POLICY BRIEF

# Strategic Health Purchasing in Tanzania

## *A Summary of Progress, Challenges, and Opportunities*

MAY 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

*The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.*

### TANZANIA AT A GLANCE

- Population (2019): **58 million**
- GDP per capita (2019): **US$1,122**
- Poverty headcount at $1.90/day (2016): **49%**
- Life expectancy (2018): **65 years**
- Current health expenditure (CHE) per capita (2018): **US$37**
- Domestic government expenditure as % of CHE (2018): **43%**
- Out-of-pocket expenditure as % of CHE (2018): **24%**
- External expenditure as % of CHE (2018): **32%**

Source: World Bank Databank

## Health Financing Schemes in Tanzania

Tanzania, a lower-middle-income country, aims to reach all households with essential health and social welfare services as outlined in the Health Sector Strategic Plan 2015–2020 (HSSP IV). HSSP IV proposes creating a compulsory single national health insurance (SNHI) scheme with a minimum benefit package, subsidies for the poor, and a greater role for the private sector in order to expand access to care. The plan has strong political support but has not yet been implemented.

Tanzania has three main types of health financing schemes:

- **GOVERNMENT BUDGET FINANCING.** Allocations of general tax revenue are pooled with on-budget support from donors into a health basket fund that is used to finance inputs for health service provision by public providers and a few private nonprofit providers.
- **PUBLIC HEALTH INSURANCE SCHEMES.** These include the National Health Insurance Fund (NHIF), Social Health Insurance Benefit (SHIB), and improved Community Health Fund (iCHF).
  - The NHIF receives mandatory contributions from public-sector employees and voluntary contributions from private formal-sector and informal-sector workers.
  - The SHIB is an additional health benefit offered by the National Social Security Fund (NSSF) for the pension fund's contributors who opt into the benefit.
  - iCHF targets low-income people, mostly in the informal sector, and is subsidized by the national government. Enrollees pay an annual fee for access to basic health services, with no copayment for services in the benefit package.
- **PRIVATE HEALTH INSURANCE SCHEMES.** These voluntary schemes target higher-income households and have low coverage.

Table 1 compares the purchasing functions in these schemes.

Table 1. **Purchasing Functions in Tanzania's Health Financing Schemes**

| | Government Budget Financing | Improved Community Health Fund (iCHF) | National Health Insurance Fund (NHIF) | Social Health Insurance Benefit (SHIB) | Private Insurance |
|---|---|---|---|---|---|
| **% of Total Health Expenditure** (2015/16)* | 54% | 8% | | | |
| **Main Purchaser(s)** | Ministry of Finance and Planning (MOFP) | Regional Administrative Secretary | NHIF | National Social Security Fund (NSSF) | Private insurers |
| **Governance** | MOFP disburses funds directly to public facilities. Providers have autonomy to allocate funds according to MOFP guidelines for the use of public funds. | iCHF is managed at the regional level by the President's Office, Regional Administration and Local Government (PO-RALG), the ministry that supervises local government planning and sectoral interventions. Public facilities have autonomy to allocate iCHF funds according to MOFP guidelines for the use of public funds. | NHIF has a clear mandate anchored in legislation and reports to a management board overseen by the Ministry of Health. Public facilities have autonomy to use NHIF funds according to MOFP guidelines for the use of public funds. | NSSF has a clear mandate anchored in legislation and reports to a management board under the Ministry of Labour and Employment Public facilities have autonomy to use SHIB funds according to MOFP guidelines for the use of public funds. | Private insurers are governed by legislation and report to the Tanzania Insurance Regulatory Authority. Private facilities have autonomy to use funds. |
| **Financial Management** | The annual budget is based on MOFP's plan, budget papers, and historical expenditures and is approved by Parliament. Budget overruns occur. Deficits are financed through reallocation of funds according to the budget law. Accounting officers request approval for reallocation of funds from the Minister of Finance. | The iCHF budget is based on a capitation formula, and overruns are not allowed. | The NHIF's budget, approved each year by Parliament, is based on the revenue it receives from the 6% payroll contributions from both employees and employers. Budget overruns occur when premiums collected are insufficient to cover claims. Deficits are covered using reserves accumulated from the previous years' surpluses. | The annual budget is based on the previous year's budget and enrollment trends. Although budget overruns have not occurred, the NSSF Act allows for supplementary budget by approval of the Minister of Labour and Employment. | Private insurers' budgets are based on projected revenue. Budget overruns occur when claims exceed premiums collected. Deficits are covered by profits from the insurance company's other lines of business. |
| **Benefits Specification** | Explicit guidance from the National Package of Essential Health Interventions for primary care and hospital care; no exclusions and no defined process for revisions | Not explicit; uses broad intervention categories for primary and hospital care with no specific exclusions; no clear process for revisions | Explicit benefit package of primary care and hospital care, with exclusions; revisions are based on enrollee feedback via public consultations | Explicit benefit package of primary care and hospital care, with exclusions; revisions are based on enrollee feedback via public consultations | Explicit benefit package of primary and hospital care with exclusions; no clear process for revisions |
| **Contracting Arrangements** | Loose agreements with public providers and some private nonprofit facilities | All public facilities included; selective contracting with private nonprofit providers | All public facilities included; selective contracting with private providers | Selective contracting with public and private providers | Selective contracting with private providers |
| **Provider Payment** | Line-item budgets, salaries, and allocation to health facilities based on a capitation formula | Capitation; enrollees select their preferred provider | Fee-for-service | Capitation; enrollees select their preferred providers and fee-for-service payments are made for referrals | Fee-for-service |
| **Performance Monitoring** | Monthly facility activity reporting on DHIS2; ad hoc supportive supervision visits by district and regional health teams | Ad hoc supportive supervision visits by district and regional health teams; the openIMIS integrated platform is used for enrollee renewal, beneficiary identification, claims management, and provider payment | NHIF inspects providers and audits medical claims | Biannual supportive supervision visits to providers | Accreditation of providers and auditing of medical claims |

** National Health Accounts 2015/16*

# Progress and Challenges in Strategic Health Purchasing

Tanzania has made progress in strategic health purchasing in its health financing schemes by prioritizing services through explicit benefit packages, contracting with both public and private providers, paying health providers through output-based payment, and various forms of provider performance monitoring. The following overall system improvements can be linked to the progress achieved to date:

- Increased flow of resources to lower-level facilities that provide high-value primary health care (PHC) services
- Better resource allocation that takes into account catchment and remoteness, redirecting resources from urban to rural facilities
- Increased community participation in health facility governance committees (HFGCs) to improve accountability and transparency
- Increased capacity of facilities to improve financial management

Highlights of progress and remaining challenges are described below.

**GOVERNANCE.** All of the schemes have a clearly defined institutional home where most purchasing functions are carried out. The public and private insurance schemes have clearly defined mandates anchored in legislation. Private providers have full management and financial autonomy, while public providers have limited management autonomy but full autonomy for planning, budgeting, and spending, within MOFP guidelines on the use of public funds. Financial autonomy gives providers the flexibility to respond to incentives in provider contracting and payment.

**FINANCIAL MANAGEMENT.** All of the schemes have a defined process for setting the purchaser's budget. They also have mechanisms for tracking budget execution/spending, which are enforced, but budget overruns routinely occur in every scheme except the iCHF scheme. iCHF uses a budget-neutral capitation formula that considers the contributions collected and the purchaser's budget.

**BENEFITS SPECIFICATION.** The National Package of Essential Health Interventions (NPEHI) developed by the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) defines priority services, based on population health needs, and is revised periodically. It informs the development of standard treatment guidelines but is not a minimum benefit package. Public and private insurance schemes use the NPEHI and standard treatment guidelines as a basis for developing their own benefit packages, which generally target most illnesses and health conditions affecting Tanzanians. However, linkages between these benefit packages and resource estimation and provider payment are weak, which hampers efforts to ensure adequate resources to provide the benefits. The insurance schemes use public forums and consumer education to inform enrollees of their entitlements.

**CONTRACTING ARRANGEMENTS.** While the tax-financed and iCHF schemes rely on loose agreements with providers, the NHIF, SHIB, and private insurers have more formal contracting arrangements. Public schemes contract with both public and private providers; private schemes contract with private providers only. Schemes have different standards for public and private providers: Public providers are automatically included, while private providers are subject to selective contracting, which includes accreditation and quality standards. More can be done to "level the playing field" and develop similar standards for accreditation and contracting linked to performance and provision of quality services.

**PROVIDER PAYMENT.** All of the schemes use output-based payment, which is linked to service delivery objectives. Most schemes use fee-for-service payment; the tax-funded schemes and iCHF use capitation, with a formula that takes into account service utilization, catchment population, and remoteness of health facilities. The catchment population parameter ensures that facilities receive funding commensurate with the population they should be serving; the distance parameter ensures that facilities in remote, hard-to-reach areas are adequately financed. The Direct Health Facility Financing (DHFF) initiative has enhanced the flow of funds to lower-level providers and has increased provider autonomy in planning and implementation to implement fiscal decentralization and foster service improvement. DHFF has led to increased accountability and governance in the health system at the PHC level, increased health system responsiveness to patients who receive care in facilities, and improved health-seeking behavior and service utilization at primary care providers.

**PERFORMANCE MONITORING.** Provider and system performance monitoring is partially automated but is not routinely used for purchasing decisions, except by iCHF. The introduction of DHFF has gone hand in hand with improved provider monitoring, through the Facility Financial Accounting and Reporting System (FFARS). HFGCs comprising health facility managers and community representatives have been established to provide oversight, support planning and budgeting, and ensure accountability for budget execution and expenditure reporting. FFARS and HFGCs have enhanced the facility-level financial management of primary health providers by providing a uniform system for recording and reporting transactions, improved public financial management, and increased community participation and accountability overall. The NHIF and SHIB have well-defined processes for accreditation and monitoring, through regular medical audits and facility inspections. iCHF has made significant inroads in automating processes using the open source Insurance Management Information System (openIMIS), which automates registration and claims management and is integrated with government payment systems. It allows access to information at the district, regional, and national levels to inform decisions on provider payment and performance. openIMIS has also facilitated portability of the benefit package beyond the registered provider, allowing enrollees access to services across various regions in Tanzania.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the five main types of schemes in Tanzania. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Tanzania**

| Purchasing Function | Indicators of Strategic Purchasing | Goverment Budget Financing | iCHF | NHIF | SHIB | Private Insurance |
|---|---|---|---|---|---|---|
| Governance | Purchasing functions have an institutional home that has a clear mandate and allocation of functions. | ○ | ○ | ●● | ●● | ●●● |
| | Providers have autonomy in managerial and financial decision-making and are held accountable. | ●● | ●● | ●● | ●● | ●●● |
| Financial Management | Purchasing arrangements incorporate mechanisms to ensure budgetary control. | ●● | ●●● | ●● | ●● | ●● |
| Benefits Specification | A benefit package is specified and aligned with purchasing arrangements. | ○ | ●● | ●● | ●● | ●● |
| | The purchasing agency further defines service delivery standards when contracting with providers. | ○ | ●●● | ●●● | ●●● | ●●● |
| Contracting Arrangements | Contracts are in place and are used to achieve objectives. | ○ | ○ | ●● | ●● | ●● |
| | Selective contracting specifies service quality standards. | ○ | ○ | ○ | ○ | ●● |
| Provider Payment | Provider payment systems are linked to health system objectives. | ●● | ●●● | ●● | ●● | ●● |
| | Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation. | ●● | ●●● | ●● | ●● | ●● |
| Performance Monitoring | Monitoring information is generated and used at the provider level. | ●● | ●●● | ●● | ●● | ●● |
| | Information and analysis are used for system-level monitoring and purchasing decisions. | ●● | ●●● | ●● | ●● | ●● |

** Private facilities and SAGA hospitals have financial autonomy, but most county public facilities do not.*

Despite these areas of progress, health purchasing in Tanzania still has a number of challenges and limitations, including multiple fragmented schemes with no harmonization across purchasing functions. Because these schemes manage only 8% of total health expenditure, improvements to their purchasing functions can have only limited effect. Tanzania aspires to have a single national health insurance system but does not have a clear framework for how the various purchasers will be merged or their role in the new SNHI scheme. All of the schemes use output-based payment methods, but the payment methods and rates differ across the schemes. The multiple funding sources lead to conflicting incentives to providers. Another limitation is that data are collected in disconnected systems—such as DHIS2, FFARS, PlanRep, and openIMIS—which impairs data quality and integration of information from different stakeholders. Facility managers also need to improve their capacity for financial management, and HFGCs need strengthening so they can provide better planning, budgeting, and financial oversight to health facilities.

## Opportunities to Improve Health Purchasing

Planning for the proposed SNHI scheme provides an important opportunity for Tanzania to make purchasing more strategic, through more streamlined health financing and purchasing, a more complete separation of functions between the purchaser and providers, improved incentives for service delivery through more effective provider payment methods, and integrated data and performance monitoring systems.

To take advantage of the gains made so far and achieve the country's goal of UHC, Tanzania will need to clearly define the roles of the NHIF, SHIB, and iCHF under the proposed SNHI scheme and develop sufficient capacity for strategic purchasing. Integrating health information and data management systems will facilitate evidence-based decision-making for strategic purchasing. DHFF has been an important vehicle for improvements to provider autonomy and accountability, but sustaining the gains will require additional public resources beyond the current basket funding.

*SPARC and its technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partners in Tanzania—Ifakara Health Institute and the University of Dar es Salaam—will validate the SPARC findings with Tanzanian stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Tanzania.*

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## Annex. **Strategic Purchasing Progress Indicators**

| | | | |
|---|---|---|---|
| **Governance** | **Purchasing functions have an institutional home that has a clear mandate and allocation of functions.** | ○ | An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak. |
| | | ●● | An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement. |
| | | ●●● | An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement. |
| | **Providers have autonomy in managerial and financial decision-making and are held accountable.** | ○ | Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems. |
| | | ●● | Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak. |
| | | ●●● | Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective. |
| **Financial Management** | **Purchasing arrangements incorporate mechanisms to ensure budgetary control.** | ○ | A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced. |
| | | ●● | A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur. |
| | | ●●● | A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur. |
| **Benefits Specification** | **A benefit package is specified and aligned with purchasing arrangements.** | ○ | A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms. |
| | | ●● | A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms. |
| | | ●●● | A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified. |
| | **The purchasing agency further defines service delivery standards when contracting with providers.** | ○ | The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak. |
| | | ●● | The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts. |
| | | ●●● | The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts. |
| **Contracting Arrangements** | **Contracts are in place and are used to achieve objectives.** | ○ | Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers. |
| | | ●● | Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers. |
| | | ●●● | Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance. |
| | **Selective contracting specifies service quality standards.** | ○ | The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards. |
| | | ●● | The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards. |
| | | ●●● | The purchaser contracts selectively with public and private providers based on uniformly applied quality standards. |
| **Provider Payment** | **Provider payment systems are linked to health system objectives.** | ○ | Some output-based payment is used. |
| | | ●● | Output-based payment is used, and payment systems are linked to specific service delivery objectives. |
| | | ●●● | Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management. |
| | **Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.** | ○ | Provider payment rates are determined based only on the purchaser's available budget. |
| | | ●● | Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers). |
| | | ●●● | Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation. |
| **Performance Monitoring** | **Monitoring information is generated and used at the provider level.** | ○ | Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits). |
| | | ●● | Provider-level monitoring is at least partially automated and is used for purchasing decisions. |
| | | ●●● | Provider-level information is automated, fed back to providers, and used for purchasing decisions. |
| | **Information and analysis are used for system-level monitoring and purchasing decisions.** | ○ | Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type). |
| | | ●● | System-level analysis is automated and carried out routinely. |
| | | ●●● | Information and analysis are used for system-level monitoring and purchasing decisions. |