AN ASSESSMENT OF THE HEALTH FINANCING SYSTEM IN TANZANIA: IMPLICATIONS FOR EQUITY AND SOCIAL HEALTH INSURANCE

REPORT ON SHIELD WORK PACKAGE 1

Gemini Mtei[1], Jo Mulligan[4], Natasha Palmer[4], Peter Kamuzora[2], Mariam Ally[3], Anne Mills[4]

[1] Ifakara Health Research and Development Centre;[2] University of Dar es Salaam

[3]Ministry of Health and Social Welfare, Tanzania;[4] 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
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 Ministers' 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

1. INTRODUCTION

1.1 The SHIELD Project

The overall 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.

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. First 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 organizations 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 addresses key equity challenges and ensures 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 the background and starting point for the more detailed critical evaluation of the existing health system. We also consider proposed developments for future health insurance developments. 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 expansion.

It is clear that any future proposals for developing the health financing system will need to be grounded in what is acceptable and feasible to key stakeholders including the Ministry of Health and Social Welfare (MOHSW), the donor community, representatives of the main insurance organizations and other interested parties. An important part of the SHIELD project is also to understand the role of stakeholders in determining the acceptability of different options for health system financing, health insurance reform and future equity goals. While, this is the focus of Work Package 4, early findings are reported in part in this report.

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 gives highlights of the main policies driving the health sector. Equity implications of the health system are discussed in section six and includes a discussion of issues relevant to financing and benefit incidence. The report ends with preliminary findings from the stakeholders analysis in section seven and next steps for the SHIELD project in section eight.

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 recognized in the literature on equity in health financing in Tanzania. Not much has been done in this area apart from partial reviews on user fees. In addition, the last NHA in Tanzania was conducted in 2001 hence its information is not up to date bearing in mind the fact that various other financing arrangement have recently been put in place. This fact 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 contribution mechanisms of each financing mechanism, benefit package and distribution, coverage, and accessibility. In addition to document review we conducted semi structured in depth interviews with key stakeholders in order to ascertain the degree of support or opposition to the existing health financing system and any proposals for its development. A more detailed explanation of the methodology of the stakeholder interviews is provided in section 7. Finally, we also participated in a workshop on the CHF to explore views on the CHF and this is also reported in section 7.

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 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 37million. About 40 percent 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 kilometer in arid regions to 51 persons per square kilometer in well-watered highlands of Tanzania.

About 80 percent 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 percent of the total population. GDP is growing by an annual average of 6.7 percent and the agriculture sector, which contributes about 45 percent of GDP is growing by 6 percent. The country's per capita income is estimated at US$270 per year.

2.2 Governance and Politics

Tanzania is a result of a union between Tanganyika and Zanzibar in 1964. Tanganyika got its independence in 1961 under President Julius Kambarage Nyerere while Zanzibar revolted in 1963 under President Abeid Aman Karume and later the two countries formed a union in 1964 and became the United Republic of Tanzania. The country is led by a constitution with three governing bodies namely *Executive* (consisting of the president who is the chief of state and commander in chief, vice president and 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 high court, people's district courts, kadhis court/islamic courts). Since independence in 1961 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 above 18 years old and the elections are every five years. A person can not be a president for more than ten years. Currently there are about 17 parties and the CCM still holds the presidential seat and makes up about 84 percent of the parliament representatives which are 317 in total. The Civic United Front (CUF) is the second leading party and occupies 9 percent of the parliamentary seats. Other parties that have representatives in the parliament are CHADEMA, TLP and UDP. Gender-wise, women form about 30 percent 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 and in 2005 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 1000 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)

2.31 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 the most recent few 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 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.

2.32 Malaria

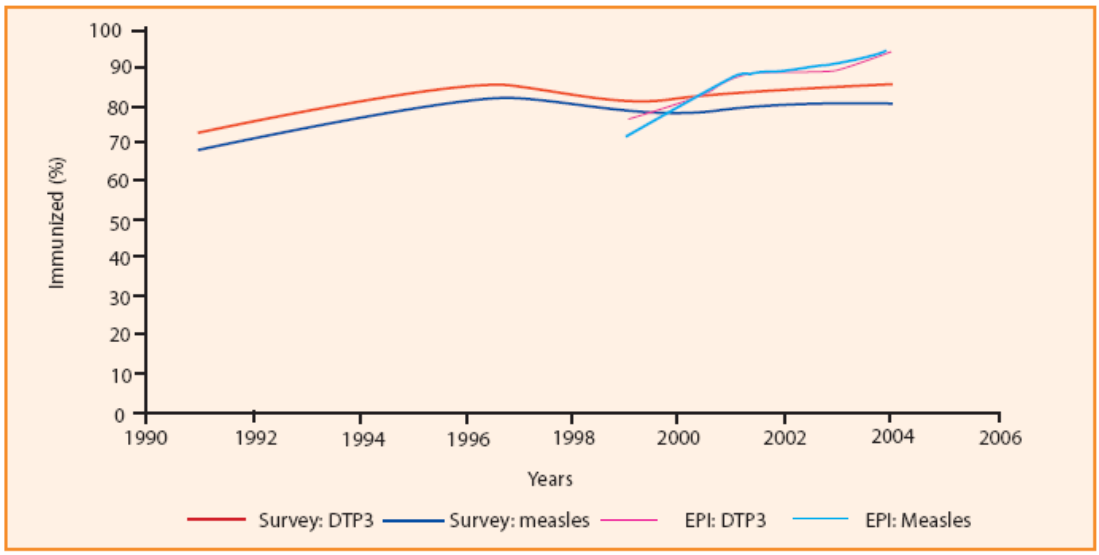
Malaria, along with anaemia, is still the main cause of mortality for children under five years. In 2004 malaria and anaemia accounted for 48 and 10 percent of deaths for under five children respectively. Malaria is also the leading disease for out patient diagnoses and hospital admission for both under fives and those aged five and

above. In 2004, malaria accounted for about 39 percent of OPD diagnoses for under five years and 48 percent for those age five and above; while for inpatient cases it accounted for about 33 percent and 42 percent for patients under five years and those age five and above respectively (MOHSW 2006).

2.33 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 DPT3 and measles vaccinations have returned to 1996 levels after a slight decline in 1999. The 2004 coverage rates are 80 per cent for measles and 86 per cent for DPT3, exceeding the 85 per cent DPT 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

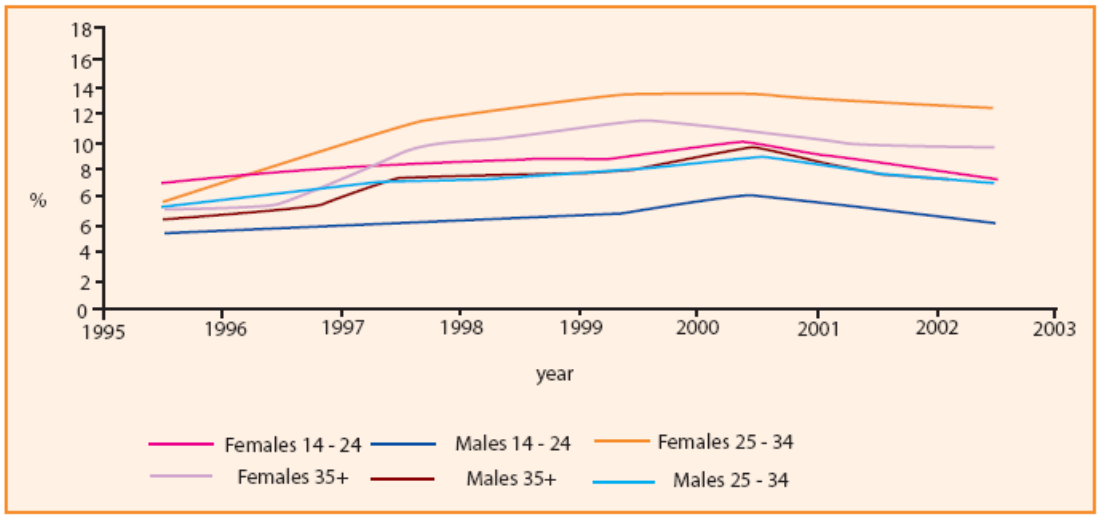
2.34 HIV/AIDs

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 ESRF (2003) show that by 2015, the economy will be 8.3 per cent smaller and the per capita GDP will be around 4 per cent lower as a result of HIV/AIDS. The Tanzania HIV/AIDS indicator survey shows that 7 percent 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 per cent, 8.2 per cent for male blood donors, compared to 11.9 per cent in female blood donors.

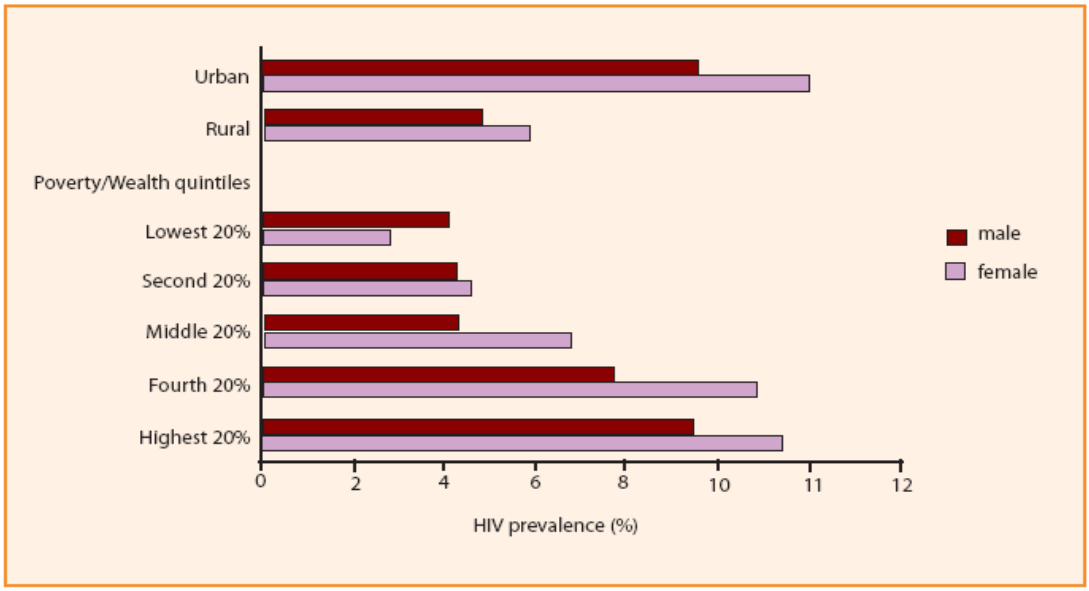
Figure 2: Blood donor data: age and sex specific HIV prevalence, 1996-2003



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 percent respectively compared to 6 and 5 percent in rural women and men. The infection difference in wealth quintiles is skewed to the highest wealth quintile of which 11 percent of the tested individuals were HIV positive compared to 3 percent in the lowest quintile.

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



Source: Poverty and Human Development Report, 2005

2.35 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 is monitored: assisted deliveries by health professionals. Nationally, between 1999 and 2004, there was a slight increase in the proportion of births assisted by health professionals, from 41 per cent in 1999 to 46 per cent in 2004.

3. THE HEALTH SYSTEM

3.1 Historical policy background

After the attainment of 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 financing and providing health services free of charge 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, the central government started the health sector reform process in an effort to better utilize health resources, improve primary care, increase user access, and cut rising costs. These reforms represented significant organizational, managerial, and financial changes to health care planning and services.

3.11 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 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.

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

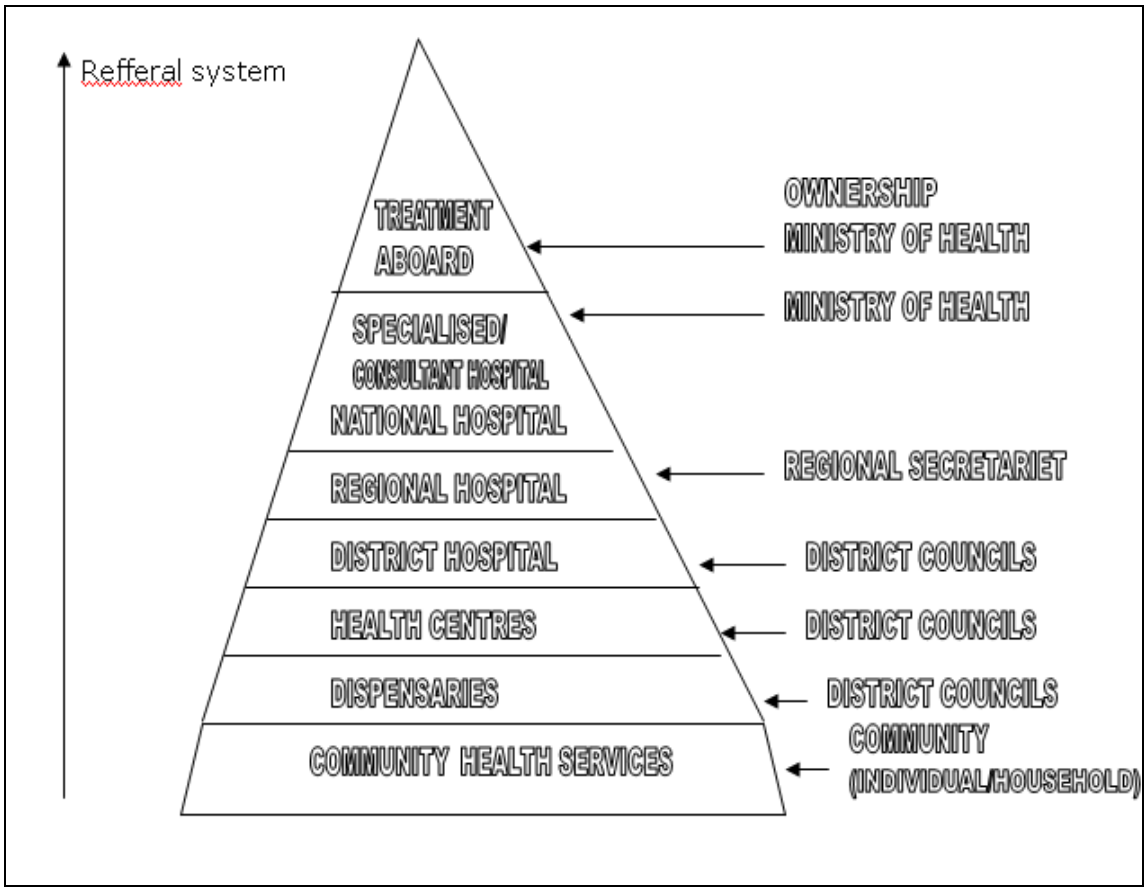
Table 2: Key events in health financing reform

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 Civil servants
2001	• Official Implementation of CHF aimed at informal rural sector

3.2 Public health sector

The government remains the main provider of health services in Tanzania and owns about 64 percent of all total health facilities. About 87 percent of all facilities are dispensaries; health centres and hospitals account for about 9 and 4 percent. The total number of health facilities is 5379. About 45 percent of the population live within 1 km of a health facility, 72 percent within 5 km and 93.1 percent within 10km of a health facility (MOHSW 2006). Under the administrative set-up 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 specialized hospitals.

Figure 4: Tanzania Referral System Arrangements



Source: www.moh.go.tz

At the national level, the 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; and 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 decentralizing government health functions. The roots of the decentralization process can be found in the rapid growth of the public health sector between 1972 and 1980 with the 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 to this the government decided that the focus should be to strengthen district health services requiring devolution of power from the centre to the district. Such shifts of power, of course had to be accompanied with strengthened management capacity.

3.3 The private sector

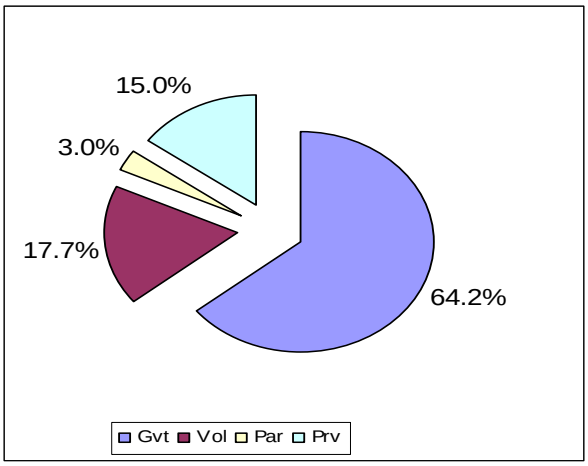
The prohibition of private practice in the health sector in 1977, masked private sector activity rather than eliminated it. The government lifted the ban in 1991 as part of a broader set of government policy reforms to encourage private activity. Private individuals were now allowed to establish, own 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 percent of total health facilities respectively (table 3 and figure 5).

Table 3: Health Facilities in Tanzania

	Health Centers	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

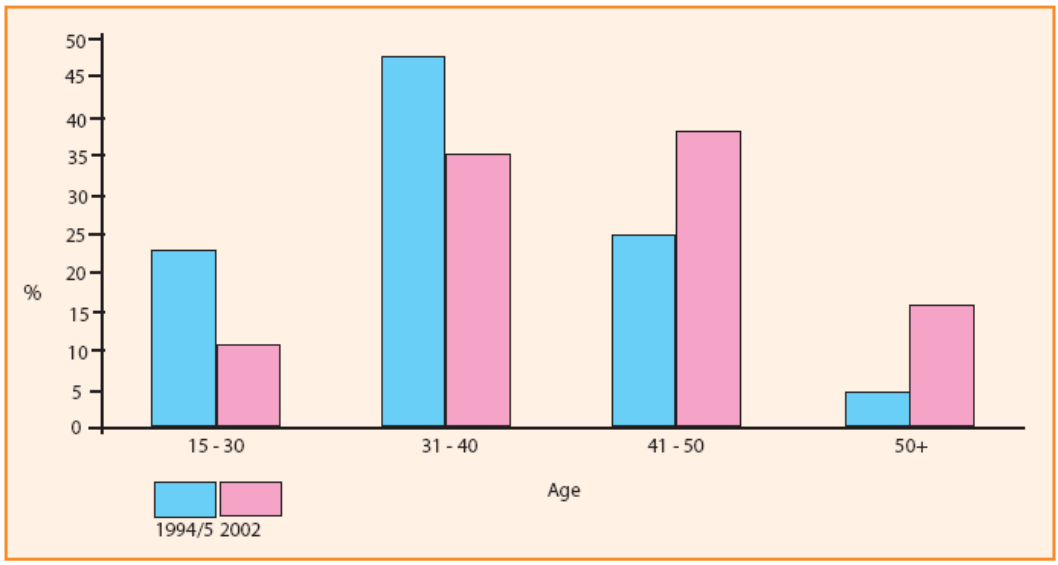


Key: Gvt = Government, Vol = Voluntary organizations, Par = Parastatals, Prv = Private
Source: Data from Annual Health Statistical Abstract, 2006

3.4 Human resources

The government is the main employer of health workers employing about 74 percent of all health staff. Overall, 65 per cent of the 54,200 health workers in 2002 were located in the public sector, 22 per cent in private not-for-profit and 14 per cent in private-for-profit. Faith based organizations employ 22 percent; while private sector and para-statal owned facilities respectively employ 3 and 1 percent 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 per cent), followed by the professional group of nurses and midwives (24 per cent) (Kurowski, Wyss et al. 2003). Between 1994/5 and 2001/02, the number of active health workers per 100,000 population decreased by 35 per cent: 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 below).

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 per cent of the health workers, mainly constituting low skilled cadres, were employed in the rural areas. The16 per cent who are employed in urban areas represent a disproportionate share of high skilled cadres. Even after corrections for infrastructure distribution, regional variation in staff per 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 not only negatively affect quality of care, but also reduce the utilisation of health services and ultimately impact negatively on health outcomes. Existing constraints in staffing are likely to be further aggravated by the HIV epidemic’s impact on increased mortality and morbidity in the work force; and because of increasing demands placed on the health sector for additional care of those infected.

4. HEALTH FINANCING AND EXPENDITURE

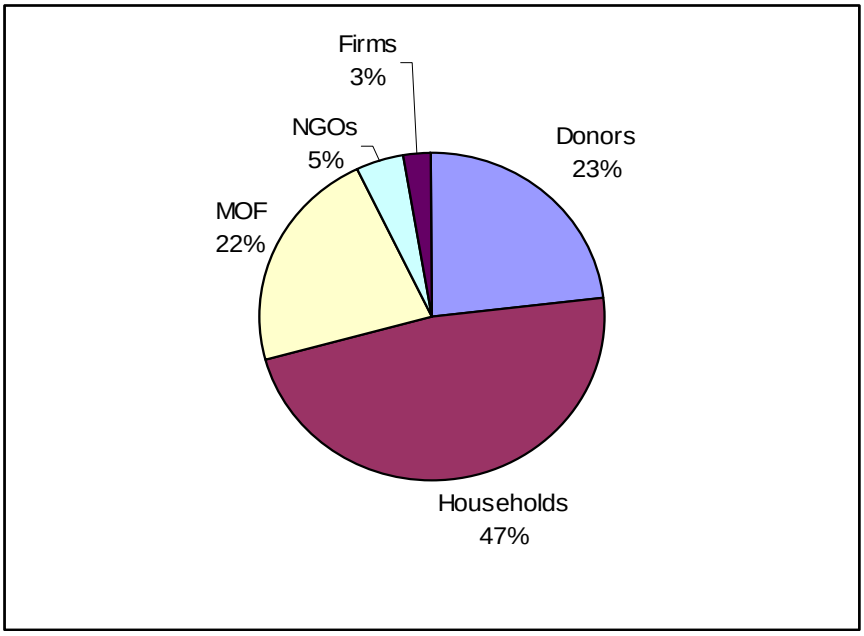
The aim of this section is to consider how and where money is spent by the health system. Unfortunately the latest available comprehensive data for Tanzania is from the NHA of 2001; however this is combined here with more recent data from the public expenditure reviews to provide as up to date a picture as possible on the flow of funds in and around the health system.

4.1 Overview of health financing

The National Health Accounts (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 NHA, 2001 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 percent 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 percent 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

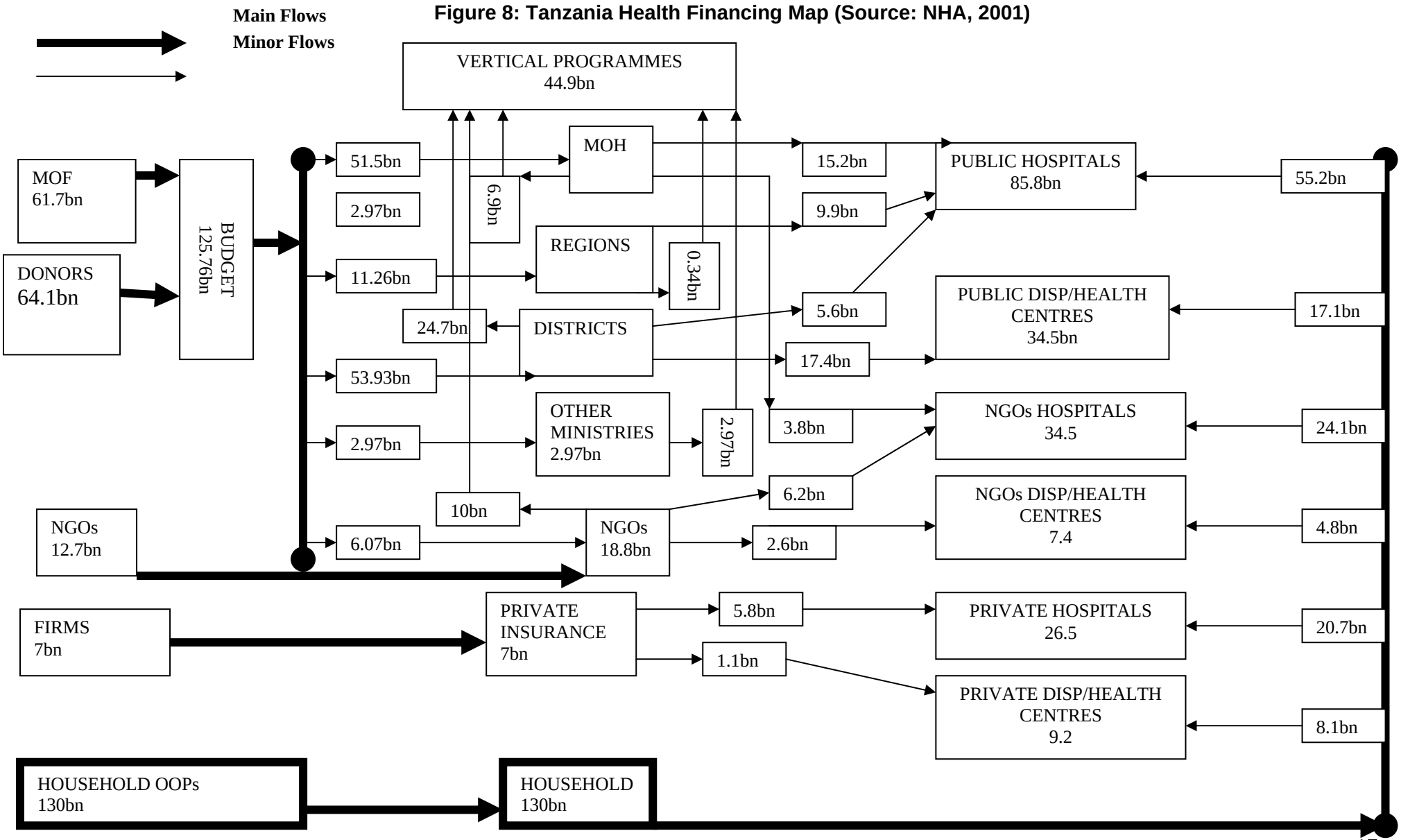


Source: NHA 2001

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)

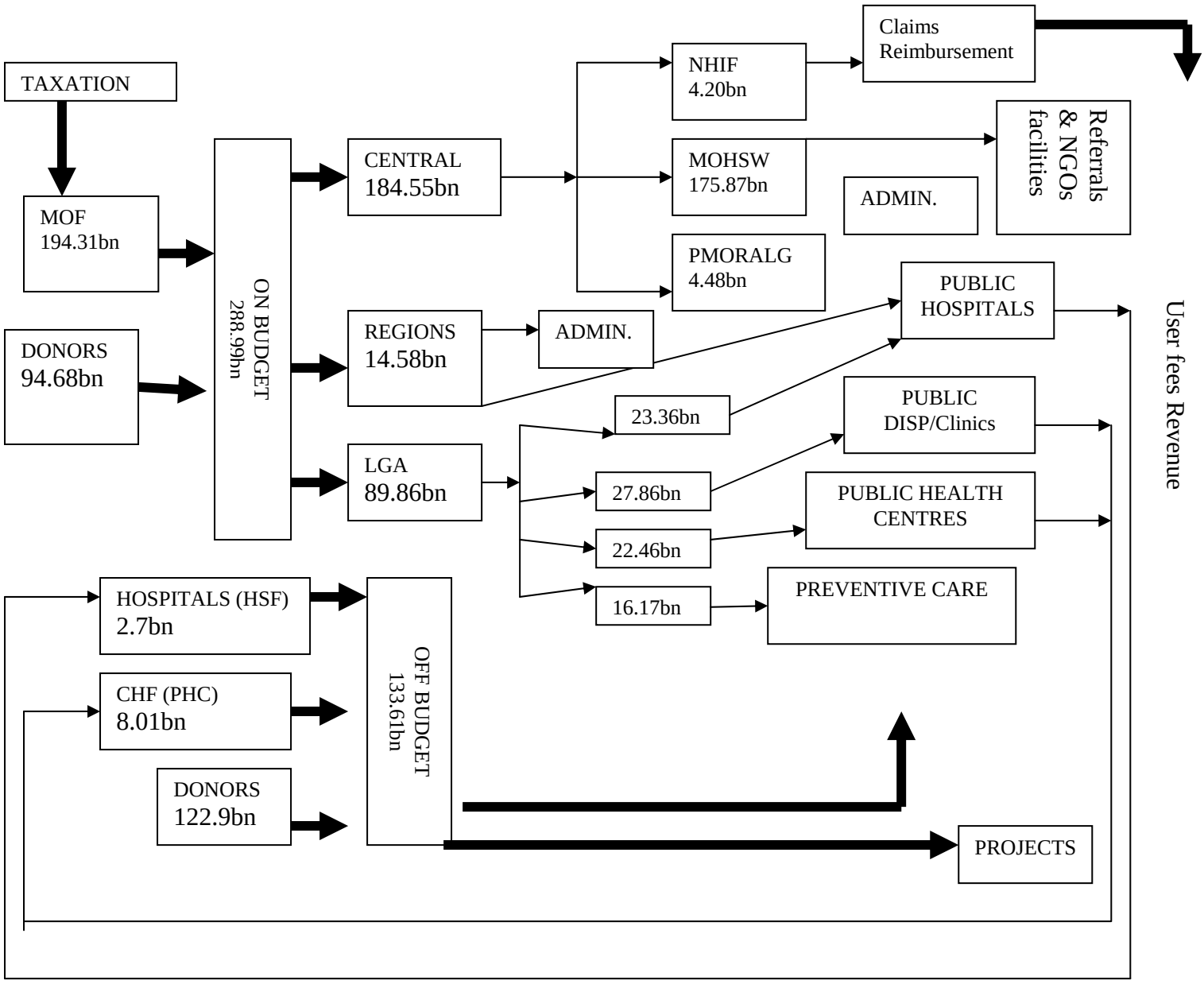


4.2 Government expenditure on health

As shown in the financing map, public spending in the health sector, including the MOF budget allocation and development partners support, amounted to 126 billion Tsh. The government budget allocation from tax was 22 percent 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 Ministry of Finance (MOF).

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



Source: Health Sector Public Expenditure Review Update FY06

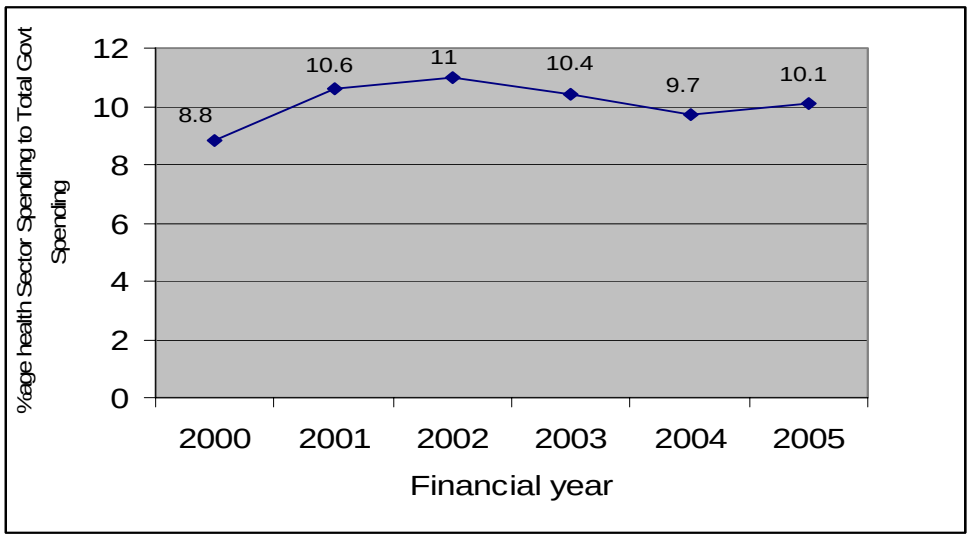
Figure 9 shows the flow of public health expenditure financing from source to various agents and providers for the year 2005. According to this figure, government on budget actual expenditure was about 289billion Tanzania shillings for the year 2005. This is about a 36 percent increase from the previous 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 MOH spent about 60 percent of the total on-budget allocation or 43 percent of total public health expenditure. Allocation to local government was about 31 percent 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 percent of total government spending, which means there has been a slight jump in the government allocation to the health sector budget.

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 percent 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 about 27 and 37 percent respectively. In monetary terms, these were about 61bn Tsh and 117bn Tsh for the two years respectively. For the FY06, the share of development partners to total on-budget spending is about 30 percent which is about 129bn as shown in Figure 4.2.

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 shows that, combining all these sources, donor support to public total expenditure on health makes up about 42 percent of public health expenditure, equivalent to 224bn Tsh while the total public spending is approximately 531bn Tsh (on-budget and off-budget) (MOHSW 2006)

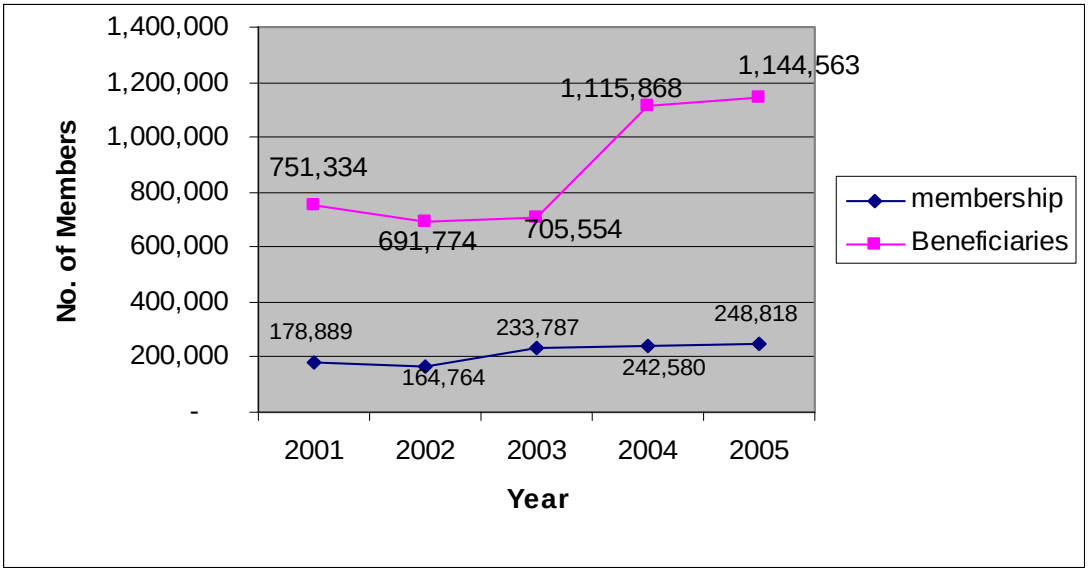
4.4 Health insurance schemes in Tanzania

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.

4.41 National Health Insurance Fund

The National Health Insurance Fund (NHIF) was established in 1999, began its operations in 2001, and currently covers all public servants at both central and local government levels together with up to 5 family members.[2] Since its establishment, NHIF has seen a continuous increase of membership (see Figure 11) as the members have increased 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



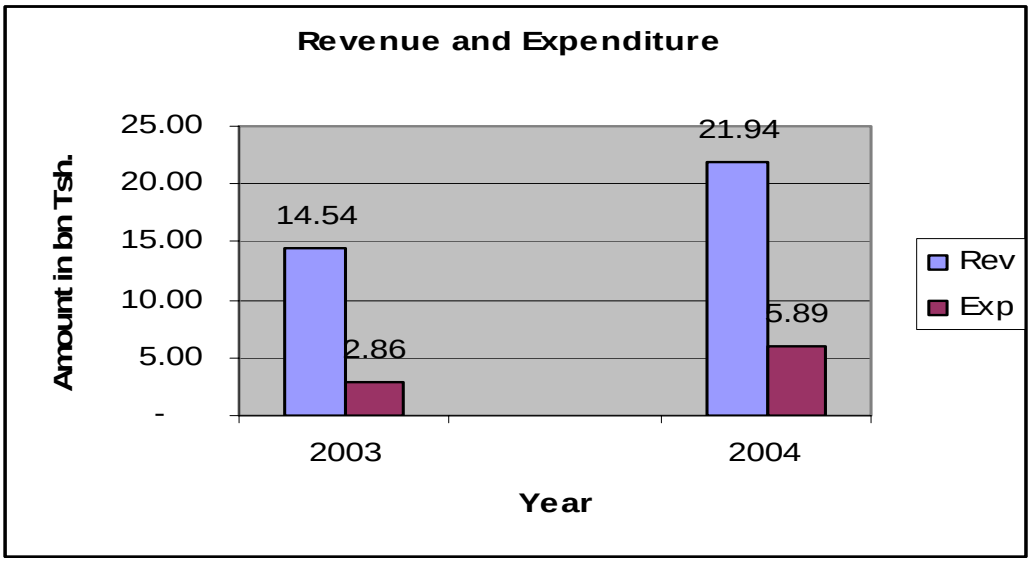
Sources: (NHIF 2004; Kiwara, Minja et al. 2006)

The NHIF offers both inpatient and outpatient care as part of its benefits package. However, NHIF has specific limits of spending granted to the beneficiaries. Any amount in excess of the fixed expenditure will be paid by the beneficiary in an attempt to counter consumer moral hazard. The main source of NHIF revenue is members' contributions. The members compulsorily contribute 6% of personal salaries per month. Employees pay three percent and the employer tops up the remaining three percent of the employee's salary per month. Total NHIF contribution to the health sector for the FY06 is approximated to be 20.4bn (MOHSW 2006), equivalent to about 5 percent on-budget spending and 4 percent of total public spending on health.

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

The NHIF income and expenditure statement shows an increase of about 51 percent in total revenue from the year 2003 to 2004 whereas members contributions to total revenue account for about 95.4 and 92.6 per cent in years 2003 and 2004 respectively. Total expenditure to total revenue for the years 2003 and 2004 were about 20 and 27 per cent respectively. This implies that the spending level is still very low and much of the fund remains unutilized. 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 percent of total expenditure in 2003 and 64 percent in 2004.

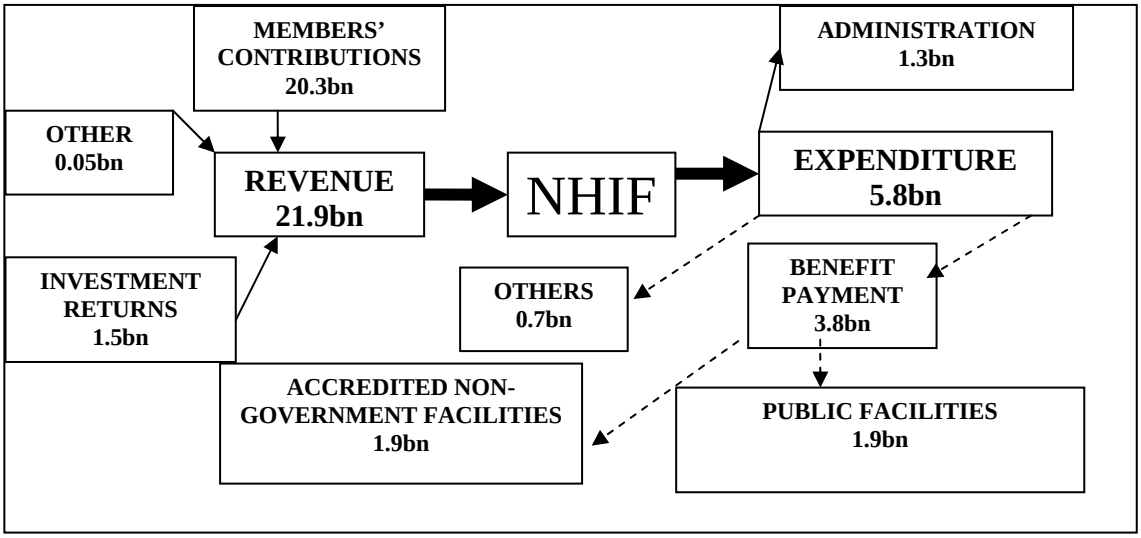
Figure 12: Nominal Revenue and Expenditure for 2003 and 2004



Source: NHIF Income and Expenditure, June 2004

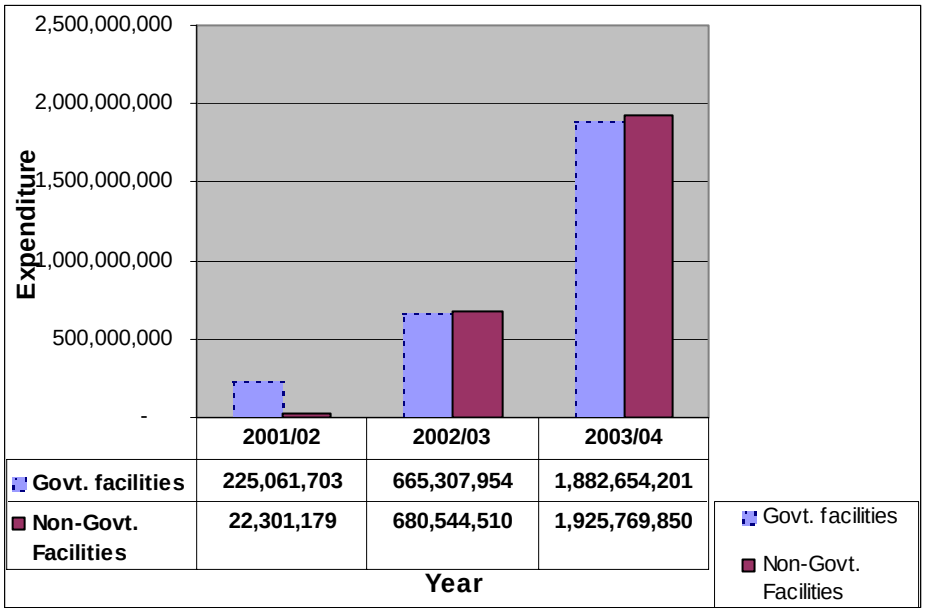
At its commencement in 2001, about 91 percent of total expenditure went to accredited government facilities since very few non-governmental facilities had been accredited. In the second and third year of NHIF operation, the proportion of benefit payments for government and non-government accredited facilities was about 49 and 51 percent respectively, of total expenditure. Within this period, more non-government facilities have been accredited and this includes mission facilities. In 2004 about 39 percent of total reimbursements was spent on outpatient care while inpatient care accounted for about 28 percent. 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 percent 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 percent 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 percent of members contribute less than 10,000 Tanzanian shillings

4.42 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, with members 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: (i) to mobilize financial resources from the community for provision of health care services to its members; (ii) provide quality and affordable health care services through sustainable financial mechanism and (iii) improve health care services management in the communities through decentralization 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 percent 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% what the councils have collected as members' contributions to the CHF, grants from councils, organizations or any other donor and any other money 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 membership contributions account for about 15 percent of total revenue while user fees at primary facilities account for 85 percent (MOHSW 2006). CHF contribution to the health sector is also captured in the public expenditure review under the off-budget expenditure section. As shown in Figure 4.2, the CHF contribution to the health sector in 2006 is approximated to be about 8.01bn, which is about 1.5 percent of total public expenditure on health.

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 percent respectively compared to the expectation of 30 percent. Chee et al, (2002) in their assessment of the CHF in Hanang district found that membership in 2001 was around 3 percent of total households. More recent data indicate this fell further to 2.2 per cent in 2003 (Musau 2004). This is an alarming finding given that CHF membership in the same district had reached a peak of 23 percent in 1999, yet within just a few years had fallen dramatically to less than 3 percent. 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 is set at 1000 shillings per visit at health centre level and many community members are 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 sensitization/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 in availability 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 mobilization 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 utilized 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 and 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.

4.43 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 organizations, others are operated by various NGOs or receive assistance from various donors and international organizations. Currently, there is no systematic documentation of the contribution of such schemes to the overall health sector resource envelope.

4.44 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 percent 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.

4.45 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 percent 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.

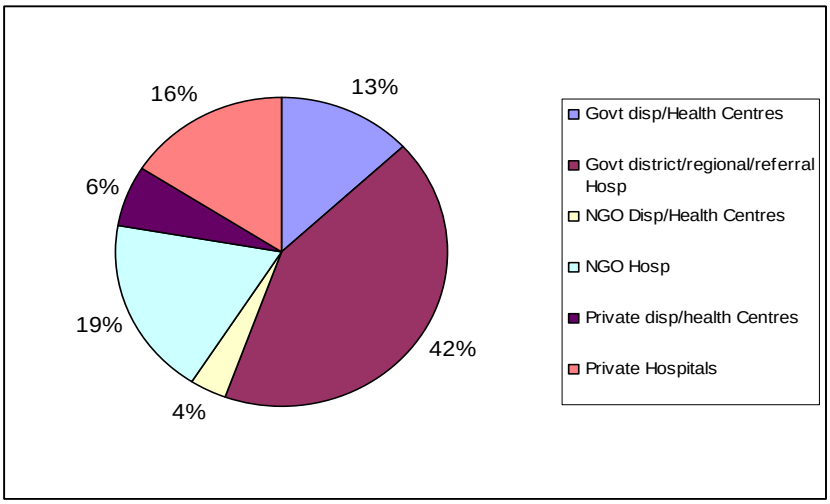
4.5 Household out of pocket expenditure

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 percent of total health expenditure. The largest proportion of out of pocket expenditure is at the hospital level, absorbing around 77 percent of the total. Government facilities (hospitals/dispensaries/health centres) occupied the biggest share of out of pocket spending, accounting for about 55 per cent 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 percent each.

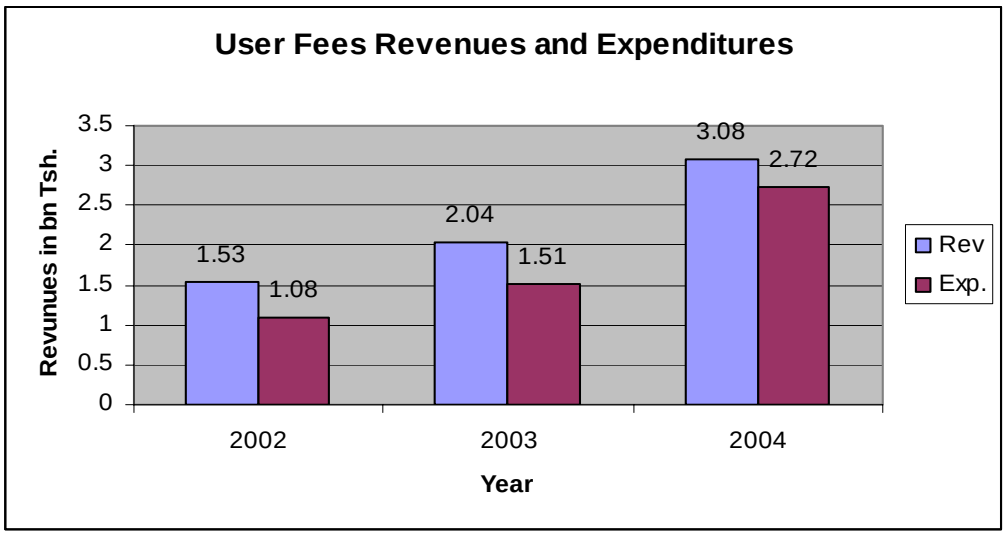
Figure 15: Breakdown of household out of pocket expenditure



Source: NHA, 2001

Between 2003 and 2004 user fee revenue and expenditure at the public hospitals increased approximately by 51 and 80 percent 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 percent of total spending. User fees charged at both the primary and hospital levels account for only 2 percent 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 health accounts does 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 percent of total government expenditure on health is spent on drugs (URT/WHO/EU 2005), which is low compared to the average of 25 percent 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 NGOs 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 an opponent. This increase in 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 'privitization' of the health sector reflected the need to regulate private hospitals and facilities. Thus two key pieces of regulation are the passage of the Private Hospitals Act (1991) and the Amendments to the Pharmaceuticals and Poisons Regulation in 1990. Both changes essentially legalized private practice for pharmacists, hospitals and medical practitioners. Legislation also restricts registering 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.

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 curriculam for the training of different cadres in the pharmacy profession.

Other health sector human resource regulating tools include the Nurses and Midwives Registration Act, 1997 and the Health Laboratory Technologists Registration Act, 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 set the standards for qualifying as a health laboratory technologist keeps and maintains the registration list of all health laboratory technologists, and also the 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 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 and 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. The power of the minister goes further to the

control of salary scales payable to medical practitioners employed at private hospitals as well as allowances and other benefits. However, in practice this mandate has not been well implemented 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 mandate to conduct inspections in private facilities to ascertain whether the medical treatment is provided in accordance with specified conditions. However, again there is very little evidence on the extent to which this is actually implemented.

5.3 Pharmaceutical regulation

The regulation of pharmaceuticals is now covered by the 2003 Food, Drugs and Cosmetics Act and overseen by the Tanzanian Food and Drugs agency (TFDA). This covers the qualification and registration of pharmacists, and regulation of manufacture, importation, labeling, 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. According to this act only accredited pharmacists are allowed to operate and carry on the business of a pharmacist. 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 for the National Health Insurance Fund (NHIF) for public servants is guided by the NHIF Act, no. 8 of 1999. All operations of 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 given by the National Social Security Fund Act no. 28 of 1997. Among other benefits including retirement benefits for employees, the act gives mandate to 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 agrees 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 the NHIF itself. The need for regulation of the health insurance industry has been stressed in anecdotal reports, with one single body taking 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 itself pose a challenge for the development of the CHF since it does not allow much flexibility in the way the schemes are organized in what are often very different settings.

There is as yet no specific regulatory framework for private health insurance, and 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 by themselves 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

This section provides a summary of the main policies governing health in Tanzania.

5.51 National Health Policy

The National Health Policy, revised in 2003, provides the over arching framework 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 raise life expectancy basing on the maintenance of equity, quality and affordability in the provision of health services. 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;
- Effective donor and other stakeholder co-ordination.

On health financing the policy is clear that the government will continue to be the major financer of health services. However, the policy also emphasizes 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 organizations, as discussed in earlier section. .

5.52 Vision 2025

In 2000, Tanzania formulated Vision 2025. This was developed as a tool to give direction for long term national development. The scope of the vision encompasses attainment of high quality of life, assuring 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 emphasizes that to attain high quality of life, the improvement of

the health sector is crucial. In particular, the policy 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.

5.53 National Poverty Eradication Strategy

Implementation of the Vision 2025 goes together with the National Poverty Eradication Strategy (NPES 2010) which was formulated in 1998 with the objective of providing a framework to guide poverty eradication initiatives (URT 1998). Among the components of poverty that have been stated in the NPES 2010 is poor health and nutrition; and 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 centers and to reduce distance to the health facilities together with reducing the level of the maternal mortality rate. Among the policies to be adopted to fulfill these objectives, the NPES emphasizes: increased allocation of resources for health sector development, increased allocation of resources to preventive health services and promoting and strengthening rural health facilities. Priority is also given to HIV/AIDS and other communicable diseases.

5.54 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 poverty reducing growth in Tanzania. It emphasizes 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 policy 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 percent in 2001 to 24 percent by 2010; and those below the food poverty line from 27 percent in 2001 to 14 percent 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 analyzing 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 percent 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 do 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 ability to finance health care will differ between these groups.

Therefore, in analyzing 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 compared to 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 percent of the total TZ population)	Those in formal employment
CHF	-Membership fee (5000/annual/ household) -govt contributions -User fees at Dispensaries and HC	Voluntary	Primary care at Dispensaries & HC	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 for 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 whose rates are categorized by level of income. There is very little information on who is actually paying tax in Tanzania and the impact 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. Therefore its financing impact is not progressive but neutral. For many, the premium of 3 percent of income is too high and impacts on 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. However with the CHF 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 people's 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.[3] 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 what they are exempted for and 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, and average consumption, capacity to pay for health care and amount spent on health care determined. 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 catastrophic 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

[3] 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

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 (% 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. 3 Issues relevant to benefit incidence

6.31 Access to health care

Health service utilization 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 ORS for diarrhea. Wealthier households and those in urban areas have more opportunities for accessing health care and there is a significant difference in health care utilization between the rich and the poor and between those in urban and rural areas.

There are also noted inequities in the distance 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 percent of the poorest in rural areas live within 10kms of hospital compared to 42 percent of the least poor; while in urban areas, 97 percent of the poorest are within 10kms from a hospital

compared to 99 percent 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 2004/05 reports that about 37 percent of the women reported that they couldn't access health care because of distance and the need to take transport (TDHS, 2004/05). The 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 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 percent of pregnant women from the highest quintile had slept under an ITN, the previous right, compared to only 5.5 percent of the lowest quintile. The gap is even higher in geographical distribution where about 59 percent of pregnant women in urban areas sleep under ITNs compared to about 10 percent of pregnant women in rural areas (URT 2005).

6.34 Access to public health services

There are mixed findings when it comes to access to publicly subsidized goods such as vaccinations. Results from TDHS shows that children from the least poor groups have more access to vaccines (table 6.3) compared to the children from the poorest quintiles. About 58.3 percent 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 percent of the better-off visited an NGO facility for malaria treatment compared to 3 percent 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. HEALTH SECTOR STAKEHOLDERS ANALYSIS

The health sector in Tanzania is comprised of many stakeholders including the Ministry of Health and Social Welfare, the Ministry of Finance, Local government and regional administrations, health care providers, civil societies, health financing schemes, development partners and politicians. The aim of this section is to explore these stakeholder views to identify important concerns in the health system, and the relative strengths and weaknesses of each of the actors in influencing health sector policies and decisions. A prime focus is on views on the potential of insurance mechanisms for the non formal sector to facilitate rapid extension of cover in pursuit of eventual universal mandatory coverage. Understanding into stakeholder views was obtained via two methods: (i) in depth interviews with identified stakeholders, (ii) review of government and donor statements regarding user fees and community

participation in health and (iii) attendance at a MOHSW workshop on the operation of the CHF held in Dar es Salaam earlier this year.[4]

7.1 In-depth interviews

The first task was to identify stakeholders who have some kind of influence over health sector policy decisions. There is very little literature concerning different stakeholder abilities to influence policy decisions in Tanzania. Therefore the identification of the stakeholders was done through the experience of the MOHSW staff and the experience of the various joint health sector review meetings organized by the MOHSW. Stakeholder names were also drawn from the CHF workshop. A team of three individuals comprising a representative from the MOHSW (Policy Department), a policy analyst from the University of Dar es Salaam and a researcher from IHRDC conducted the interviews. The selection of stakeholders was done through a purposive sampling where an initial listing of various stakeholders was refined following discussions with MOHSW staff, donor partners, researchers working in the field and representatives of the various health financing schemes. The sample of 30 stakeholders identified and those eventually interviewed is shown in the table below.

Table 9: Health sector stakeholders

	Proposed Sample	Interviewed
MOHSW	6	4
Ministry of Finance (MOF)	2	-
Politicians	2	-
Donors	6	4
Health Insurance Schemes	6	4
Academic/research	4	2
Civil Society Groups	2	1
Workers unions	2	-
Total	30	15

At the time of writing it was possible to conduct in-depth interviews with only 15 of the 30 proposed stakeholders. However, efforts are being made to ensure that all groups are represented in the next round of interviews and a full write up will be available as part of work package 4. For those interviews that were conducted, informed consent was obtained and all interviews were tape recorded and hand written notes taken.

[4] CHF Best Practice Workshop held at the Golden Tulip Hotel January 31st – February 2nd, 2007.

Interviews were conducted in a mixture of Kiswahili and English depending on the interviewee.

The questions that the in-depth interviews sought to answer were: (i) what are stakeholder views on current health system and future equity goals? (ii) who are the stakeholders with much more influence/strength in driving health sector policy decisions?, (iii) what are the sources of power for such kind of stakeholders? (iv) what design of health financing would ensure equity and what possibilities are there for cross-subsidization and establishment of a universal social health insurance?

The interview transcripts were analyzed by the three individuals who conducted the interviews and comprised two steps. First the responses of each stakeholder were recorded manually using a simple table. Secondly responses were grouped into different categories from which the differences or similarities of the stakeholders could be drawn. Key themes which emerged from the interviews were further analysed to assess the extent to which there was a consensus for possible solutions.

The analysis first attempted to map out the relative positions of key actors in the health sector. It then examined stakeholders' perceptions about current equity problems of the health system; stakeholders views about their own and other stakeholders potential to influence health financing policy, role of cross-subsidization within equity goals, and the strength of other stakeholders in the health system; stakeholders' views on what specific features of insurance design are likely to be important or feasible with the current system. The list of those who were interviewed is attached in Annex 1. The following section provides a preliminary analysis of stakeholder views which will be updated in due course as part of work package 4. A summary of discussions from the CHF workshop is also contained in this section.

7.2 Mapping actor influence on health policy in Tanzania

It is clear that different actors have varying levels of influence on health financing issues in Tanzania. Moreover, the source of that influence also varies. Interviewees from the MOHSW, researchers and health financing schemes generally agreed that that development partners are the most influential health sector actors. The strength of donors comes as a result of their support in terms of resource supply, which includes financial resources and technical expertise.

"…the group that has influence is development partners, if there are initiatives to say they look at this area (health financing) as the area that can be built on its regimes/bases, because the government listen to them a lot, I can tell you that the next morning we can collectively do a lot of changes…"

(Financing scheme actor).

"…(the) donor community helps us in providing equipments, expertise and funds, for example they are assisting us in CHF, and they give us support in budget…. we still need them…"

(MOHSW actor).

The development partners themselves acknowledged this power but also said that while the source of the strength is largely financial they also brought technical resources to the sector. One significant collective group of actors is the donor partner group which works very closely with the MOHSW. According to the MOHSW and medical scheme interviewees, the source of power for the development partners is their spirit of working as a group.

"…development partners have a way of settling their differences and come up with same idea…"

(Medical scheme actor)

The strength of influence in Tanzania depended not only on how much each partner brought to the basket fund but also on historical patterns of joint working. Some donor partners have a strong history of joint working in the health sector, whereas other donor partners who once enjoyed good relations with the MOHSW have found themselves outside the main donor group following disagreements on particular health financing policy issues. The user fee debate (see below) in particular has polarized many of the key actors into taking definite positions either in support or opposition and this has influenced subsequent relationships. Within the donor partner group itself, it is argued that, although each individual partner might have its own interest depending on its country's policy, such differences are settled in their group meeting to arrive at a united idea to take to the MOHSW.

Next to the development partners the other two powerful stakeholders within health financing are the MOHSW and the Ministry of Finance (MOF). According to development partners, the MOF is more powerful and influential than the MOHSW because it has control over the budget allocation and can limit the amount that goes

to the health sector. In addition it controls the overall basket fund to which all development partners contribute. The MOHSW is, however, still very much responsible for policy development and it does this through a close collaboration with the development partners and the local government.

Individual politicians are also argued to have a significant influence over policy decisions since they are the ones responsible for presenting issues in parliament and they are the ones who vote on key decisions.

"…technical people might advise/propose but we forget that, end decision is done by ministers/politicians hence they have big influence… politics starts from the ministers to ward executives… any one with influence in society makes decision…"

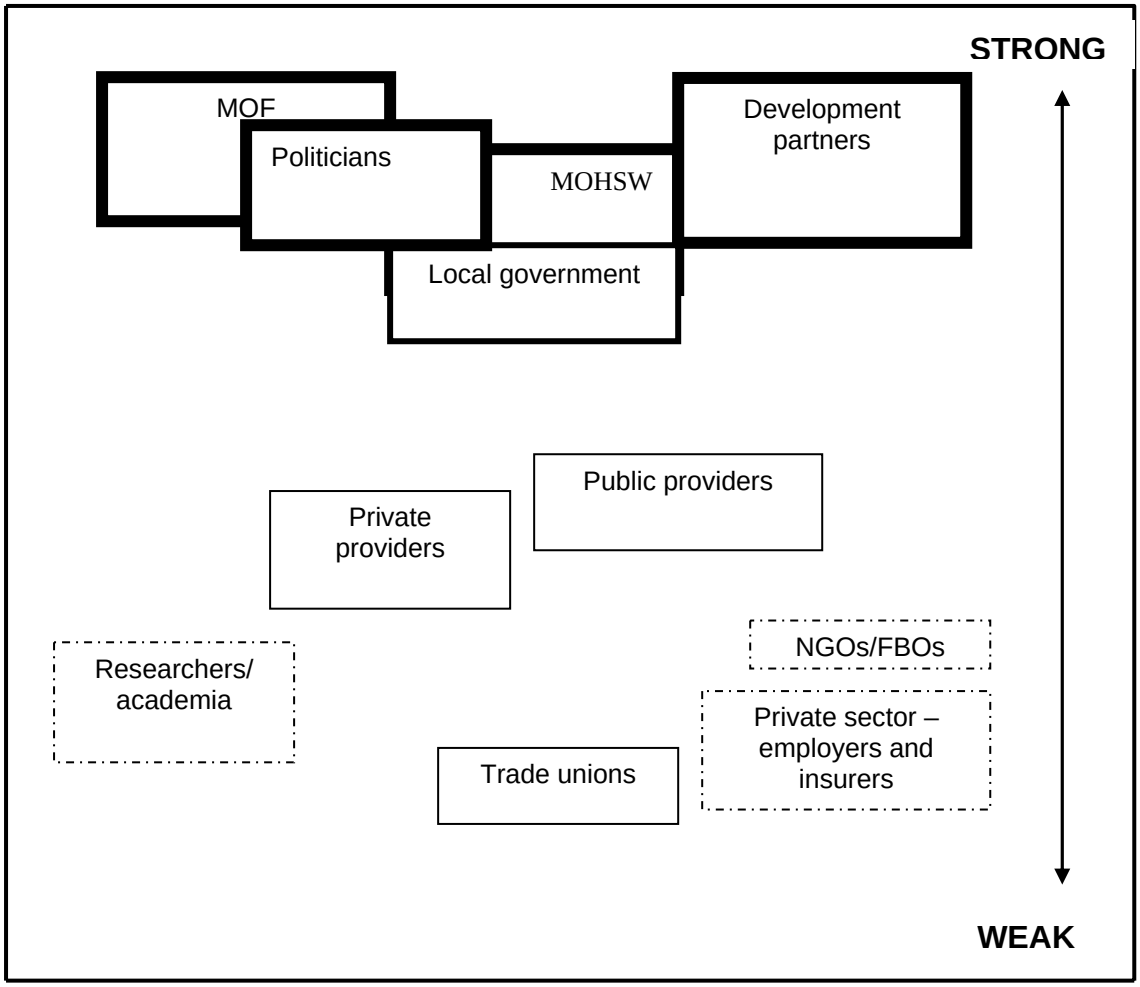
(Former MOHSW employees)

Stakeholders who are not considered to have much power included researchers and academicians. Yet it was acknowledged by many stakeholders that often research should be used as a way to support policy arguments for the MOHSW: *"…good policy should draw from the existing well founded research work…"* (health financing scheme actor). The researchers themselves were pessimistic and accepted that their lack of influence stems from a lack of co-ordination on their part and limited systematic involvement by the MOHSW. This may reflect a lack of capacity within the MOHSW to properly engage and use the results of research but also signals that researchers themselves need to find different ways of strengthening the policy 'uptake' environment. There are only few existing specialized research institutions in Tanzania and very few looking explicitly at health financing issues.

The other relatively weak stakeholder group in Tanzania is the group of NGO and faith based organizations. Paradoxically they are very important in terms of the provision of services, and the government collaborates with them extensively via public private partnership initiatives. In addition, many community based health financing (CBHF) schemes are operating under NGOs and FBOs. Yet they are not well integrated into the policy process, are largely uncoordinated and have no strong influence. Similarly civil society groups and the trade unions have negligible influence in health system decisions. This is perceived to be due to their lack of technical expertise or not having significant resources to invest in the health sector.

The relative influence of the various stakeholders is summarized in the figure below. The boxes overlap each other depending on the level of influence health sector on decisions or policies. The heavy bolded lines linked boxes show the stakeholders who closely collaborate in making health sector decisions. The far bottom boxes show other health sector stakeholders who are perceived to have little influence on health sector policy decisions. The dashed lined boxes show the stakeholders who might have much input or influence but who are currently not being integrated in the health sector policy making

Figure 17: Stakeholder Map



7.3 Current equity problems in the health system

Almost all interviewed stakeholders said they appreciated the efforts of the government and the MOHSW in particular in promoting equity in the health system. It was generally perceived that the government is making a strong effort to ensure that services are available to the people. MOHSW staff commented on the importance of

first establishing a good network of health care services and facilities and then dealing with the improvement of access since *"…you can not access what you do not have…".* Issues identified as important included increasing the number of facilities especially primary facilities and thereby reducing the distance to dispensaries and health centres. It was also recognized that there had been substantial efforts to reduce drug stock outs.

Stakeholders were asked about the potential of existing financing schemes to address equity concerns. Despite the many different schemes available including the NHIF and CHF, stakeholders identified a number of challenges for promoting equity. Access to care was a major concern expressed by many stakeholders. Although much had been done by the government, it was perceived that access to health care is still not guaranteed for all. Some stakeholders argued that while the government had made efforts in guaranteeing *physical* accessibility, *'functional'* access is still a problem. There are still barriers to access especially for the poor who can not pay for health care. The operation of the exemptions and waivers system was cited as a main weakness in this area. In particular, setting up systems for identifying the poor and deciding what their characteristics should be has proved to be a huge challenge for the health system.

Concerns about the exemptions and waivers system were often linked by interviewees to the operation of the CHF in primary facilities since those eligible for waivers for user fees are also automatically eligible for a waiver of the CHF premium. Yet stakeholders argued that the real burden of paying for health care is not at the primary care level (where the CHF generally operates) but at the expensive hospital/referral level. Stakeholders also were concerned that the indirect costs of accessing health care should also be addressed by the waivers system to reduce the burden of out of pocket expenses. A donor partner's comment on the overall complexity of the exemption and waivers system is typical:

"…Why should a child of 4 years from a rich family be exempted…… on the other side on waivers it is quite cumbersome if you are poor and not falling into exemption groups, to get really a waiver is not easier …". (donor partner)

Here it was felt that exemptions should be based on the ability to pay and seriousness of illness at that particular time. Some stakeholders also raised the

issue of non-income barriers to health care including long distances to facilities especially to referral care. One of the interviewed researchers argued that:

"…there are some places where you can be referred and die on the way especially for emergency care because of lack of transport or long traveling distance…"

One problem is the geographical distribution of population in Tanzania. A researcher comments:

"Tanzania has people everywhere a fact that makes the per capita cost of health care delivery very high when you want services to reach everybody" (academic actor)

Stakeholders were asked who they thought were most adversely affected by the health system as it is currently configured. The responses are not surprising with the poor in rural areas, older people, orphans, and the disabled all cited as the most vulnerable groups living in Tanzania. An MOHSW stakeholder explained:

"…population census tells us that we die early at around 40 and we don't care for those reaching 70 years and in this case geriatric problems are not given attention… we have elders in our home places of which their treatment is a big problem…" (MOHSW actor)

It was thought that the government should find further ways of paying for health care for such groups and consider how to better involve third party payers. Those who were seen to benefit most from the system inevitably included those with higher incomes who were seen to have more options of accessing health care, those holding 'good' positions in society together with those living near the health care facilities.

Finally, the crisis in human resources and the poor physical health system infrastructure were highlighted by several respondents as a critical barrier to addressing equity concerns. Despite investment in new facilities, new dispensaries and health centers remain empty simply due to the lack of qualified staff, particularly in rural areas. Stakeholders from the MOHSW accepted that the issue is one of planning and that one solution is to return to the old system of direct posting of staff to designated areas in the country. Development partners suggested that mobile

health clinics providing general health services (such as are found in the case of specialized services such as eye care) could be another way forward. A group of qualified medical staff could move and camp within a region for a particular period and provide services.

The education sector in Tanzania was cited by a stakeholder from one of the insurance schemes as a good example of how to deal with the human resource crisis in health. Many of the services delivered at the primary care level could be delivered after a short intensive six month training programme rather than the traditional 2 or 3 years.

"…Primary health care has not been taken with greater attention as what the education sector has done… there is a need of preparing a crash program in primary health care staff… I don't believe that staff at primary facility need to learn for three years so that he can give service…" (health financing scheme actor)

7.4 Views on user fees in Tanzania

Although not explicitly addressed in the stakeholder interviews it is important to briefly note the user fee debate which has taken place in Tanzania as it throws light on stakeholder attitudes to community participation in health financing in general in Tanzania. The MOHSW believes that there is a strong argument for keeping user fees and CHF premiums as a way of enhancing community participation in health financing. The user fee debate in Tanzania is vigorous, prompted in large part by national and international pressure for their removal (see for example, Gilson and McIntyre (2005), Pearson (2004), Save the Children (2005)). Yet it is important to note that there also exists strong support for the retention of fees within Tanzania. In 2005 a group of donors published a joint statement setting out their support for the current Government policy (McLaughlin, Schmidt et al. 2005). The group strongly argued that there was a continued need for user fees, at least in the interim in Tanzania for several reasons. First user fees are viewed as necessary for introduction of social and community health insurance as they provide the incentive to enrol in alternative, less regressive schemes. Second they point to the fact that user fees represent only one aspect of out of pocket expenses for health care and that their elimination does not eliminate all barriers to care. They argued that the poor cite "costs" which encompass transport, lost time at work as a deterrent, but

they also cite perceptions of quality, preferences for traditional medicine, health worker attitudes.

The donor policy statement further argued that fees shouldn't necessarily be considered in terms of their contribution to the overall sector resource envelope as this will remain small, but in terms of improving the availability of flexible funds at the facility or council level where they often represent the major source of discretionary funding for health facilities. More generally, the donor group believe that it is not user fees at primary care facilities, which impoverish households but rather the larger fees for inpatient hospital and surgical care combined with disability, and long-term illness, such as AIDS. The elimination of fees at lower levels does not address the need to protect households from impoverishment due to illness.

It is hard to say what direction the user fee debate will take. Arguably the joint statement had the positive effect of consolidating support around the government's present policy and focusing attention on other urgent matters such as strengthening capacity within the MoH to coordinate and lead efforts on fair and sustainable financing; improving the exemption and waivers system as well as continuing to strengthen the allocation and use of public expenditure on health. However many critics, inside and outside of Tanzania, continue to lobby for the whole scale removal of user fees in favour of a properly funded health care system.

7.5 Views on the role of the Community Health Fund

The MOHSW together with partners hosted a three day workshop on CHF 'best practices' in Tanzania. The aim was to share experiences on the performance of the CHF and chart a way forward. As indicated earlier the CHF is viewed as a crucial step towards attaining universal coverage and therefore exploring the views of stakeholders on its potential is important. In preparation for the workshop IHRDC also prepared a background paper reviewing the evidence on the performance of the CHF in Tanzania (Mtei and Mulligan 2007). The workshop attracted almost 150 participants from central and local government, development partners, research institutions, and non-governmental and civil society organizations. The event provided a useful opportunity to distill the views of stakeholders on the performance of the CHF and how it could be further developed in the context of attaining universal coverage.

The issues of poor enrolment, poor community perceptions and the lack of capacity to manage the scheme in many councils was raised by many participants as some of the most important issues for the CHF to tackle if it is to develop. Another issue is the limited referral and inpatient coverage of most CHF schemes, despite referral care incurring the highest out of pocket payment by members, and the fact that hospitals in some cases are not willing to join the CHF as they have their own schemes.

Some participants saw the government matching grant as an important mechanism for improving the quality of health services rather than just being a general funding source at the council level. This in turn would encourage enrolment. A related issue is the potential inequity of a matching grant which compounds the effect of low revenue raising potential of an area. The question of the future reliability of the matching grant was raised, and confirmation given that while it is currently provided for in the Medium Term Expenditure Framework, future funding constraints might result in some change to the scheme. The matching grant was initially funded under World Bank support, and is currently under the basket fund. The possibility of a fixed rate per council rather than 100% matching of the premium was also mooted as a way of tackling inequity concerns.

There was much discussion over the potential for improved risk-sharing through cross-subsidisation, either between districts, or preferably between schemes, ie NHIF or private schemes as part of a more coherent national social health insurance system. The response from NHIF participants to this was reasonably positive, although tempered by the desire to ensure that the CHF is first properly strengthened and seen to be working.

A number of key factors were reiterated by participants as necessary to sustain the CHF: (i) political commitment, both from leaders at all levels, and from the population; (ii) availability of improved health services; (iii) an attractive benefit package; (iv) ongoing capacity building to CHF managers at all levels; (v) continuous sensitization and advocacy, again at all levels; (vi) community participation in and ownership of the CHF; (vii) transparency among stakeholders; (viii) improved monitoring and evaluation; (ix) the maintenance of a CHF budget within the MTEF both as matching grant and to support councils; (x) and linkages with existing cohesive societies and other SHI schemes.

Representatives from the NHIF described how they saw the roles of both NHIF and CHF within a national health insurance system. Collaboration between the two schemes was proposed in the areas of advocacy, information sharing through joint meetings, support on issues related to scheme management, and joint reporting at council level. However, the issue of financial cross-subsidization was not raised. There is no doubt that in terms of actor power the NHIF will carry considerable weight in influencing whether cross subsidization will take place. More analysis is needed to determine whether the NHIF and other formal sector schemes are really willing to integrate more formally with the CHF and this will be part of work package 4.

Doubts on cross-subsidization notwithstanding, there was an overall consensus on the role of the CHF as an important precursor for Social Health Insurance, with local district-based schemes resulting in the development of a national scheme.

7.6 Future of health insurance in Tanzania

The overall aim of the stakeholder analysis is to explore views on future directions for the health system and the extent to which universal coverage via the various existing health insurance schemes, including the CHF, is obtainable or desirable. Almost all the stakeholders in the in-depth interviews and the CHF workshop had a positive view towards the idea of universal health insurance. A development partner comment is typical:

"…first attempts or foundations are certainly already there…since we have NHIF, NSSF, CHF… these are all social insurance models targeting different segments of the population…eventually this could cover all of the population…"

However some stakeholders cautioned against rushing towards a single scheme. A requirement for arriving at a national social health insurance scheme is to first strengthen the existing financing initiatives and gradually think of the way of unifying them.

"…there is no need of forcing groups immediately into a unified system…each group started in its own environment and objectives…and all these are heading towards some form of health insurance…unification should be something automatic…for now it is premature to start thinking of putting them into one basket and form social health insurance…" (Researcher)

Respondents from the MOHSW also supported the idea of gradually moving towards universal coverage by strengthening the existing schemes first**.** They stressed the need to build upon on social solidarity within the scheme themselves before transferring the benefits across different groups. Some stakeholders suggested developing ways of combining the formal schemes such as the NHIF and NSSF first. Several stakeholders argued that the government could also support the linking of all the schemes through the taxation system.

"…government can be pro-active…large business people who pay tax and are known, can contribute to national health insurance fund through taxation system and should contribute according to how much they earn…" (director of a health financing scheme).

Once the existing financing arrangements have been strengthened, for example when all districts have established community health funds and enrollment increases, it maybe possible to form a risk equalization fund from which the poor can be cross-subsidized. Some respondents also thought that the government could take the initiative and pay for those who are not able to contribute. Moreover, politicians are believed to play a big role in initiating the social health insurance

"…to have social health insurance is possible but there are its conditions, first there should be a deliberate move of politicians…a real move…initiation should start with the politicians…" (health financing scheme interviewee)

If universal coverage is to be achieved the issue of cross subsidization between and within schemes needs to be addressed. Several stakeholders argued that internal cross subsidization already exists within the NHIF since contribution is compulsory and employees on higher salaries contribute more compared to those in lower salaries. Thus higher income earners to an extent cross-subsidize the low income groups. Stakeholders recognize that this is not the case with the CHF which charges a flat rate contribution which is largely regressive in impact. As a financing scheme respondent reflected:

"…to a pastoralist with 1000 cows, to pay Tsh 10,000 is a peanut compared to someone with no cow…"

Respondents were much more cautious regarding cross-subsidization between the different schemes and this reflects the wider political climate. The feeling is again to let the existing schemes establish themselves first and only when they are strong enough should the idea of a risk equalization fund be explored. It seems that the possibility of cross subsidization is there but working out the mechanisms will be a lengthy process. Respondents from the financing schemes argued that cross subsidization arrangements should not compromise sustainability. Existing schemes need to get well established and once they are strong enough, a risk equalization fund could be formed and be used to cross-subsidize the weaker schemes and the poor. However it was difficult to get consensus on when such arrangements might realistically be in place

7.8 Preliminary stakeholder conclusions

In summary, while the move towards universal coverage is seen as the ultimate destination by most if not all stakeholders, they were less clear on how this will be achieved other than via the incremental rolling out of the existing schemes. There is as yet no consensus on how schemes can be integrated and even less on how cross subsidization might be encouraged. Some of the schemes are lukewarm about moving towards integration too soon and this is understandable given that many of the schemes are relatively young and have yet to establish. The fact that the CHF (seen as crucial in achieving universal coverage for the poor and the informal sector) is facing many challenges regarding low enrollment and management and accountability of funds makes the task of persuading the formal sector schemes to support it that much harder. What is clear is that all stakeholders share the same vision that every Tanzanian citizen, including the very poorest, should have access to health care. There may be differences on the speed and method with which that vision can be attained but supporting and developing the various social health insurance schemes already operating within Tanzania is seen as a crucial first step.

8 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 is suggests 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 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 subsidization between the CHF and NHIF, resulting in very fragmented risk pools. The NHIF has some ability for cross subsidization 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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Appendix 1 List of The Interviewed Stakeholders

ORGANIZATION	NAME	TITLE/POSITION
PUBLIC SECTOR		
Ministry of Health and Social Welfare (MOHSW)	Dr. F. Njau	Head Health Sector Reform
	Dr. P. Mbuji	Preventive Services
	Mr. F. Masaule	Head of Advocacy Unit
	Mr. P. Ilomo	Former MOHSW Employee
DEVELOPMENT PARTNERS		
Swiss Development Cooperation (CDC)	Ms. J. Mahon	Health Advisor
The World Bank	Ms. J. Mclaughlin	Lead Health Specialist
Germany Technical Cooperation (GTZ)	Mr. M. Kuper	Health Specialist
	Ms. N. Siegert	Consultant
World Health Organization (WHO)	Mr. M. Mapunda	Health Systems Strengthening Officer
ACADEMICIANS AND RESEARCH INSTITUTIONS		
University of Dar es Salaam (UDSM)	Dr. D. Mushi	Senior Lecturer – Economist
Tanzania Gender Networking Programme (TGNP)	Prof. M. Mbilinyi	Head of Programme Activism Lobbying and Advocacy (ALA)