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Commentary

Progressive Pathway to Universal Health Coverage in Tanzania: A Call for Preferential Resource Allocation Targeting the Poor

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CONTENTS

Abstract—Universal health coverage (UHC) can be a vehicle for improving equity, health outcomes, and financial well-being. After publication of the World Health Organization's report in 2010, many countries declared their goal of achieving UHC. A key lesson from research evidence and country experience in implementation of pro-poor UHC is that public budget plays a crucial role in financing the poor. It has long been recognized that if a country wants to reduce the gap between the poor and non-poor, deprived groups should receive preferential allocation of health care resources to achieve more rapid improvements in their health. Based on a technical analysis of public funds allocation mechanisms in Tanzania, we argue that these mechanisms should prioritize the poor more explicitly and give them preferential treatment to close the gap with the non-poor in service utilization and health outcomes.

Universal health coverage (UHC)—the availability of quality, affordable health services for all when needed without financial impoverishment—can be a vehicle for improving equity, health outcomes, and financial well-being. After publication of the World Health Organization's (WHO) *World Health Report* in 2010, many countries declared their goal of achieving UHC.[1] In its *Global Health 2035* report, the Lancet Commission on Investing in Health argued that progressive pathways to universal health coverage are an efficient way to achieve health and financial protection.[2] Though most African countries have government programs for the poor, effective population coverage is low and programs face severe financial constraints.[3] A key lesson from research evidence and country experience in implementation of pro-poor UHC is that the public budget plays a crucial role in financing the poor.[4]

Keywords: equity, health finance, Tanzania, UHC

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It has been long recognized that if a country wants to reduce the gap between the poor and non-poor, vertical aspects of equity need to be addressed—that is, the unequal treatment of unequal.[5,6] In other words, deprived groups should receive preferential allocation of health care resources to achieve more rapid improvements in their health. In this commentary, based on a technical analysis of public funds allocation mechanisms in Tanzania, we argue that these mechanisms should prioritize the poor more explicitly and give them preferential treatment to close the gap with the non-poor in service utilization and health outcomes.

COUNTRY CONTEXT

Tanzania, the fourth most populous country in sub-Saharan Africa (57 million in 2017), has made significant progress in economic growth and poverty reduction, yet more than a quarter of the population is still living below the poverty line. Using data from household budget surveys, the Tanzania Mainland Poverty Assessment found decreases in poverty rates between 2007 and 2012, from 34.4% to 28.1% for basic needs poverty (not meeting basic consumption needs) and from 11.7% to 9.7% for extreme poverty (not meeting minimum nutrition requirements). Over 80% of these poor live in rural areas, where poverty reduction has been relatively slow compared with Dar-es-Salaam.[7]

Tanzania has made substantial progress toward UHC, though challenges remain. The under-five mortality rate fell sharply from 166 per 1,000 live births in 1990 to 54 in 2012.[8] Overall coverage of health services, however, was among the lowest in East and Southern Africa. Nearly 10% of households had health expenditure greater than 10% of total household expenditure in 2012, and 2.5% were at the 25% threshold.[9]

Moreover, sizable disparities exist across different wealth groups. For example, comparing the bottom and top income quintiles, the prevalence rates of stunting among children are 39.2% and 19.1%, respectively, and total fertility rates are 7.5 versus 3.1, respectively. The skilled birth attendance rate for women in the bottom quintile, in turn, is less than half of that in the top (41.8% versus 95.1%), and the same pattern holds for the proportion of women of reproductive age who have problems paying for treatment (30% versus 60%).[10] Evidence shows that poor households are much more likely to experience catastrophic expenditure.[11]

Tanzania's decentralized health system is financed through a mixture of sources. In 2014–2015, per capita total health spending in Tanzania (at current prices) was 73,365 Tanzania shillings (TZS), equivalent to 40 USD, among which 37% was from external assistance, 28% from domestic revenue, 26% from out-of-pocket payments, 7% from social insurance contributions, and 2% from voluntary payment. Though external funds remain the largest financing source for Tanzania, its share has dropped from 48% in 2010. This paralleled the increasing importance of domestic revenues for health financing, with its share growing from 22% to 28% during the same period.

In 2016–2017, government health spending reached 1.5 trillion TZS, around 660 million USD, most of which flows to the Ministry of Health, Community Development, Gender, Elderly and Children and local government authorities (LGAs; Figure 1). Based on the size of each funding stream and its relevance to UHC, the rest of this article focuses on the following funding mechanisms in terms of their consideration of the poor: (1) grant transfers to LGAs for service delivery (37% of total government health spending); (2) Ministry of Health, Community Development, Gender, Elderly and Children in-kind transfers (22%), such as drugs and medical supplies, and grant transfers to faith based organizations/facilities and donor-supported national programs; and (3) government contributions to health insurance funds (12%). This commentary does not cover

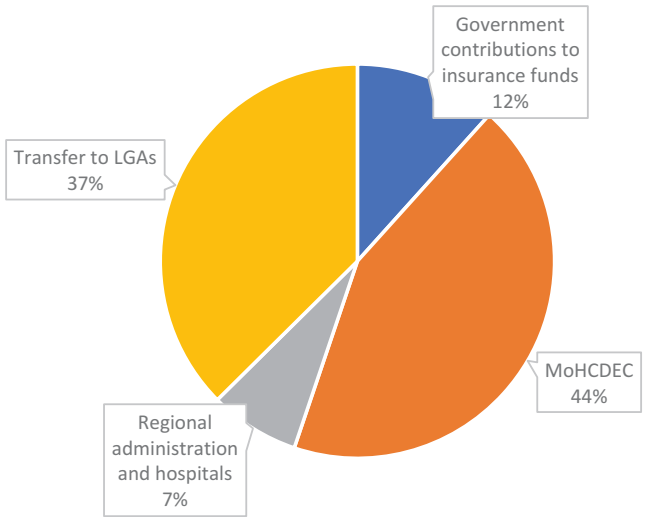

FIGURE 1. Tanzania Government Health Spending, 2016–2017.
Source: BOOST Data, World Bank.

government transfers to ministry departments, regional health authorities, government agencies, and regional and tertiary hospitals (Source: BOOST data from World Bank compiled based on data from Ministry of Finance, Tanzania).

CONSIDERING THE POOR IN GRANT TRANSFERS TO LGAS

The Health Sector Basket Fund (HSBF), a seven-donor pooled funding mechanism, uses a needs-based formula for allocation to LGAs. In 2016–2017, HSBF allocation to LGAs was about 7% of total government expenditure. The formula puts 60% weights on population size, 10% on morbidity measured by under-five mortality rate, 10% on poverty, and 20% on remoteness.

Government block grants to LGAs are the largest source of funding of service delivery at primary level. Although it is supposed to apply the same formula as HSBF, in practice, there are no consistent allocation criteria. The allocation process is reported to be driven by a combination of factors such as population needs, historical trends, and political negotiations. As a result, there is a nearly sevenfold difference between regions with the highest and lowest per capita expenditures of block grants (6,456 versus 29,570 TZS) in 2016–2017, which cannot be easily explained.

For both government block grants and HSBF transfers, less than five million USD is explicitly allocated to provide preferential treatment for the poor. Moreover, once reaching the LGAs, it is difficult to tell whether and how the poor are prioritized. In compliance with government directives, these budgets are executed against line items, which feature economic functions such as personnel compensation, goods and services, and assets acquisition, rather than the needs of the poor or service utilization. Most government block grants are spent on personnel compensation, which means that an equitable distribution of health workers will determine pro-poor use of these block grants. In Tanzania it has always been challenging for the poor areas to be prioritized when deploying health workers, because there is no dedicated resource to provide financial incentives for them to work there. The HSBF, in turn, provides almost 90% of nonsalary recurrent expenditure of LGAs, which helps ease the inadequacy of government inputs to operational expenses. However, such spending mostly benefits those who utilize services, among whom the poor are underrepresented given geographic and other barriers.

CONSIDERING THE POOR IN GOVERNMENT IN-KIND TRANSFERS

Health facilities in Tanzania, especially for primary care, often receive drug supplies from the central level. LGAs receive virtual allocation for drugs and then place requests to the Medical Stores Department, which gets funds directly from the ministry. Upon delivery of drugs, the allocation for facilities is deducted. The Tanzanian government is committed to solving the drug shortage problem. In the past two years' budget (2016–2018), for instance, more than 250 billion TZS of domestic funding was allocated for pharmaceutical services, covering vaccines, maternal, neonatal and child health, family planning, and antiretroviral and malaria drugs. These inputs can offer significant benefits for the poor because the conditions disproportionally affect this group. The challenge, however, is the low execution rate of the domestic development budget, which is the category that drugs and medical supplies fall under. In 2016–2017, the latest year for which data are available, nearly half of the domestic budget was not executed, and the expenditure for drugs and medical supplies was only 80 TZS billion. As with grant transfers to LGAs/facilities, such in-kind transfers will improve the quality of services for those who visit facilities but will not fully benefit the poor who have more limited access to providers.

Grant transfers to nongovernmental agencies (NGOs) and donor-supported programs are other in-kind transfers to LGAs/facilities. The fact that NGOs tend to work in less-accessible areas and donor programs tend to focus on basic health services (e.g., infectious disease programs) provides some assurance that the poor may benefit from these mechanisms. Yet in practice, this is highly dependent on individual NGOs or programs, and there are limited data to assess the extent to which programs are benefiting the poor.

CONSIDERING THE POOR IN GOVERNMENT CONTRIBUTIONS TO HEALTH INSURANCE FUNDS

Tanzania has two main types of health insurance funds. The National Health Insurance Fund (NHIF) was established in 1999 as a scheme mostly for civil servants but is also open to private sector employees and the self-employed as well as their family members. It covers about 7% of the Tanzanian population, offering them a comprehensive benefit package including general outpatient and inpatient care, specialized surgery, pharmaceuticals, optical services, and orthopedics. The Community Health Funds (CHF), which started in 2001, is designed to cover the rural and informal sector population. In 2015, CHF covered 19.8% of the population, offering

them a limited benefit package at primary health care facilities, mostly outpatient curative services within the district.

The government's contribution to the NHIF accounted for about 12% of government health spending in 2016–2017 and included 3% employer matching for civil servants and 6.25% of the salary of members of the police. According to 2015–2016 Demographic and Health Survey (DHS) data, NHIF covers mostly the top 40% in the income distribution, though these figures do not include retirees, who are more likely to be poor. Nevertheless, given the employment status of the majority of NHIF's beneficiaries, in the absence of pooling mechanisms with the rest of the population, it is unlikely that NHIF will directly contribute to coverage of the poor or cross-subsidize the poor.

The government's contribution to CHF is in the form of matching grants paid from the HSBF resources at the central level. Matching grants are meant to provide additional funds for LGAs to improve service delivery for CHF beneficiaries. This mechanism, therefore, can be potentially pro-poor if the poor are enrolled in CHF. There is also a directive in place to exempt CHF contributions by the poor. In practice, however, it is challenging to track how many poor people receive such subsidies for their enrollment. Moreover, wealthier districts tend to have higher contributions (six times difference), and these are the districts that receive more matching grants, which compromises the extent to which the matching grants benefit the poor. Moreover, matching grants for CHF form only a very small part of government health spending. In 2017–2018, three billion TZS from HSBF is allocated for this purpose.

THE WAY FORWARD

The review of potential vehicles for pro-poor resource allocation in Tanzania shows that HSBF allocation to LGAs in effect is the only funding stream that explicitly prioritizes the poor but at a modest scale. NHIF contributions are earmarked for members who are relatively better off, and other domestic transfers are purely based on inputs needed for service delivery. This means that the poor can only benefit if they access and use services, which is exactly the problem that needs to be addressed.

How can the poor receive preferential treatment to access and use services? A good foundation already exists. Political commitment to improving health service delivery and health outcomes is evident; in just two and a half years since the current administration took office, the government has secured 105 billion TZS for infrastructure improvement of facilities, and the budget allocation for drugs and medical supplies is at a record high.

Tanzania is at a critical stage in refining health financing policies to accelerate progress toward UHC. A health financing strategy has been developed, envisioning a single national health insurance for the entire country, guaranteed coverage of the poor, and movement toward output-based payment mechanisms. A proposal to amend legislation for the NHIF and CHF is expected to be considered this year. This will provide a platform for more pro-poor financing policies for both supply- and demand-side interventions.

The identification and registry system of the poor under the Productive Social Safety Net (PSSN), a flagship national social protection program, provides an important opportunity to prioritize health resource allocation for the poor. Under the PSSN, about 1.1 million households, 15% of the population, were identified as extreme poor. And the targeting mechanism employed by the PSSN, a combination of community-based approach and proxy means testing, has proved effective with a low rate of inclusion error.[12] This identification and registry system may be used as a tool to direct resource allocation centered around the poor. More important, it can be used to monitor and evaluate how the poor have benefited from public funds on a more frequent basis as a supplement to household surveys conducted every five years.

Building on the existing foundation of pro-poor policies, further actions are needed. From the perspective of service delivery, human resource deployment and in-kind transfer should give explicit priority to the areas where the poor concentrate for easy access. A roadmap that prioritizes poor areas in investment of key inputs will be indispensable to ensure that health human resources, operating expenses, and infrastructure upgrades are improved in an integrated manner. A combination of administrative enforcement and financial incentives, for example, will be needed to bring health workers to poor areas.

Measures that make service providers more responsive to the needs of the poor will also be required. Part of the public funding they receive may be explicitly earmarked for innovative service delivery models that provide a niche for the poor. Ethiopia's health extension workers served this purpose, making services more accessible by the poor but less preferable by the rich.[13] When transitioning to output-based financing, as the health financing strategy outlines, it is worth exploring some output measures related to how the poor are being reached and served.

On the demand side, there should be explicit efforts to bring the poor to service points by improving their knowledge, awareness, and financial barriers. The health financing strategy already envisions more public funds channeled directly through the demand

side (e.g., single national health insurance), but additional work is necessary to provide a clearly defined basic service package for the poor and establish a sustainable financing mechanism. Intensive communications and education are key for the poor to understand their entitlements and to change their care-seeking behavior. The PSSN platform is promising for enhancing engagement on the demand side.

Finally, additional resource mobilization must be concomitant with equity adjustment in allocation of existing resources. Tanzania overall still faces a lack of human resources, and operating expenses and infrastructure upgrades are starting from a very low base and rely heavily on donor support. As described in the previous section, only around five million USD is explicitly allocated based on local poverty headcount estimates Concerted efforts between central and local governments, donors, and the private sector would be necessary to provide additional resources explicitly targeted for the poor.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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