groups, by removing payment at the point of use and allowing members to pay when they can afford to (i.e flexibility in contribution). However, in practice, even relatively small contributions can often be too high for the poorest to pay (Bennett, Kelley et al. 2004).

A final criticism of the scheme relates to weakness in management and accountability. An important question is whether those working in facilities have the financial and management capacity to handle the fund, in addition to delivering services to patients. Lack of capacity and experience in community mobilisation and financial management are among the factors that are cited as hindering the implementation of CHF in councils (MOH 2006). According to Laterveer, et al. (2004), districts are not clear on CHF management rules and procedures and they reported that there was mismanagement of CHF funds in about 27% of CHF

implementers. In other instances they found CHF funds were not utilised and hence remained idle at the district level. There also appear to be problems in conducting regular audits, despite the CHF Act of 2001 insisting that schemes employ competent, qualified, auditors to audit CHF accounts (URT 2001). An assessment by the Ministry of Health showed that not all councils conducted regular audits or reported to community members (MOH 2003).

The MOHSW are committed to the CHF as a means for involving the community in health care financing and it represents an important step towards universal coverage. However there remain substantial challenges in implementation, particularly around enrolment, management and accountability of the scheme and ensuring that the poorest groups are not excluded.

4.4.3 Informal Micro Insurance and Community Based Health Financing Schemes

The number of smaller informal micro insurance schemes has increased over time in Tanzania. Currently there are about 12 schemes that have registered themselves under the Tanzania Network of Community Health Funds (TNCHF), although many others choose not to register (PHRplus 2006). Two examples of such schemes include UMASIDA and VIBINDO, both based in Dar es Salaam. Services that are covered by these schemes include primary health care, outpatient services, reproductive health, and minor surgery. Membership in these schemes is voluntary and the membership fee varies from one scheme to another. For UMASIDA the fee is Tsh. 1500 per month for a family of six members while in VIBINDO, the fee is Tsh. 750 per month for one person. Some community based health financing schemes are owned by faith-based organisations, others are operated by various NGOs or receive assistance from various donors and international organisations. Currently, there is no systematic documentation of the contribution of such schemes to the overall health sector resource envelope.

4.4.4 Social Health Insurance Benefit (SHIB) under NSSF

The National Social Security Fund (NSSF) is planning to add a Social Health Insurance Benefit component (SHIB) as part of the package it offers to members. It is expected to cover private sector employees, non-pensionable government and parastatal employees and the self-employed. Members of the SHIB scheme will benefit from health services through the financing of their 20 % contributions to the National Social Security Fund (NSSF). Given this is a recent initiative there is as yet no further information on the operation of this scheme.

4.4.5 Private Health Insurance

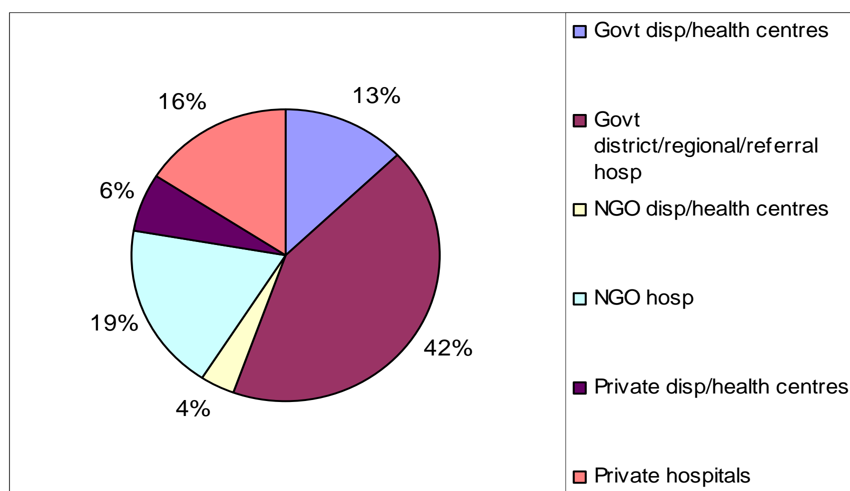
Tanzania has about 15 registered insurance companies, of which 5 have a health insurance component. Information on members who are covered by private insurance and its relative contribution to health financing is very limited. The most recent NHA in 2001 shows that the contribution of private health insurance is about 3 % of total health financing in Tanzania. The vast majority of this expenditure is at the hospital level (83%) rather than dispensary or health centre level. However, it is very likely that the amount spent by private insurers will increase given the establishment of a number of private health insurance companies within the last 5 years.

4.5 Household out-of-pocket expenditure

Household out-of-pocket expenditures include user fees charged by government and non-government providers; out-of-pocket expenditures for drugs and supplies; and other medical expenditures. User fees were introduced in Tanzania at the hospital level in 1993, as part of a broader package of reforms. As noted earlier, the revenue generated by user fees at the primary care level is used to help fund the Community Health Fund (CHF). Revenue collected at the hospital level is normally deposited into the Health Service Fund (HSF). Both revenues from the public primary facilities and hospitals are recorded in the PER under the cost-sharing component of the off-budget spending. A system of exemptions and waivers is in operation for the poor and vulnerable groups. This is described in more detail in section 6.2.

Out-of-pocket household expenditure (at both public and private facilities) remains the main source of health spending in Tanzania (MOH 2001). According to the NHA of 2001, this accounts for about 47 % of total health expenditure. The largest proportion of out-of-pocket expenditure is at the hospital level, absorbing around 77 % of the total. Government facilities (hospitals/dispensaries/health centres) occupied the biggest share of out-of-pocket spending, accounting for about 55 % of the total. Out-of-pocket spending at non-governmental facilities is equally distributed between the not-for-profit and the private-for-profit sector at 22 % each.

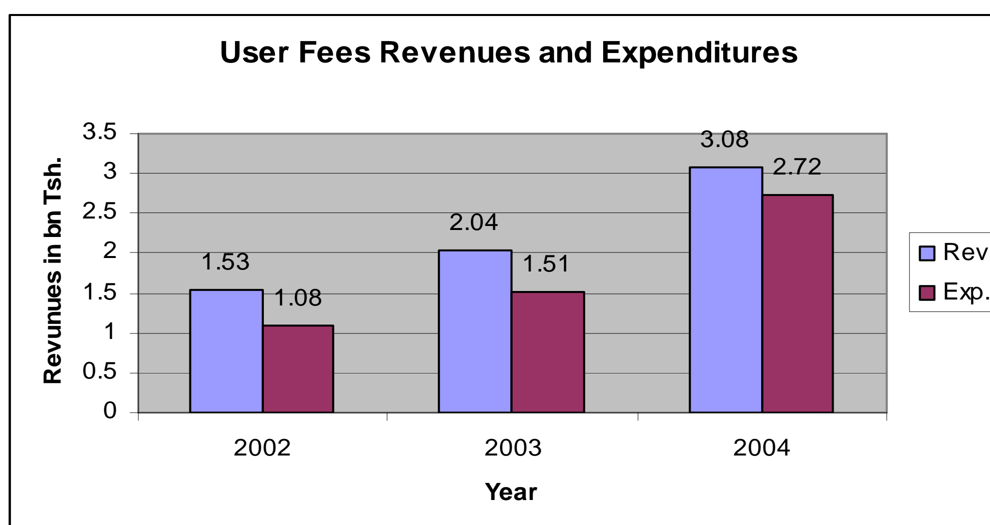
Figure 15: Breakdown of household out-of-pocket expenditure



Source: NHA, 2001

Between 2003 and 2004 user fee revenue and expenditure at the public hospitals increased approximately by 51 and 80 % respectively. However, when compared to other sources, the contribution of user fees to overall total public health care spending is small. User fees at the hospital level represented about 2.7bn Tsh in 2005, less than 1 % of total spending. User fees charged at both the primary and hospital levels account for only 2 % of total public health sector financing (MOHSW 2006).

Figure 16: Public Hospitals User fees revenue and expenditure 2002 – 2004



Source: Health Sector PER update FY05

The NHA do not break down the amount spent on the purchase of drugs in health facilities and pharmacies at either public or private facilities. Thus, it is assumed that

the amount spent at hospital and primary facilities level includes the cost of purchasing drugs. Information from elsewhere suggests that about 15 % of total government expenditure on health is spent on drugs (URT/WHO/EU 2005), which is low compared to the average of 25 % for low-income countries (WHO/Health Action International 2003). It is likely that much of out-of-pocket expenditure on drugs is spent in the private facilities. A survey of medicine prices in Tanzania showed that the median availability of the lowest price generic (LPG) medicines was 23.4 % compared to a median availability of 47.9 % and 42.9 % in the private and NGOs facilities respectively (URT/WHO/EU 2005). However, prices of drugs in private and NGO facilities were higher, approximately two and half times the prices at the public facilities.

5 REGULATORY AND POLICY FRAMEWORK

This section summarises the main regulatory and policy framework governing the provision of health services in Tanzania. As described earlier, the health sector reforms widened the range of financing options and in stark contract to the pre-reform era, the private sector became increasingly seen as a complementary partner rather than as an opponent. Increasing private sector activity led to a natural concern for the role of regulation in achieving and structuring positive benefits. Indeed. the reform documents stress the need for a ‘strong regulatory authority’ to monitor the supply, quality and geographical distribution of health services and associated industries such as pharmaceuticals (URT, 1994). In Tanzania, much of the regulation tends to be legally based and much of the recent legislation with respect to ‘privitisation’ of the health sector reflected the need to regulate private hospitals and facilities. Thus, two key pieces of legislation are the Private Hospitals Act (1991) and the Amendments to the Pharmaceuticals and Poisons Regulation in 1990. Both essentially legalised private practice for pharmacists, hospitals and medical practitioners. Legislation also restricts the registration of new private pharmacies in areas where it is deemed there is already an adequate distribution, but it is not clear whether this happens in practice. The various pieces of legislation are described in more detail below. This is followed by a summary of the main policy architecture in place, and summarised in table 4 at the end of this section.

5.1 Human resources regulation

Human resources are regulated by a number of different Acts in Tanzania. The Medical Practitioners and Dentists Ordnance Act (1966, 1968) is responsible for the

operation and control of standards of medical doctors and dentists. All medical practitioners are expected to register themselves with the Medical Association of Tanzania, which is the body legally established under the provision of this Act after the completion of the minimum required qualifications. The Pharmacy Act, 2002 established the Pharmacy Council which is responsible for registering, enrolling, and listing of all pharmacists, pharmaceutical technicians and pharmaceutical assistants in Tanzania and regulating their academic and practical qualifications. The Council also has the task of approving institutions and curriculum for the training of different cadres in the pharmacy profession.

Other health sector human resource regulatory tools include the Nurses and Midwives Registration Act of 1997, and the Health Laboratory Technologists Registration Act, also passed in 1997. The Nurses and Midwives Registration Act, 1997, established the Nurses and Midwives Council, which is responsible for regulating the professional development of nurses and midwives in Tanzania. The Council is also responsible for approving the different nursing institutions operating in Tanzania. The Health Laboratory Technologists Registration Act, 1997 established the Health Laboratory Technologists Council, which sets the standards for qualification, keeps and maintains the registration list of all health laboratory technologists. Additionally, it regulates standards of conduct and activities of health laboratory technologists.

5.2 Private providers regulation

The amendment of the Private Hospital Regulation Act in 1991, which lifted the ban on private practice, is the single most significant change relating to the regulation of the private sector. This Act is now the guiding regulation for the establishment of all private health facilities in Tanzania. Applications for the establishment of private hospitals must be approved by the Minister of Health. The Registrar of Private Hospitals is responsible for maintaining the list of the private hospitals approved for registration. Importantly, the Act contains some provision to regulate prices as well as entry and exit of providers. The Minister of Health is able to determine and review the price structures of medical treatment provided by private hospitals. For example, the Health Minister can set the maximum prices of any type of medical treatment and the ways in which prices are calculated. Ministerial power furthur extends to the control of salary scales payable to medical practitioners employed at private hospitals, as well as allowances and other benefits. In practice, this mandate has not

applied, and private hospitals are more or less free to fix their own health care prices. With respect to the quality of services, the Registrar of Private Hospitals has the remit to conduct inspections in private facilities to ascertain whether the medical treatment is provided in accordance with specified conditions. Again, there is very little evidence as tothe extent to which this has actually been implemented.

5.3 Pharmaceutical regulation

The regulation of pharmaceuticals is now covered by the 2003 Food, Drugs and Cosmetics Act and is overseen by the Tanzanian Food and Drugs Agency (TFDA). This covers the qualification and registration of pharmacists, and regulation of manufacture, importation, labelling, identification, storage and sale of pharmaceuticals. The Act also gives direction, and controls all clinical trials of drugs, medical devices or herbal drugs in Tanzania. Only accredited pharmacists are allowed to operate and conduct a pharmaceutical business. Private retailers are an important source of pharmaceuticals in Tanzania. However, they tend to be concentrated in urban areas, price competition is weak and information on treatment poor (Goodman, 2004). These failures contribute to inequitable access to quality care. There are three types of retail outlets for drugs in Tanzania: Part I and Part II pharmacies, and general stores. Part I pharmacies must be run by registered pharmacists and are allowed to sell both Part I (prescription–only,) and Part II (over-the-counter) medicines. In 2003 there were 344 Part I pharmacies, 60 % of which were in Dar es Salaam (Battersby et al. 2003). Drugs are widely available in both urban and rural areas from Part II stores and general retailers. However, there is evidence to suggest that many of the Part II stores are unregistered and therefore unregulated.

The Medical Stores Department (MSD) established in 1993 is responsible for developing, maintaining and managing procurement, storage and distribution of approved drugs and other medical supplies required for use by public facilities. In effect this act gives MSD a large degree of monopoly power and many facilities and district councils have criticized this arrangements due to frequent drug stock-outs and slow delivery (MOH 2003; MOH 2006; MOHSW 2007).

5.4 Health financing schemes regulation

Regulation of the National Health Insurance Fund (NHIF) for public servants is guided by the NHIF Act, no. 8 of 1999. All operations under this scheme, including the expansion of membership and the sources of funds are guided by this Act.

Regulation of the National Social Security Fund (NSSF) (which has recently introduced the Social Health Insurance Benefit (SHIB) for formal private sector employees) is provided by the National Social Security Fund Act no. 28 of 1997. Among other benefits, including retirement benefits for employees, the Act mandates the NSSF to cover the costs of health care services for its employees. The issue of the cost of regulation of the National Health Insurance Fund has been raised by some commentators (CHF Workshop Report, 2007). Anecdotal reports indicate poly-pharmacy by providers and moral hazard by members, resulting in inefficiency. NHIF management admitted that there are fraudulent claims at around 12 % of the total, but agreed that this compares favourably with other countries (33 % in the US) (CHF Workshop Report, 2007). One question is how to properly police the scheme since ideally this function needs to be outside of the NHIF. The need for regulation of the health insurance industry is stressed in anecdotal reports, with the need for one single body to take on the role to maintain consistency between the different schemes.

The CHF Act of 2001 gives direction on the implementation of the Community Health Fund and importantly it directs all the councils to initiate the implementation of the Community Health Fund. Some have argued that the mandatory nature of the regulation (installed before the scheme had embedded itself in many districts), may in itself pose a challenge for the development of the CHF, since it does not allow much flexibility in the way the schemes are organised in what are often very different settings.

There is, as yet, no specific regulatory framework for private health insurance, thus in practice, the General Insurance Act of 1996 is used. This regulates all kinds of insurance firms in Tanzania. Community based health financing schemes (CBHF) are registered as NGOs and registration is regulated under the Non-Government Organizations Act, of 2002. The lack of regulation of these schemes is a growing concern in Tanzania (MOHSW 2007). Such schemes are largely left to operate with little oversight or co-ordination.

Table 4: Summary of the Main Health Sector Regulatory Framework

Regulatory Area	Act/Regulation	Objectives
Health Sector Human Resources	1. Medical Practitioners and Dentists Ordinance Cap 409 (with various amendments)	Providing conditions and qualifications of practising as a medical doctor or dentist
	2. Pharmacy Act, 2002	Providing qualification conditions for being registered as a pharmacist in Tanzania
	3. Nurses and Midwives Registration Act, 1997	To control the operation of nurses and midwives in Tanzania
	4. Health Laboratory Technologists Registration Act, 1997	Set conditions for being registered as a health laboratory technologist in Tanzania
Service Provision	1. Private hospitals regulation Act, 1977 - Amendment in 1991	Set conditions for the operation of the private health care providers in Tanzania. The 1991 amendment removed the ban for the private-for-profit operation in Tanzania
	2. Private Health Laboratories regulation Act of 1997	Regulate the operation and registration of the private laboratories in Tanzania
	3. Medical Stores Department act of 1993	Controls the drugs and other medical equipment supply in the public health facilities
	4. Tanzania Food, Drugs and Cosmetics Act, 2003	Regulate all matters relating to quality and safety of food, drugs, herbal drugs, medical devices, poisons and cosmetics
Health Care Financing	1. Cost sharing implementation guideline of 1994	Lead the implementation of user fees in the public health care facilities and specify categories of health care or groups qualifying for user fees exemptions and waivers
	2. NHIF Act, no. 8 of 1999	Establishing the National Health Insurance Fund for the Public sector formal employees and regulate its operations
	3. CHF Act, no. 1 of 2001	Establishing the Community Health Fund in Tanzania and guide its implementation in informal sector in rural councils of Tanzania.
	4. NSSF Act, no. 28 of 1997	Establishing a social security fund for the private sector employees which allow them to get retirement benefits, and other benefits including health insurance benefit
	5. Insurance Act, no. 18 of 1996	Regulate the insurance business in Tanzania. The same act is used for the insurance firms providing private health insurance
	6. Non-Governmental Organizations Act, no. 24 of 2002	Providing conditions and guidelines for registration as a non-governmental organization in Tanzania. The community based health financing schemes in Tanzania are registered as NGOs under this Act.

5.5 Main health policies and strategic framework

This section provides a summary of the main policies and their strategic setting governing health in Tanzania.

5.5.1 National Health Policy

The National Health Policy, revised in 2003, provides the over arching framework and policy detail for the Tanzanian health system. The stated aim is to provide direction for achieving improvement and sustainability of the health status of all citizens. Focus is put on the reduction of disability, morbidity, and mortality, together with improving nutritional status and raising life expectancy based on the maintenance of equity, quality, and affordability in service provision. The NHP emphasizes the following areas:

- Strengthened District Health Services and referral systems;
- Diversified complementary health care financing options;
- Strengthened human resources;
- Creating public awareness at all levels through Advocacy and IEC on preventable public health problems, and the need for active community involvement;
- Improved coalition and multi-sectoral collaboration;
- Representation of stakeholders and communities in health service delivery;
- Increased public private partnership in health provision; and
- Effective donor and other stakeholder co-ordination.

Regarding health financing, the policy is clear that the Government will continue to be the major financer of health services. However, the policy also emphasises that communities are expected to contribute to financing through cost sharing and other mechanisms. The main ways in which this is achieved is via user fees in the public sector, the Community Health Fund (CHF), the National Health Insurance Fund (NHIF) and payments to private organisations, as discussed in earlier sections. .

5.5.2 Vision 2025

In 2000, Tanzania formulated Vision 2025. This was developed as a tool to give direction for longer term national development. The scope encompasses attainment of high quality of life; ensuring a peaceful environment; stability and maintenance of unity; good governance; a well educated and learning society; and ensuring a competitive economy with sustainable growth by the year 2025 (URT 2000). Vision

2025 emphasises that the improvement of the helath sector is critical to attaining a high quality of life. In particular, the strategic vision highlights improving access to quality primary health care and reproductive health services for all, reducing infant and maternal mortality rates and increasing life expectancy comparable to the level attained by middle income countries.

5.5.3 National Poverty Eradication Strategy

The National Poverty Eradication Strategy (NPES 2010) was formulated in 1998 with the objective of providing a framework to guide poverty eradication initiatives (URT 1998). The Stategy and Vision 2025 were designed to be complementary. Among the components of poverty that have been stated in the NPES 2010 is poor health and nutrition. Within this, the strategy aims at reducing the burden of disease and deaths together with increasing life expectancy. It also aims at increasing access to health centres and to reduce distance to the health facilities together with reducing the maternal mortality rate. Among the policies to be adopted to achieve these objectives, the NPES emphasises: increased allocation of resources for health sector development, increased allocation of resources to preventive health services and the promotion and strengthening of rural health facilities. Priority is also given to HIV/AIDS and other communicable diseases.

5.5.4 National Strategy for Growth and Reduction of Poverty (NSGRP)

The National Strategy for Growth and Reduction of Poverty (NSGRP), (or MKUKUTA in its Swahili acronym), was launched in 2005 and is the guiding national strategy on reducing the growth of poverty in Tanzania. It emphasises the improvement of survival, health and well being of all, in particular women and children and other vulnerable groups (URT 2005). In tackling existing health system problems, the NSGRP addresses issues of finances and infrastructure together with human and logistic weaknesses. An essential component of the strategy is to reduce the income poverty of both men and women in rural areas and increase sustainable off-farm income generating activities. The target is to reduce the proportion of the population who are below the basic needs poverty line from 39 % in 2001 to 24 % by 2010; and those below the food poverty line from 27 % in 2001 to 14 % in 2010 (URT 2005).

6. EQUITY IMPACT OF THE TANZANIAN HEALTH SYSTEM

A key aim of SHIELD is to assess the extent to which the financing burden of different financing mechanisms falls on different socio-economic groups. Similarly, the distribution of benefits arising from different mechanisms will also be assessed. Together these two concepts will determine the overall health system equity. The SHIELD project will make use of existing analyses and generate new analyses to answer this question. The purpose of this section is to review what is already known about financing and benefit incidence in the health system in Tanzania, drawing on the evidence presented in previous sections. These data together with an indication of the main gaps are presented below.

6.1 Defining equity

Equity may be defined as the requirement that individuals of unequal ability to pay make different payment (Vertical equity) or those of the same ability to pay make the similar contribution (Horizontal equity) (Wagstaff 2001). Whatever definition of equity is used the central idea is some notion of 'fairness'. In analysing the equity implications of existing health financing initiatives in Tanzania, it is important to look at barriers to access to health services of vulnerable groups namely, the poor, children, women, and disabled people. It is clear that the different methods of financing outlined above will impact differently on each group in terms of: rate and terms of contributions, benefit package, type of providers and quality of care.

Tanzania has a large proportion of its citizens working in the informal sector and about 80 % of the population live in rural areas where agricultural activities are the main source of their survival. However, there is an increasing trend of rural-urban migration, whereby people migrate from the rural areas to conduct petty businesses in urban areas. These activities yield an income that is neither guaranteed nor sustainable and leads to variations in income between groups of people working in the informal and formal sector. There is also a difference in income between those in rural areas and those living in urban areas. Demands for health services and the ability to finance health care will differ between these groups.

Therefore, in analysing equity in health financing it is important to look at how different groups of people are covered and how barriers to access are affected. Another factor relates to the social security system. In Tanzania, this tends to favour

those who are employed and in the formal sector, rather thanthose who are unemployed or working in the informal sector. Existing mechanisms such as the National Social Security Fund (NSSF), Public Servants Pension Fund (PSPF), Local Authorities Provident Fund (LAPF), Parastatal Pension Fund (PPF) and the National Health Insurance Fund (NHIF) are all designed for formal employees.

Table 5 compares the different financing initiatives across various dimensions. There then follows an initial exploration of issues and data relevant to the financing and benefit incidence studies that will comprise work packages 2 and 3 of the SHIELD project.

Table 5: Summary of possible equity impact of health financing mechanisms in Tanzania

Financing mode	Fund source	Membership	Benefit package	Population benefiting	Who pays
TAX & DONORS	Public Taxation (about 10.1% of total govt expenditure)	Compulsory for direct tax payers	All diseases are covered in principle	All (Urban & Rural) in principle. Although not everyone benefits from public services.	No data on who actually pays taxes. Those in formal employment most likely to pay direct taxes.
USER FEES	Out-of-pocket payment during treatment	Optional – only when accessing health services	All diseases depending on the ability to pay	All	All with exemptions for vulnerable groups and the poor
NHIF	Membership fees from public servants' income (6% of monthly salary)	Compulsory for public servants	Selected benefits	Public servants (about 3 % of the total TZ population)	Those in formal employment
CHF	-Membership fee (5000/annual/ household) -Govt contributions -User fees at dispensaries and health centre	Voluntary	Primary care at dispensaries & health centres	Informal sector rural population	Targeted at rural areas and those working in the informal sector. Exemptions for vulnerable groups and the poor
PRIVATE INSURANCE	-Premium	Voluntary	According to insurance policy	Mainly urban	No data. Likely to be wealthier groups
INFORMAL SCHEMES	Membership fee. Varies across schemes	Voluntary	Selected	Informal sector urban population	No data. Likely to be wealthier groups

6.2 Issues relevant to financing incidence

There is very little information on the financing incidence of the main contribution mechanisms other than user fees and to a lesser extent the CHF. This will be a major part of work package 2. For government financing, the main contribution mechanism is through taxation. Normally the revenue collected goes into the basket fund and the allocation to the health sector and other ministries is done by the Ministry of Finance after receiving the budget plan from the respective ministry. Citizens contribute to health services through the Pay as You Earn (PAYE) tax system which overall is progressive in nature and to an extent ensures equity in-terms of contribution. According to the tax structure, those with a monthly income below 80,000 Tanzanian shillings do not pay tax and those above that pay tax depending on what they earn (TRA 2005). Income tax is divided into four bands with rates categorised by level of income. There is very little information on who is actually paying tax in Tanzania and the impact that this has on household income.

In the NHIF, members contribute the same proportion (6 %) of their income which is equally shared by the employee and the employer. Its financing impact is therefore not progressive, but neutral. For many, the premium of 3 % of income is too high and adversely affects their consumption patterns. However, more information is required on the willingness to pay different premium rates and the impact on disposable income.

With respect to the CHF, all members pay the same amount per year regardless of income and it is therefore more regressive in nature. Those with a low income end up paying a greater proportion of their income compared to higher income earners, though the income gap in rural areas tends to be small. Wwith the CHF however, there is the potential for introducing differential timings and spreading out the cost of the premium across the year or to coincide with times of harvests. This could mitigate some of the worst effects.

There have been a number of studies examining the impact of user fees and out-of-pocket expenditures in Tanzania. Save the Children (2005) conducted a series of studies in rural Lindi to establish the impact of user fees. They argued that the typical amount of household income remaining for health expenditure after the

deduction of non-food expenditure is minimal and there are strong equity arguments for the removal of fees. Laterveer, Munga, et al. (2004) also examined the equity implication of health sector user fees charged at the dispensary and health centre level in Tanzania. They also point to the inability of the waivers and exemptions to properly protect the poor and vulnerable groups. This is also supported by Mamdani and Bangser (2004), in a review of poor peoples' experience of health services in Tanzania.

Whilst rules for exemptions for poor individuals have generally accompanied the introduction of user fees in developing countries, there are often incentives, such as the link between user fees and staff payments and salaries, which make health centres reluctant to apply them. A system of exemptions and waivers was supposed to be an integral part of the user fee policy introduced in 1994 and, by extension, of the CHF.[4] However, the failure of the waiver system in particular to protect the poorest is generally agreed as the major weakness regarding cost-sharing in Tanzania (Laterveer, Munga et al. 2004). In effect, the majority of those who are liable for exemption are not aware of which exemptions they qualify forand thus, what they are supposed to pay. It is argued that only health facility employees are aware of the operation of waivers and exemption (Mubyazi, Massaga et al. 2000).

There has only been one formal study of the impact of catastrophic health expenditures in Tanzania (Soma, 2006). This study, conducted in Ifakara, South-Eastern Tanzania, grouped households into socio-economic status quintiles using consumption information, average consumption, capacity to pay for health care and amount spent on health care determined. The findings showed that average household consumption, capacity to pay, amount spent on health and the share of capacity spent on health varied significantly by socio economic status. Household spending on health was highest in health centres, followed by hospitals and traditional healers. In the vast majority of cases households used their own funds to pay for health care, but average spending was higher when assistance was received from outside the household. The proportions of households experiencing

[4] Exemptions are for priority population groups, eg under-five children, pregnant women, and for selected diseases/conditions, eg typhoid, chronic illness, AIDS, TB and leprosy, epidemics. Waivers target the poor and vulnerable on grounds of ability to pay

catastrophic[5] health expenditures also varied depending on the definition of catastrophic used and also by socio-economic status quintile (see Table 6 below). However, regardless of the threshold used and socio economic status, the prevalence of catastrophic health expenditures was high. An important consideration for SHIELD will be to see if these findings are more widespread using comparable methodologies and sampling strategies.

Table 6: Households experiencing catastrophic health expenditures in Ifakara, Tanzania

SES quintile	Catastrophic health spending cut off (percentage of total expenditure)					
	30%		40%		50%	
	Number	Percentage of quintile	Number	Percentage of quintile	Number	Percentage of quintile
Most poor	17	15	9	8	6	5
More poor	7	6	4	4	2	2
Poor	9	8	5	5	3	3
Less poor	15	14	8	7	4	4
Least poor	5	5	4	4	2	2
TOTAL	**53**	**10**	**30**	**5**	**17**	**3**

Notes: N= 557 households, Source: Soma (unpublished thesis)

6. 2 Issues relevant to benefit incidence

6.2.1 Access to health care

Health service utilisation in Tanzania shows a strong and inverse relationship with socio-economic status. There is now a growing body of evidence on equity of access to health services in Tanzania. For instance, Smithson (2006) reanalysed data from the Tanzania DHS and showed that women from richer households are: 3.4 times more likely to use modern contraception than the poorest; 2.8 times more likely to receive skilled assistance at delivery; and, 8.7 times more likely to give birth by a caesarean section (3.6 times for women in urban areas). On the other hand, the poorest women are more than 7 times more likely to give birth at home and receive no post-natal check-up for their infants. Compared to their poorest counterparts, the children of richer women are 40 % more likely to receive treatment for fever at a health facility, and 20 % more likely to receive any oral rehration solution diarrhoea. Wealthier households and those in urban areas have more opportunities for

[5] “Expenditure at such a high level as to force households to reduce spending on other basic goods (e.g. food or water), to sell assets or to incur high levels of debt, and ultimately to risk impoverishment"
In addition, expenditure is regarded catastrophic" if a household's financial contributions to the health system exceed 40% of income remaining after subsistence needs have been met".(Xu, Ke, Evans, D. et al. 2003.

accessing health care and there is a significant difference in health care utilisation between the rich and the poor and between those in urban and rural areas.

There are also noted inequities in the distancestravelled to health facilities between the rural and urban. An average distance to the hospital in urban areas is about 3kms compared to 27kms in rural areas. For instance, about 34 % of the poorest in rural areas live within 10kms of hospital compared to 42 % of the least poor; while in urban areas, 97 % of the poorest are within 10kms ofa hospital compared to 99 % of the least poor (Smithson 2006). The long distance to health facilities has been cited as a key barrier to health care access. The Tanzania DHS of 2004/05 reports that about 37 % of the women reported that they could not access health care because of the sheer distance and the cost of transport (TDHS, 2004/05). Obviously, This impact is much higher in rural compared to urban areas and in the poorest group compared to least poor (see table 7). The conclusion is clear: those who most need health care are consuming it least (Smithson 2006).

Table 7: Percentage of women who cited distance to facility as a barrier to health care access by wealth quintiles and residence

Wealth Quintiles and Residence	Percentage
Lowest	51.9
2nd	48.9
3rd	43.5
4th	34.8
Highest	16.6
Urban	15.9
Rural	46.2

Source: TDHS, 2004/05

Results from the DHS show a variation in the ownership and usage of Insecticide Treated Nets (ITNs) across social economic groups and between urban and rural areas. For example, 47 % of pregnant women from the highest quintile had slept under an ITN, the previous right, compared to only 5.5 % of the lowest quintile. The gap is even higher in geographical distribution where about 59 % of pregnant women in urban areas sleep under ITNs compared to about 10 % of pregnant women in rural areas (URT 2005).

6.2.2 Access to public health services

There are mixed findings when it comes to access to publicly subsidized goods such as vaccinations. Results from the DHS shows that children from the least poor groups have more access to vaccines (table 8) compared to the children from the

poorest quintiles. About 58.3 % of the children aged 12 to 23 months from the poorest families, received all the four vaccinations (BCG, DPT-HB, Polio, and Measles) compared to children from the highest wealth quintile. There is also a difference in terms of urban and rural areas as shown in table 8 below.

Table 8: Access to Child vaccination by wealth quintiles and residence (12-23 months children)

Wealth Quintiles and Residence	Vaccine type and coverage				
	BCG	DPT-HB (3doses)	Polio (3doses)	Measles	All 4 Vaccines
Lowest	87	75.2	74.3	65.2	58.3
2nd	90.5	82.7	80.9	79	70.8
3rd	91.3	88.1	87.7	81.4	70.8
4th	93.8	93.4	91.0	89.7	80.6
Highest	96.9	95.6	87.5	90.9	80.7
Urban	96	94	88.4	89.7	81.5
Rural	90.3	84	82.5	77.7	68.8

Source: TDHS, 2004/05

A study conducted by Njau and others in Kilombero, Ulanga and Rufiji DSS, showed no significant difference by socio-economic groups in the use of government facilities for the treatment of malaria (Njau, Goodman et al. 2006). However, the wealthiest groups were significantly more likely to use an NGO facility. Thirteen % of the better-off visited an NGO facility for malaria treatment compared to 3 % of the poorest. This study further showed that the probability of getting an anti-malarial drug was almost the same for the poorest and the better off in public facilities while the better off were most likely to get drugs in NGO facilities (which tend to give higher quality services) than the poorest.

7 CONCLUSIONS

Many gaps remain in determining who is paying and who is benefiting from health care in Tanzania. For example, there is very little information on the incidence on the tax burden between different income groups; where household out-of-pocket expenditures are spent; and the nature and extent of financing to and within the private sector. What data there are suggest that the poor tend to pay a much greater proportion of household income on health care than the less poor, and are more likely to suffer from catastrophic health expenditures. Access to funds at the time of

illness is a critical issue for households in Tanzania, and one that causes short and long term difficulties for families.

Health insurance is regarded as the best method to protect households from health payments that may be catastrophic, and a move towards social health insurance is a core element of the Government's health financing policy. There is a strong feeling within the MOHSW that those who are able to contribute should contribute via the NHIF, the CHF or one of the other pre-payment schemes. The CHF, in particular, is seen as the main way of attaining universal coverage for all. However, while there appears to be support for the CHF amongst many stakeholders in Tanzania, the evidence on its performance is weak and implementation is variable throughout the country. Factors such as low community participation, poor use of revenues collected and inconsistent drug availability at health centres, threaten its potential for reaching universal coverage in Tanzania. The rolling out of the CHF raises many questions such as how to ensure its sustainability within districts, how to make the system of exemptions and waivers work more effectively and how to improve the management of the scheme by district implementers.

There is also a need to address equity concerns between the CHF and other pre-payment schemes given that, for example, NHIF members receive a subsidy, which substantially exceeds the annual per capita spending on health. Furthermore, more information is needed on the overall breakdown of household out-of-pocket payments between user fees, drugs, and other medical supplies. Even higher income individuals who are covered by the various pre-payment schemes face potentially considerable out-of-pocket payments, in the form of co-payments and payments for services outside of the benefit package.

Finally, there is currently limited scope for cross-subsidies in the Tanzanian health system. In particular, there is no scope for cross-subsidisation between the CHF and NHIF, resulting in very fragmented risk pools. The NHIF has some ability for cross-subsidisation between the poor and less poor but tax funding of health services is the main mechanism through which income cross-subsidies are promoted within Tanzania. The fact remains, however, that the tax base is small, and funding, even with substantial donor support, is extremely limited. The SHIELD project will make an important contribution by comprehensively estimating overall financing and benefit incidence and exploring the nature and extent of existing and potential cross-subsidies in the Tanzanian health system.

The next phase of SHIELD will synthesise and analyse primary data to provide insights into the precise extent and nature of financing and benefit incidence and related health system cross-subsidies. In addition, the factors that influence financing and benefit incidence will be explored in detail. Strategies for addressing equity, sustainability and other health system challenges, particularly through the CHF, will be explored in detail in relation to their ability to address the equity, sustainability and other health system challenges. Given the importance for the successful implementation of any possible changes in the health system of the acceptability of such changes to key stakeholders, extensive stakeholder analyses will also be undertaken in future SHIELD work. It is hoped that this work will contribute to informing policy development towards achieving a more equitable and sustainable health system in Tanzania.

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