

**EQUITY OF ACCESS TO HEALTH SERVICES IN  
TANZANIA:  
CHALLENGES TO ACHIEVE UNIVERSAL HEALTH COVERAGE.**

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51<sup>st</sup> International Course in Health Development/Master of Public  
Health (ICHD/MPH).

September 22, 2014- September 11, 2015.

KIT (ROYAL TROPICAL INSTITUTE)

Vrije Universiteit Amsterdam

Amsterdam, The Netherlands.

## **Equity of access to health services in Tanzania: Challenges to achieve universal health coverage.**

A thesis submitted in the partial fulfillment of the requirement for a degree of Masters of Public Health.

By Ligwa Emmanuel James.

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### **Declaration.**

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The thesis "**Equity of access to health services in Tanzania: Challenges to achieve universal health coverage**" is my own work.

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51<sup>st</sup> International Course in Health Development

September 22, 2014- September 11, 2015.

KIT (Royal Tropical Institute/Vrije Universiteit Amsterdam

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**Dedication.**

This thesis is dedicated to my family for their moral and material support during my stay and study in Amsterdam, The Netherlands.

## **Acknowledgement.**

Many individuals participated in and assisted me in the preparation of this thesis. To mention each and every body would exhaust the patience of the reader. Hence I have limited myself to list only those who were directly involved in the preparation of this thesis.

The most profound sincere appreciation goes to the Netherlands universities Foundation for International cooperation (NUFFIC) for granting me a scholarship to pursue my Master's degree studies here in Netherland.

My heartfelt sincere thanks go to the whole course administration and coordination and the whole of the education team at Royal Tropical Institute (KIT) under the administration of the Program Director for their support and guidance of my studies and my knowledge gained will develop my carrier.

My very special thanks go to my tireless thesis advisor and back stopper whom I worked with very closely since the initial development of thesis up to the end.

Furthermore I would like to extend my special sincere thank to the Town Director for Njombe Town Council who is my employer for giving me permission to pursue my Master's degree for the benefits of the community in Njombe Town Council. Otherwise without permission from my employer I would not have been able to join the course.

I appreciate my family and friends for the moral and spiritual support they gave me during the whole period of my studies and thesis writing.

Finally I would like to extend my sincere thanks to the class mates of the International Course in Health Development (ICHD) group for making the year end peacefully and joyfully with a lot of fun and sharing of the constructive ideas. I will miss them.

## **Definitions of terms.**

**Out-of-pocket payments.** Direct payments made by a patient to a health care provider at the time of service delivery. They are health care funds which are not channeled through any financing intermediary. They include user fees paid directly to public health facilities, co-payments made by members of a health insurance scheme, and payments made to private providers by individuals not covered by any form of health insurance (McIntyre, 2007).

**Exemption.** An exemption is a statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the cost sharing operationalisation manual (Burns and Mantel, 2006).

**Waiver.** A waiver is granted to those patients who do not automatically qualify for statutory exemptions but are in need of the same, and classified as 'unable to pay' (Burns and Mantel, 2006).

**User fees.** Also known as co- payments- are formalized out pocket expenditures incurred at a time of health care use (Kapinga, 2012).

**Exemption mechanism.** Government policies or guidelines that reduce or completely exempt people from the full user fees, this protects these individuals from the full burden of fees which is charged at government health facilities (Hussein, 1995).

**Universal Health Coverage (UHC),** is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. (WHO, 2010).

**Equity** is broadly defined as distributing the burden of financing health services according to ability to pay, and promoting a distribution of health care benefits according to need for, or the capacity to benefit from, such care (Mills *et at*, 2012).



<b>Table 1. List of abbreviations.</b>	
<b>ADB</b>	African Development Bank.
<b>ADDO</b>	Accredited Drug Dispensing Outlet.
<b>AIDS</b>	Acquired Immunodeficiency Syndrome.
<b>BOT</b>	Bank Of Tanzania.
<b>CHF</b>	Community Health Fund.
<b>CHMT</b>	Council/District Health Management Team.
<b>CHSB</b>	Council Health Service Board.
<b>CIA</b>	Central Intelligence Agency.
<b>DDH</b>	Designated District Hospital.
<b>DMO</b>	District Medical Officer.
<b>FBO</b>	Faith Based Organization.
<b>GDP</b>	Growth Domestic Product.
<b>HFGC</b>	Health Facility Governing Committee.
<b>HIV</b>	Human Immunodeficiency Virus.
<b>MOHSW</b>	Ministry of Health and Social Welfare.
<b>MOFEA</b>	Ministry of Finance and Economic Affairs.
<b>NBS</b>	National Bureau of Statistics.
<b>NGO</b>	Non Government Organization.
<b>NHIF</b>	National Health Insurance Fund.
<b>NHP</b>	National Health Policy.
<b>NSGRP</b>	National Strategies Growth for Reduction of Poverty.
<b>OOP</b>	Out of Pocket.
<b>P.A.Y.E</b>	Pay As You Earn.
<b>PEPFAR</b>	President Emergency Plan For AIDS Relief.
<b>PPP</b>	Power Purchasing Parity.
<b>SHIELD</b>	Strategies for Health Insurance for Equity in Less Developed Countries.
<b>TB</b>	Tuberculosis.
<b>TDHS</b>	Tanzania Demographic Health Survey.
<b>TGPSH</b>	Tanzania German Program to Support Health.
<b>THE</b>	Total Health Expenditure.
<b>TIN</b>	Taxpayer Identification Number.
<b>TRA</b>	Tanzania Revenue Authority.
<b>TZS</b>	Tanzania Shillings.
<b>URT</b>	United Republic of Tanzania.
<b>US\$</b>	United States Dollar.
<b>VAT</b>	Value Added Tax.
<b>WB</b>	World Bank.
<b>WDC</b>	Ward Development Committee.
<b>WHO</b>	World Health Organization.

## **Abstract.**

**Background:** User fees and out of pocket payments are forms of health care financing in Tanzania which are considered inequitable as the poorest and vulnerable groups are not able to access the health services at the point they need or even they are able to access the health services they must pay at the expense of other basic needs and suffer financial catastrophic and impoverishments. Therefore financial risk protection, as well as access to care is a cornerstone of the universal health coverage.

**Objective:** The general objective of this thesis is to review the challenges in reaching equity of access to health services in Tanzania and to achieve universal health coverage.

**Methodology:** Literature review.

**Findings:** User fees and OOP payments have an impact on the utilization of the health services at the households and at the health facilities. Some families have experienced catastrophic health expenditures and impoverishment. Findings also show that Tanzania has an exemption and waiver policy which is ineffective due to: (i) Poor targeting (ii) Lack of reimbursements (iii) Shortage of resources and (iv) Lack of monitoring and evaluation. Other options have been analyzed to finance the health services which are CHF which have several challenges which are: (i) Low enrollments (ii) CHF design (iii) Community health services and (iv) Highly regressive. The NHIF challenges are: (i) unspent funds (ii) Lack of drugs (iii) Under spending of funds. The donor funds challenges are: (i) Delays in releases (ii) Unpredictable flows (iii) Not released 100 % (iv) Released with conditions

**Conclusion:** (i) User fees and OOP payments are major barrier to access health services (ii) They can be the cause of catastrophic health expenditures and impoverishment (iii) Exemptions and waivers policies in Tanzania do not function as stipulated (iv) CHF have low coverage (v) NHIF have huge reserve of funds (vi) Donor funds are unpredictable.

**Recommendations:** The government of Tanzania should (i) Strengthen the prepayment schemes. (ii) Cross subsidize between NHIF and CHF (iii) Review the capacity of NHIF (iv) Harmonize with donors (v) Strengthen the exemption and waiver (vi) Earmark tax to pay for the poor.

**Key words:** User fee and OOP; catastrophic health expenditure; impoverishment; exemptions and waiver; universal health coverage.

**Total word counts: 13,881 - 740 words for references in the main body of the text= 13,141 Words.**

## **Introduction.**

I'am medical doctor holding a degree in Doctor of Medicine (MD). I'am currently working in Tanzania as District Medical Officer (DMO) in Njombe district in the southern highland of Tanzania since 2007. I have chosen to write my thesis on equity of access to health service in Tanzania: challenges to achieve universal health coverage because health financing in Tanzania to achieve universal health coverage is a limiting factor. The majority of the poor and most vulnerable populations do not have access to quality health services because they are not able to pay or if they are able to pay they may suffer other consequences. The topic relates to the global issues as each country now is looking for the best way to finance the health sector in order to protect the poor and most vulnerable population.

Therefore the general objective of this thesis is to review the challenges in Tanzania in reaching equity of access to health services and achieving universal health coverage and make some recommendations for possible improvement to be worked out by the government of Tanzania.

General user fees and OOP payments are forms of health financing in Tanzania which are inequitable as the poor and most vulnerable population are not able to access the quality health services due to the fact that they are not able to pay at the point of using the health services and even if they are able to pay they may do so at the expense of other basic needs and suffer financial catastrophe. The user fees and OOP payments are forms of payments which are regressive. This thesis aims to analyze alternative ways to finance the health sector and provide good quality health care and access to the poor and most vulnerable population. But still there are some challenges in those financing mechanism such as the CHF, NHIF and donor funds as will be described.

In order to protect the poor and most vulnerable groups in Tanzania, an exemption and waiver policy was introduced with the user fees. But the implementation of this policy is ineffective because it does not meet the objectives of protecting these groups of population. There are several challenges as will be described in this thesis.

The findings of this thesis will be shared with Ministry of Health officials, policy makers at the national level, regional level and at the district level in

order to make progress towards achieving universal health coverage in terms of financial protection.

This thesis is organized into six chapters. Chapter one includes the background on Tanzania where information like the demographic, economic situation and the organization of the health services in Tanzania are described. Chapter two includes the description of the problem, justification and methodology. Chapter three describes the finding and discussion on impact of user fees and OOP payments on the utilization of the health facilities and on livelihoods of households. Chapter four includes the analysis of the other options to finance health services in Tanzania. Chapter five is the discussion on the challenges for implementing the exemption and waiver policy in Tanzania. Chapter six is the conclusion, recommendations and plan of action of the recommendations made from the thesis.

## CHAPTER 1. BACKGROUND ON TANZANIA.

### 1.1. General context and demography.

The United Republic of Tanzania (URT) is a union of two former states which are Tanganyika and Zanzibar that united in 1964. The country is situated on the eastern shores of Africa and is bordered by Kenya and Uganda to the North, the Democratic Republic of Congo, Rwanda, Burundi and Zambia on west and Malawi and Mozambique to the south (TDHS, 2010). The country is located between longitudes 28°E and 40°E, latitude 1°S and 12°S. The population is 44,928,923 (100%) of which 21,869,990 (48.7%) are male and 23,058,933 (51.3%) are female with an annual growth rate of 2.7% (NBS, 2012). **(See table 2).**

The country is divided into 26 administratively regions, 141 districts and 163 Councils. It has a total area of about 947,480 Km<sup>2</sup> of which 885,000 Km<sup>2</sup> constitutes land and 62,480 Km<sup>2</sup> is composed of water (NBS, 2012).

<b>Table 2. Summary of the Key finding in the population distribution in Tanzania.</b>			
<b>Indicator</b>	<b>Total</b>	<b>Male</b>	<b>Female</b>
Population	44,928,923 (100%)	21,869,990 (48.7%)	23,058,933 (51.3%)
Population under 1 years	1,499,389 (3.3%)	747,826 (3.4%)	751,563 (3.3%)
Population (0-4) years	7,273,832 (16.2%)	3,637,982 (16.6%)	3,635,850 (15.8%)
Population( 0-14) years	19,725,456(43.9%)	9,864,400 (45.1%)	9,861,056 (42.8%)
Population (15-64) years	23,466,616(52.2%)	11,185,603 (51.1%)	12,281,013 (53.3%)
Women of reproductive age (15-49 years)	10,905,117(47.3%)	-	10,905,117 (47.3%)
Population +65 years	1,736,851 (3.9%)	819,987 (3.7%)	916,864 (4%)
Infant mortality rate (per 1,000)	43.74	45.78	41.64
Birth rate (%)	4.6		
Maternal mortality ratio (Per 100,000)	454		

Life expectancy (years)	61.24	59.99	62.62
Total fertility rate	4.95		

**Source: National Bureau of Statistics [NBS], 2012.**

## 1.2. Economic situations of Tanzania.

Tanzania is one of the world's poorest economies in terms of per capita income but it has achieved high overall growth rates based on gold production and tourism. Tanzania has largely completed its transition to a liberalized market economy, though the government retains a presence in sectors such as telecommunications, banking, energy and mining (Index Mundi, 2014). Although agriculture provides 85% of exports, and employs 80% of the work force (Index Mundi, 2014), it constitutes only 27.6% of the economy. **(See table 3)**. The World Bank, International Monetary Fund and bilateral donors have been providing funds to rehabilitate Tanzania's aging economic infrastructure, including rail and port infrastructure that are important trade links for inland countries.

Continued donor assistance and solid macroeconomic policies supported a positive growth rate. In 2008, Tanzania received the world's largest Millennium Challenge Compact (MCC) grant, worth US \$698 million, and in December, 2012 the Millennium Challenge Corporation selected Tanzania for a second Compact. GDP growth in 2009-13 was a respectable 6-7% per year due to high gold prices and increased production (Mundi Index, 2014).

Agriculture experienced an average growth rate of 4.4% in between 2000 and 2008 (BOT, 2010). Currently the government has increased its spending on agriculture to 7% of its budget (Index Mundi, 2014).



about 14.6 million Tanzanians are not able to access health care. If a household cannot afford even a basic meal, it is unlikely that it will be able to afford health care. An estimated 7.2 million of Tanzanians live below the food poverty line (Stoermer *et al*, 2013).

#### **1.4. Organization of the health services.**

The Tanzania Health System is organized in a referral pyramid, starting from the village level, where there are village health posts; the ward level, where there are community dispensaries; the divisional level, where there are rural health centers; the district level, where there are district or district designated hospitals; the regional level, where there are regional hospitals; zonal level, where there are referral/consultant hospitals; and the national level, where there are national and specialized hospitals. The final referral system of patients can be done abroad (Kwesigabo *et al*, 2012). **(See figure 1).**

- ❖ At the National level, the Ministry of Health and Social Welfare administers and supervises the National Hospitals, Consultant Referral Hospitals, Special Hospitals, Training Institutions, Executive Agencies and Regulatory Authorities.
- ❖ At the Regional level, provisions of health services are administered by the Regional Administrative Secretary with the technical guidance of the Regional Health Management Team. Also supervise district hospitals
- ❖ 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 District Health Management Teams (DHMT).



**Figure 1. Referral health system in Tanzania.**



**Source: Kwesigabo et al, 2012**

Health facilities include hospitals, health centers and dispensaries. District Designated Hospitals (DDH) complement the Government district hospitals for those districts where there is no government hospital. The number of health facilities is 6,150 (MOHSW, 2011). Among these 75.5% are owned by Government, while FBO/volunteers contribute 12.5% of health facilities. **(See table 4).**

**Table 4. Number of health facilities by type and ownership.**

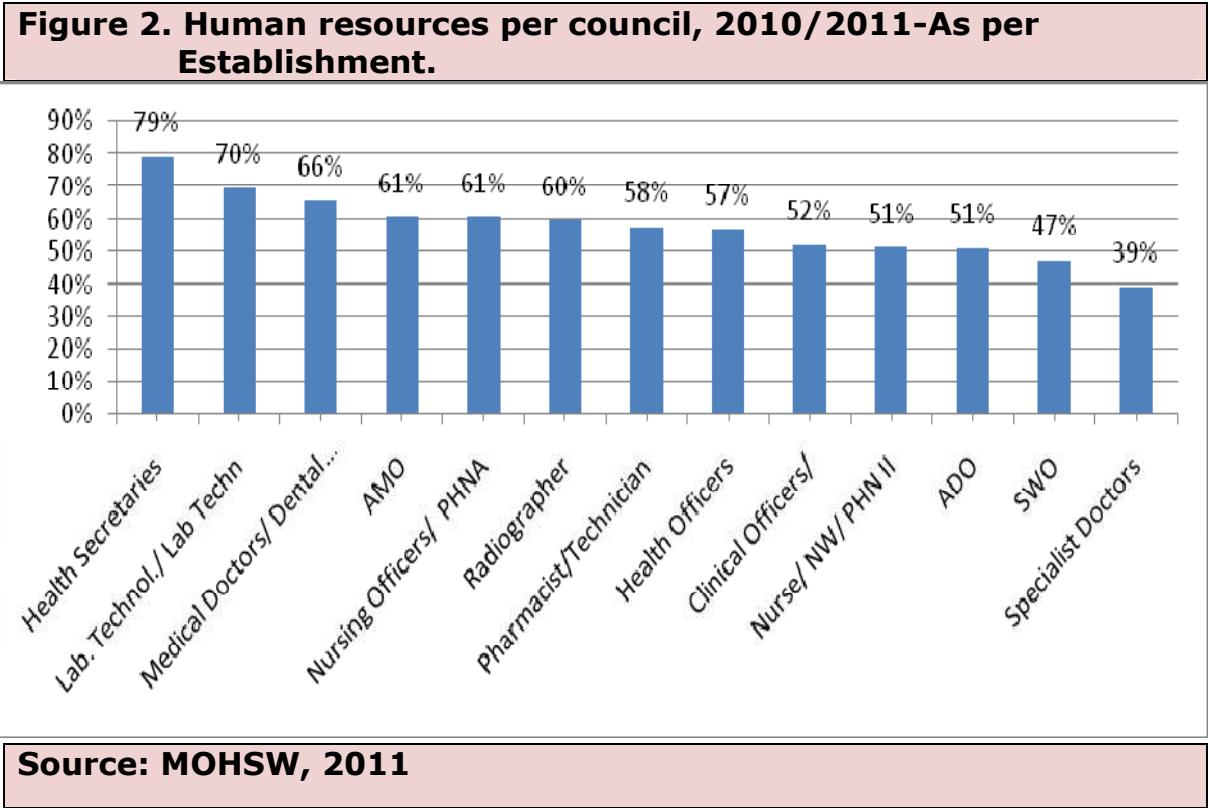
No.		GOV T	DDH	FBO/VA	Parastatals	Private	Total
1.	Hospitals	99	17	77	11	36	240
2.	H/Centers	417	1	103	13	44	578
3.	Dispensaries	4127	0	590	117	498	5332
4.	Grand total	4643	18	770	141	578	6150
5.	Percentage	<b>75.5</b>	<b>0.3</b>	<b>12.5</b>	<b>2.3</b>	<b>9.4</b>	

**Source: MOHSW, 2011.**

**1.5. Human resources for health.**

In an assessment done in 2011/12 revealed that there is serious shortage of both number and qualified health workers of different cadres in most of the councils. They found that the available number of Specialist Doctors, social welfare officers (SWO) and Assistant Dental Officers were below a half of the requirement according to the establishment, while cadres such as nurse/nurse midwives/public health nurse II, clinical officers, health officers, pharmacist/pharmacy technician and radiographer have increased slightly (to above 50%, but still below 60%) (MOHSW, 2011). **(See figure 2).**

The minimum number of health workers required to provide quality health services in these health facilities is 145,454 but there are only 63,447 available making a shortages of about 82,007 which is 56.38% (MOHSW, 2014).



**1.6. Health financing in Tanzania.**

Health services in Tanzania are financed through different sources of funds. These will be elaborated in chapter 4.

## **CHAPTER 2. PROBLEM STATEMENT AND JUSTIFICATION.**

### **2.1. Problem statement.**

The health care system of Tanzania is increasingly facing challenges in an effort to extend the services to the majority of the population due to: budget constraints, overconcentration of the resources to higher level facilities which benefit few people, donor dependency which is unreliable and disbursed very late due to several reasons including conditions (Masito, 2013; WHO, 2000), and increasing dependency on OOP payments. The emerging goal of the national health financing system is to provide universal health coverage and social health protection in which the objective is to improve access to the services by removing barriers to care especially for the poor and those in rural areas (Haazen, 2012). Payment for health care needs to be arranged in an equitable manner whereby those with high ability to pay, pay a relatively higher share of their income to health financing compared to those with lower ability to pay (Mtei *et al*, 2014).

Total health expenditure (THE) has increased over the last ten years. Currently the trend of total expenditures on health in Tanzania as a share of Gross Domestic Product is about 7.0% of THE (WHO, 2013). The public allocations to fund health sector is about 11% of total government expenditure which is below the Abuja commitment of average 15% which was agreed during that meeting (Mtei and Makawia, 2014; WHO, 2013). Data from National Health Accounts show that OOP expenditure in Tanzania in the past years has now increased up to 33% of THE (WHO, 2013) which is considered higher than the benchmark of 20% below which catastrophic health expenditures and impoverishments to the households is relatively low. The pooled funds are decreasing and have gone down to 36% of total health expenditure (WHO, 2013) in recent years. This has been attributed to the decrease over the last five years donor funds to 33% of total health expenditure (**see table 5**). Therefore the public funds are not enough to finance health services in Tanzania as there are only 46 US\$ (WHO, 2013) while the requirement for universal health coverage is estimated to be 65-86 US\$ (PPP) (McIntyre *et al*, 2014).

<b>Table 5. Trends in the National Health Accounts (NHA) indicators in Tanzania.</b>											
<b>No.</b>	<b>Indicator</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
1.	Total health expenditure (THE) % of the Gross Domestic Product (GDP)	3	4	7	6	5	6	7	8	7	7
2.	General government expenditure on health (GGHE) as % of THE	44	47	59	64	63	65	39	39	39	36
3.	Private expenditure on Health (PvtHE) as % of THE	56	53	41	36	37	35	61	61	61	64
4.	GGHE as % of General Government health expenditure	8	9	17	16	16	15	11	11	11	11
5.	External resources on health as % of the THE	31	35	43	41	45	48	40	40	38	33
6.	Out of pocket (OOP) expenditure as % of the THE	45	37	22	22	15	16	15	32	32	33
7.	Out of pocket as % of the PvtHE	82	70	54	42	42	42	52	52	52	52
8.	Total Health expenditure/capita at PPP (NCU per US\$)	35	45	78	72	72	79	106	117	117	126
9.	General Government expenditure on Health/capita PPP (NCU per US\$)	16	21	46	46	45	51	41	45	46	46
10.	Private Insurance as % of PvtHE	5	7	8	10	10	10	2	2	2	2

**Source: World Health organization (WHO) expenditure data base, 2013.**

User fees and OOP payments place full burden of paying for health care services on individuals who need to use when need. This constitutes a major barrier to access health services particularly for the poor and vulnerable, and even people with ordinary income can be threatened by catastrophic expenditures (Yates, 2009). According to the World Health Organization (WHO, 2000) user fees and OOP payments for health care financing at the point of service is an inequitable means of financing the health system.

Some of the effects (consequences) of increasing user fees and OOP payments are lack of attendance to the hospital, increased expenditure for health services which compromise other expenditures (catastrophic expenditures) like food, school fees, some family had to borrow money, some sell their properties, while some may be dying, seeking alternative health care treatment, and trapped in medical poverty. Other consequences of insufficient funding are poor quality services, lack of healthcare workers motivation, and lack of drugs and diagnostics equipments.

## **2.2. Justification.**

The fundamental goal of the healthcare system is to improve population health. While trying to achieve this goal the healthcare system should ensure that households are protected from incurring healthcare expenditure that is too high relative to their income. This is referred to as financial protection of the health system (Baeza and Packard, 2006).

The health financing system in Tanzania is highly fragmented with different sources of funds like donor funds, tax, CHF, national health insurances funds, OOP payments and user fees (Haazen, 2012; Borghi *et al*, 2012). This fragmentation results in substantial inefficiencies in the use of resources and often-conflicting incentives for the various actors in the health system and reduces the opportunities for cross subsidies of risk in the overall health system (Haazen, 2012; McIntyre, 2007). Given the limited funding that is available, it is clear that rationalization of these various modes of financing must take place to ensure improved access to services, improved quality, and ongoing sustainability (Haazen, 2012). Moreover, the existing public financing mechanisms must be reviewed to ensure that they promote access to services for the poor and vulnerable (Haazen, 2012; McIntyre, 2007; Chomi *et al*, 2014).

Health services in Tanzania benefit the rich more than the poor as the poorest 20% receive less benefit than they need (Makawia *et al*, 2010). The poorest are also less likely to be enrolled in health insurance program and end up paying more OOP payments. In order to bring equity and achieve universal health coverage Tanzania introduced an exemption and waiver policy after the introduction of user fees at the health facilities. The implementation of exemption and waiver systems is widely ineffective and does not meet the objectives of ensuring access to quality services for the needy poor and achieve universal health coverage. It has several challenges as it will be described in this thesis.

User fees exemptions and waivers are steps towards improved financial equity in Tanzania. However, research suggests that many users still end up paying for services that are exempted through unofficial payments (Babbel, 2012). This shows that more effort is needed to put the policy into place.

This study will explore and describe the impact of user fees, OOP payments on utilization of health facilities and on livelihoods of households. It will also explore the challenges of the implementation of exemption and waivers systems. The study will come up with recommendations that may enable government of Tanzania to formulate policy which will protect the poor from paying for health services. The findings also can be used to inform the policy makers to strengthen other sources of health care financing to achieve equity and universal health coverage.

### **2.3. Main objective.**

To review the challenges in Tanzania in reaching equity of access to health services and universal health coverage.

### **2.4. Specific objectives.**

1. To explore, describe and analyze the impact of user fees and OOP payments on the utilization of health services in Tanzania.
2. To explore the impact of user fees and OOP expenses on the livelihoods of households.
3. To review the options available in Tanzania in order to protect the poor against the increasing cost of treatment to bring equity in health.
4. To explore and analyze the challenges of the implementation of the exemptions and waivers systems in Tanzania.

5. To compare situation of Tanzania with experience from other countries.
6. To make recommendations to the government of Tanzania.

## **2.5. Methodology.**

**Data collections:** This thesis is based on literature review.

**Search strategy:** Included an Internet search in order to access published and unpublished literature through Google, Google scholar, PUBMED. I searched on the websites of international organization like WHO, World Bank. I used the information from the Tanzania government websites including the MOHSW, MOFEA, NHIF and NBS to obtain various reports. I searched for English language. I also searched on the reference lists of the relevant articles.

**Inclusion criteria:** This thesis includes studies done in Tanzania after 1990 when the user fees were introduced. Other literature was found from sub Saharan countries with similar context as Tanzania in terms of health system financing. Few literatures were drawn from other low middle income countries in Asia and Latin America to complement the evidence.

**Exclusion criteria:** All literature and studies before 1990 were excluded from the studies.

**Key words in single or in combinations: (see table 6).**

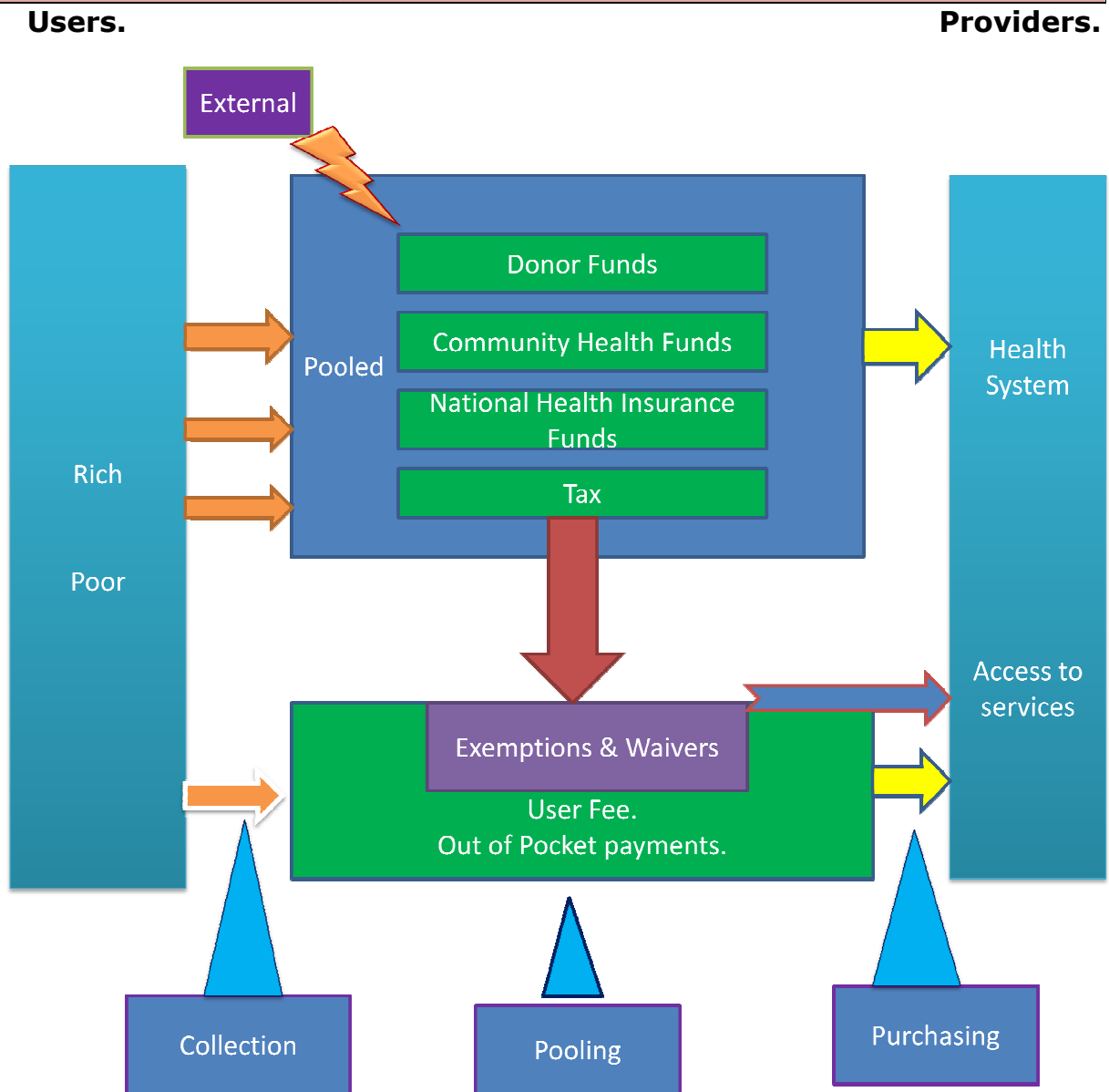
**Limitations:** This thesis is based on the literature review. Due to the time shortage the researcher was limited on the secondary data available. I acknowledge that primary data could be used to obtain more precise data in order to reflect the real situation in the country.

<b>Table 6: Summary of the Search strategy.</b>				
<b>No.</b>	<b>Search engine</b>	<b>Objective 1 and 2 (Chapter 3)</b>	<b>Objective 3 (Chapter 4)</b>	<b>Objective 4 (Chapter 5)</b>
1.	<b>Pub med.</b> <ul style="list-style-type: none"> <li>❖ Published literature</li> <li>❖ Peer review</li> </ul>	<b>Key words</b> Impact of User fees and OOP payments; Catastrophic health expenditures, Impoverishment; Determinants of catastrophic health expenditures; Universal health coverage & Out of pocket	<b>Key words.</b> Challenges with CHF, Universal health coverage & prepayment schemes, Studies on Tax & Tanzania. National health Insurances Fund and Tanzania.	<b>Key worlds.</b> Exemptions and waivers; Universal health coverage; challenges with exemption and waivers; errors in targeting.
2.	<b>Google</b> <ul style="list-style-type: none"> <li>❖ Grey Literature</li> <li>❖ Reports</li> <li>❖ Unpublished literature</li> </ul>	Universal health coverage, OOP payments, user fees.	Challenges with CHF, Tax external/donors and Tanzania, NHIF reports in Tanzania. Health financing in Tanzania.	Exemption and waivers.
3.	<b>Google scholar</b> <ul style="list-style-type: none"> <li>❖ Published literature</li> <li>❖ Unpublished literature</li> <li>❖ Peer review</li> </ul>	<b>Key words.</b> Impact of user fees & OOP; Catastrophic health expenditures, Universal health coverage and OOP payments; Determinants of Catastrophic health expenditure.	<b>Key worlds.</b> Community health funds enrollments, Universal health coverage, studies on taxes and Tanzania	<b>Key worlds.</b> Exemptions and waivers; Universal health overages; challenges with exemption & waivers; targeting
4.	<b>Institution websites</b> WHO, MOHSW ,MOFEA WORLD BANK BOT, NBS, NHIF This I was searching for policy, reports, Grey literature, strategies	<a href="http://www.who.int">www.who.int</a> <a href="http://www.worldbank.org">www.worldbank.org</a>	<a href="http://www.bot.go-tz">www.bot.go-tz</a> <a href="http://www.nhif.go-tz">www.nhif.go-tz</a> <a href="http://www.mohsw.go-tz">www.mohsw.go-tz</a> <a href="http://www.nbs.go-tz">www.nbs.go-tz</a> <a href="http://www.mofea.go-tz">www.mofea.go-tz</a>	
5.	<b>Reference list for the articles.</b>	All published and unpublished articles	All published and unpublished articles	All published and unpublished articles



## 2.6. Conceptual framework.

**Figure 3: Conceptual framework for review in reaching equity of access to health services and universal health coverage in Tanzania.**



**Source: Adapted from course materials from KIT, 2014/2015.**

The government's goal for the national health financing strategy is to provide universal coverage and social health protection to the population. A

prime objective is to improve access to services by removing barriers to care— especially for poor and vulnerable people and those in rural areas— and to ensure that sufficient resources exist to enable health care providers to deliver basic package of high-quality health care services (Haazen, 2012).

I have used this conceptual framework because it captures the three fundamental financing functions for achieving universal health coverage: collections of revenues, pooling and purchasing.

User fees and OOP payments are both sources of financing the health sectors in Tanzania. These payments are considered as barriers to universal health coverage in Tanzania.

The exemption and waiver system in Tanzania is another means of achieving universal health coverage because it provides access to poor and vulnerable groups. But the implementation of the exemptions and waiver system is widely ineffective and does not meet the objectives of ensuring access to quality services for the poor and vulnerable groups.

The pooled funds which consist of donor funds, CHF, NHIF and tax all finance the health services in Tanzania.

In order to describe all of these the author of the thesis has described each objective in a separate chapter in details.

## **CHAPTER 3. IMPACT OF USER FEES AND OUT OF POCKET TO THE HOUSEHOLD AND HEALTH CARE UTILIZATION.**

### **3.1. OOP payments, catastrophic expenditure and impoverishment.**

#### **Definitions and methods to measure.**

**Catastrophic health expenditure** is defined as the OOP payments that exceed some threshold share of household expenditures or income (Russell, 2004; Wagstaff and Van Doorslaer, 2003; Xu *et al*, 2003). It is expenditure for the medical care that endangers the family ability to maintain its customary standard of living. Spending a large fraction of the household's budget on health care must be at the expenses of consumption of other goods and services (Kimani, 2014).

Two methods have been used to define catastrophic health expenditures. The first method is where the catastrophic health expenditure is defined in relation to where total household expenditure or income is used as the denominator. In this method, 10% is commonly used as the threshold (Wagstaff and Van Doorslaer, 2003; O'Donnell *et al*, 2008). However using the same threshold for both the poor and rich households is problematic for equity because the richer households may likely to exceed the threshold level with less adverse effects than the poor ones. (Wagstaff and Van Doorslaer, 2003).

The second method of defining catastrophic health expenditure is where it is defined as a share of net spending on non basic needs. This spending on non basic needs is referred to as the "nondiscretionary" by Wagstaff and Van Doorslaer (2003) and also referred to as "capacity to pay" by Xu (2005). Therefore when using health expenditure as the share of non food, the common threshold is 40% (Wagstaff and Van Doorslaer, 2003; O'Donnell *et al*, 2008).

**Impoverishment.** The extent to which catastrophic expenditure pushes people below the poverty line or further down the line (Wagstaff, 2008). Households are said to be impoverished by catastrophic health expenditure if its pre- payment total consumption exceeds the poverty line but health expenditure pushes its post payment consumptions below the line. The threshold poverty line can be either the national one or the international one. Impoverishment due to health care payment are normally calculated as the difference between poverty estimate that is delivered from households

resources before paying for healthcare (OOP payment) and after paying for health care (Net of OOP expenditure)(Wagstaff and Van Doorslaer, 2003; O'Donnell *et al*, 2008).

### **3.2. OOP payments as a share of total health expenditure (THE).**

A threshold of 20% of OOP payments as a share of total health expenditure is considered as the benchmark below which the risk of the households incurring catastrophic health expenditure and impoverishments is relatively low (Xu *et al*, 2010). However as the OOP payments goes above 20% as a share of total health expenditure the risk of the households to incur the catastrophic health expenditure increases. A study done in 89 countries showed that the more the countries rely on OOP payments the more the households face catastrophic health expenditure and impoverishment (Xu *et al*, 2010). Catastrophic health expenditures occur both in poor and rich countries, however, about 90% of the people affected reside in low income countries (XU *et al*, 2003).

Globally about 150 million people suffer from financial catastrophic health expenditure each year and about 100 million people are pushed into poverty due to OOP payments for health care (XU *et al*, 2007). Catastrophic health expenditures can occur regardless the amount of money paid to the health services. Rich households might pay a large medical bill without experiencing the negative implications, while the low level of spending among the poor households can have a severe financial implication for their livelihoods (Xu *et al*, 2003).

### **3.3. Situation in Tanzania.**

High OOP health expenditures have a serious impact on vulnerable people who subsequently experience debt, income loss, cannot access the health services, seek alternative treatments and face catastrophic health expenditures (Su TT *et al*, 2006). Matee and Simon (2000) conducted a study to evaluate the impact of user fees on the utilization of the dental health services in Tanzania. The study compared the dental attendance, demands for the dental services and treatments patterns in 17 out of 20 regions in Tanzania. The results showed that there was 33.2% decrease in the attendance for dental services but no effects on either demands or

treatments patterns. This pattern demonstrates to us that the utilization of the health services in Tanzania is affected by user fees at health facilities.

An evaluation study of user fees in Tanzania household reported that some individuals were not able to pay in the health facilities. The study elaborated that of the 55% who were unable to pay for the health services in Tanzania, 43% had to borrow some money to cater for the health services, 20% opted for self medications, 10% opted for traditional healers and only 16% were exempted from paying the services (MOHSW, 1999). In a situation where the family does not have funds to access health services there are coping mechanisms which the family can adapt in order to save the life of the loved one in the family as demonstrated by the above study findings.

A study a using random sample households in northern rural in Tanzania to identify the main drive of the costs for facility delivery and financial consequences for households among the rural women in Tanzania showed that about 73.3% of the women with facility delivery reported having made OOP payments for delivery related costs, transport cost was 53.6% and provider fees was 26.6%. Further the results showed that 48.3% of the women reported that they had to spend or borrow money or sell some of their household assets in order to meet the cost of delivery, with the poor reported too frequently as compared to the rich (Kruk *et al*, 2008). The OOP payments for facility delivery are substantially higher and are usually driven by the higher cost of transport and unofficial payment under the table (Kruk *et al*, 2008).

OOP payments is one of the health financing mechanism across many developing countries such as Tanzania (O'Donnell *et al*, 2008) and often leave the households exposed to the risk of financial catastrophe and poverty as the cost of health care are frequently too high. Even a relative small expenditure on health can be financially disastrous for poor households (Su TT *et al*, 2006; Fan *et al*, 2005). The threat that OOP expenditure poses to household living standards is increasingly recognized as a major consideration in financing health care and direct OOP payment for health care is recognized as limiting access to the healthcare services and endangering the welfare of the households (Van Doorslaer *et al*, 2006; Kwesiga *et al*, 2015).

Protecting households from catastrophic expenditures has remained a challenge. Therefore exposure to catastrophic health expenditures is being reported as an important motivation in the movement towards the prepayment scheme and particularly the mandatory health insurance scheme (WHO, 2005). The World Health Organization (WHO, 2005) called for universal health coverage emphasizing the need to protect households from catastrophic medical expenses and impoverishment arising from seeking health care.

The incidence of catastrophic health care payments and the proportion of the population falling below the poverty line as a result of direct payments when seeking health care are better indicators in monitoring progress in financial protection as one of the objectives of universal health coverage across countries (Mtei *et al*, 2014). An evaluation on the progress towards universal health coverage in Tanzania showed that about 2% of the population incurs catastrophic health expenditures and about 1% was pushed below the poverty line due to OOP payments for health care (Mtei *et al*, 2014). These observed levels of catastrophic and poverty incidences due to OOP payments in Tanzania are low compared to other low and middle income countries but they are still unacceptable because the overall target of universal health coverage is to protect every individual who needs care against catastrophic and impoverishment effects of OOP payments (Mtei *et al*, 2014).

It is important to note that the catastrophic and impoverishment assessments only include individuals who sought health services and ignore the ones who due to financial barriers cannot manage to access health care. Hence the observed levels of catastrophic and impoverishment effects might under-estimate the financial protection problem (Mtei *et al*, 2014).

An analysis done by the Haazen (2012) using the household budget survey (2007) in Tanzania showed that health expenditure accounts for 4.2% of the poverty head count. Furthermore the results showed that health expenditure accounts for 7.6% of the total poverty in Dar es Salaam and about 4.3% in other urban areas as shown below in the table. Therefore improving access to the prepaid health insurance scheme and reducing OOP payments can have a major effect on poverty.

**Table 7. Poverty Impact of Health Expenditures**

	Poverty head count (%) (1)	Poverty without health expenditure (%) (2)	Poverty head count due to health expenditure (%) (3)=(1)-(2).	Percentage due to health expenditure (4)= (3)/(1)x100
Dar es salaam	16.40	15.15	1.25	7.6
Other urban	24.10	23.06	1.04	4.3
Rural	37.60	36.10	1.50	4.0
Total	33.60	32.19	1.41	4.2

**Source: Haazen, 2012.**

### 3.4. Experience with other countries.

The evidence from Kenya in a study done by Chuma and Maina (2012) to estimate the incidence and intensity of catastrophic health expenditures and impoverishments showed that each year Kenyan households spend over a tenth of their budget to pay for the health care and that payment is higher among the poor who spent about 33% of their resources on health care payments as compared to the rich who spent only 8%. Further more the result showed that each year about 1.48 millions Kenyan are pushed below the national poverty line due to OOP payments. Also a study done in 2003 in Kenya showed that about 4.1% of the households incurred catastrophic health expenditures due to OOP payments (Xu *et al*, 2006).

A study done by Kwesiga *et al* (2015) in Uganda on assessing the catastrophic health expenditure and impoverishments from OOP payments using the Uganda national health survey the results showed that using thresholds of 10% of households income, about 23% of Ugandan households had catastrophic health expenditure and based on both the 1.25 US\$/day and Uganda poverty line about 4% of the population were impoverished by OOP payments. The study ended by concluding that there is a need to move from OOP payments for healthcare to the mandatory health insurance scheme in order to protect the people from financial hardships and effects of OOP payments.

In Burkina Faso Su TT *et al* (2006) used Naunce Health District survey data of 800 households and found that about 6-15% of the households reporting illness incurred costs greater than 40% of their non food consumption expenditures while in Uganda about 3% and 2.9% of the households

incurred catastrophic expenditure in 2000 and 2003 (Xu *et al*, 2006). In Nigeria 40.2% of the households incurred greater than 10% of their expenditure (Onoka *et al*, 2011) in which the poorest were at greater risk to develop the catastrophic health expenditures compared to the non poor.

### **3.5. Determinants of catastrophic health expenditure.**

The following are some determinants of catastrophic health expenditure:

- ❖ Area of residence is one of the determinants of catastrophic health expenditure. A study done in Botswana found that households that were living in rural areas were found to have higher catastrophic health expenditure than urban households (Akinkugbe *et al*, 2012). This can be explained by the fact that rural households have to encounter the cost of transport, food and shelter for a person who accompanies the sick patients when accessing the health services. The same findings are documented by Xu *et al*, 2006 in Kenya. However a study done by Gotsadze *et al*, 2009 in Georgia found that households that were in the capital city were found to face a higher catastrophic health expenditures (14.8%) as compared to the households that were living Eastern (11.2%) and western (10.1%) part of the country. This can be probably explained by the fact that at the capital city there are higher complex health services such as sophisticated equipments which require a higher cost and more private clinics in the urban areas as compared to the rural areas. Their presence also attracts the relatively poor.
- ❖ Chronic disease is another determinant of catastrophic expenditures. A cross sectional study done by Brinda *et al* (2014) in Tanzania showed that households with patients with chronic disease were found to have higher catastrophic health expenditures. This is because these families are likely to use inpatients services regularly in order to care for the patient with a chronic illness. In Uganda the use of inpatients services were the greatest cause of catastrophic expenditures among the non poor (Xu *et al*, 2006). The use of inpatients services can be explained by the high cost associated with the hospitalization like drugs and the cost of food for the sick person.



- ❖ Characteristics of the head of the household (gender, education and working status) are also a key determinant of catastrophic health expenditure. This can be explained by the fact that being employed and having a higher level of education could be translated into more opportunities to cope with financial burden such as borrowing money, selling assets and also families with educated persons are more likely to use preventive services (Kimani, 2014). Several studies had documented this. In Uganda household heads with lower education level are associated with a higher rate of catastrophic health expenditure (Xu *et al*, 2006). In Kenya, Xu *et al*. (2006) found that household heads with higher education and who were working had decreased odds of catastrophic expenditure. Female headed households and those with an educated household head were found to be less likely to face catastrophic health expenditures in Botswana (Akinkugbe *et al*, 2012).
- ❖ Household's characteristics such as size and composition of the households have been found to be key determinants of catastrophic health expenditure. Households' size signifies the degree of wealth and the number of people using the health services. The young and the old people in the family tend to make more use of the health services and also may lack financial sources (Kimani, 2014). The larger the family size the higher probability of incurring catastrophic health expenses as the large family is more likely make greater use of the health services (Brinda *et al*, 2014). This is because large family is often poor. A study done in Lesotho found that households' size was associated with catastrophic health expenditure in which the presence of senior members and children in the family increases the risk of catastrophic health expenditure (Akinkugbe *et al*, 2012).
- ❖ Socioeconomic status is a key determinant of catastrophic expenditures. A study done by Brinda *et al* (2014) in Tanzania showed that households with low economic status are associated with catastrophic expenditure and poverty in the family. The study showed that Tanzania has a higher prevalence of catastrophic health expenditure of about 18% at a threshold of 40%.

- ❖ The use of insurance is associated with lower catastrophic health expenditures. Several literatures have documented this as positive such as a study done by the Lamiraud *et al*, (2005) in South Africa showed a positive impact on reducing the catastrophic health expenditures in the country. In Mexico the introduction of the popular health insurance were found to reduce the catastrophic health expenditure (Knaul *et al*, 2006).

## CHAPTER 4. THE OPTIONS AVAILABLE IN TANZANIA TO FINANCE THE HEALTH SECTOR.

### 4.1. Introduction and overview.

The goal of national health financing is to provide universal health coverage, social protection, improve access to services by removing barriers to care especially for the poor and those in remote areas and to ensure that sufficient resources exist to enable health care providers to deliver basic packages of high quality. Provision of health services needs to be determined by the individual needs and not ability to pay (Haazen, 2012; Mtei *et al*, 2007). Various other options are analyzed in this chapter with their contribution to the % of the share of the funding and their kakwani as shown below in the table.

<b>Table 8. Distribution of incidence for the health financing in Tanzania.</b>			
<b>No.</b>	<b>Financing mechanism</b>	<b>% share total funding</b>	<b>Kakwani Index</b>
1.	Community health Fund	1%	-0.49
2.	National health insurance fund	3%	0.42
3.	Donor funds/external resource	38%	
4.	Taxes:		
	Direct tax- Personal income tax	7%	0.53
	Corporate tax	5%	0.42
	Indirect tax-VAT	21%	0.03
	-Excise tax	6%	0.13
	-Import tax	4%	0.14
<b>Source: Mtei <i>et al</i>, 2012.</b>			

### 4.2. Community Health Funds (CHF).

#### 4.2.1. Background.

The community health fund in Tanzania was introduced in 2001 by the Ministry of Health and Social Welfare to make health care affordable and available to the rural and informal sector where about 85% of the population live (Mtei and Mulligan, 2007; Bultaman *et al*, 2013; Kamuzora and Gilson, 2007; Borghi *et al*, 2013). The CHF is based on risk sharing whereby members pay small contributions on yearly bases in order to offset large

payments to health facilities if they fall sick. The objectives of CHF (URT, 2001) are: (i) To mobilize financial resources from the community for the provision of the basic health care services to its members. (ii) To provide quality and affordable basic health care services through sustainable financing mechanism. (iii) To improve protection of the people against the financial consequences of health illness such as catastrophic health expenditure.

#### **4.2.2. Current Institutional structure of the CHF.**

The CHF is integrated into the district level government structure as well as local wards and the village administration. The policy guidelines and subsidies remain the responsibilities of the national level (Stoermer *et al*, 2011; URT, 2001). The following is the structural management of CHF in Tanzania. (**See annex 3**).

- ❖ **National level:** The Ministry of Health and Social Welfare, Prime Minister Office, Local Government Authorities and National Health Insurance Fund are charged with the overall management of the community health fund.
- ❖ **District Level:** The Council Health Services Board (CHSB) and Council Health Management Team (CHMT) with the lead of District Medical Officer (DMO).
- ❖ **Ward level:** Ward Development Committee (WDC) through Ward Health Committee.
- ❖ **Village Level:** Village council through Health Committee and Health Facility Governing Committee (HFGC).

#### **4.2.3. Memberships to the CHF.**

Memberships in CHF are voluntary and each household contributes the same amount of membership fees as agreed by members themselves (Bultaman *et al*, 2012 and 2013; Mtei and Mulligan, 2007). Households that do not pay the memberships fees are required to pay user fees on an individual basis when accessing the health services at the health facility. The memberships fees varies across district between TZS 5,000 (~ US\$ 3) to 15,000 (~9 US\$) per year and covers the cost of households of six people and the governments provides a matching grant of equal amount as subsidy upon request in the respective districts (Bultaman *et al*, 2012 and 2013; West-Slevin and Dutta, 2015). Households that are not able to contribute to the

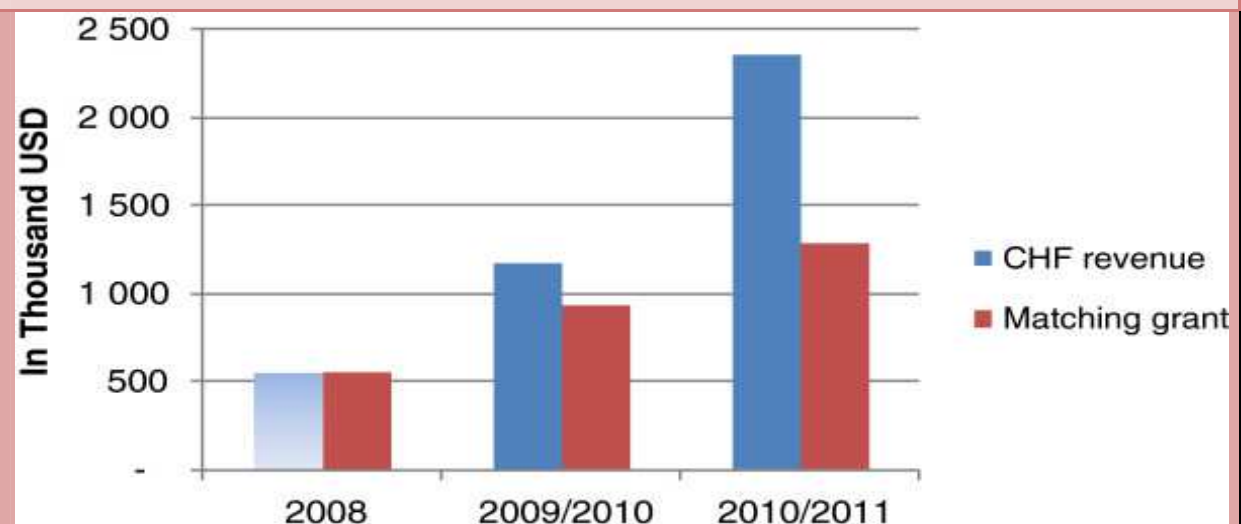
membership's fees can benefit through the exemptions policy (Mtei and Mulligan, 2007). In Tanzania as of January, 2012 there were 108 districts with a functioning CHF out of 133 district (NHIF, 2012). There were 593,643 households with 3,438,000 memberships which is approximately 8.1% of the population (NHIF, 2012).

#### 4.2.4. Benefits packages of the CHF.

The benefits package is determined locally at the district council level and includes all services that are offered at the primary care level services which include both inpatient and outpatient services which are provided at dispensaries and at health centers levels (Bultaman *et al*, 2012 and 2013; West-Slevin and Dutta, 2015; Shaw, 2002). **(See annex 2)**. However some district has included the district hospital in the CHF to make the scheme more attractive.

The community health fund in the year 2010 generated TZS 3.0 billion (~US\$1.8M) in which TZS 2.1 billion (~US\$1.3M) was used for the provision of health care benefits and 30% was used for administration costs (Bultaman *et al*, 2012). Borghi *et al* (2013) in his analysis showed that the revenues generated from the community health fund increased for three years and the matching grants are reimbursed as shown in the figure below.

**Figure 4. Overview of Community health fund revenue and matching grants between 2008 2011 in US\$.**



**Source: Borghi *et al*, 2013.**

From the above figure we can see that the amount generated of matched funds does not keep track of the funds generated as was promised by the government.

#### **4.2.5. Reaching the poor with CHF, pooling and purchasing.**

According to the community health fund act funds consist of the following sources (i) Members contributions (ii) Government contributions (iii) Donor/NGO funds (URT, 2001). Some of the development partners have also been contributing funds in the CHF to pay for the poor: for instance, Mpwapwa budgeted TZS 3,000,000 in 2009/10 for pro-poor support, Compassion (NGO) paid for 39 groups of students, and Africare (NGO) had a plan to pay for 180 households. Similarly, Dodoma Urban budgeted TZS 4,000,000 in 2009/10 for pro-poor funds (Stoermer *et al*, 2012) and the Rungwe Tea Growers association paid TZS 50 million for their members for 5000 households (Sheuya, 2006). A review by Mtei and Mulligan (2007) in Muheza district showed that the council released TZS 3,000,000 for the year 2005/06 and secured additional funding to provide CHF membership cards for the poor, estimated to be 733 families. Despite these efforts, key resource persons indicated that many poor and vulnerable groups are still required to pay directly in order to access health care.

Available evidence from a study done by Msuya *et al* (2004) showed that CHF improved access to the health care because members are more likely to seek health care to the formal health care providers compared with the non members. They found that household with a sick member were 15% more likely to get treatment than households which are not insured (Msuya *et al*, 2004). The CHF members were also less likely to sell properties in order to seek health care hence avoided catastrophic expenditures. Similarly the study showed that members of CHF particularly the poor reduced seeking care of traditional healers, and self medication. This confirms that being insured with CHF increases the chance of seeking health care as compared to none insured (Msuya *et al*, 2004).

60% of the funds generated from CHF should be used for procurement of drugs as the shortage of the drugs in health facilities is big and 40% should be for administration and other activities like repairs of the building, purchase of furniture, training and any other activities to improve health facilities (Rohregger, 2014; URT, 2001).

A review of the international literature indicated that CHF schemes appear to extend coverage to a large number of rural and low income populations that would otherwise be excluded (Preker, Carrin *et al*, 2002). Similarly, another major systematic review of community health insurance provides evidence that CHF schemes can provide protection to their members by significantly reducing the level of OOP payments for health care (Ekman, 2004).

#### **4.2.6. Challenges with the community health funds in Tanzania.**

CHF aim to build up risk pooling mechanism protecting the population, contributing to improved quality of healthcare, to community empowerment, and to affordable, equitable access to health services for rural population and informal sector communities throughout the year (Stoermer *et al*, 2011). However, CHF face a number of problems which so far have hindered the achievements of these objectives as described below.

##### **4.2.6.1. Enrollment.**

CHF enrolment varies greatly across Tanzania. Generally the CHF has achieved 6-10% of enrollment rate in the 14 years of implementation (Kamuzora and Gilson, 2007; Marwa *et al*, 2013). Overall, enrolment lags far behind expectations due to:

- ❖ **CHF premiums.** In some districts are considered too high by potential beneficiaries especially for people with low and often unreliable income, the payment of single sum of TZS 10,000 to 15,000 means a lot of money and most of them are not willing to sell any of their animals in order to pay the premium (Kamuzora and Gilson, 2007). Msuya *et al* (2004) cited low income and income un-reliability as further reasons for low enrolment. They found that 60% of richer households in Igunga district joined the scheme compared to 33% of the poorest households. Macha *et al* (2012) reported that about 38% were not able to pay due to the high premium.
- ❖ **The low quality of services.** Is also another reason enrolment rates tend to decline substantial after the first year of enrolment, as people see no reason to enroll again. Those who initially register into the scheme may drop out quickly if the quality of care does not reach expectations. Bonu *et al* (2003) argue that the poor enrolment rates in many CHF may be linked to a perception of poor quality of care. Other

studies also concluded the same finding in Tanzania (Chee *et al*, 2002; Musau, 2004). Perceived poor quality of the services is mostly associated with lack of drugs and essential medical equipments, shortage of diagnostic equipments leading to inappropriate diagnosis.

- ❖ **Lack of information.** In the current model of CHF there is no clear role indicating specifically who is responsible for mobilizing the community members to join the scheme (Stoermer *et al*, 2011). In some districts the health facilities undertake this exercise; in some districts community based organizations are formed while in some villages councils take the responsibility. Generally no active force is in place which make to join remains a community member initiative. Much depends on the role of health facilities workers who are not active by the fact that health facilities workers perceive patient paying user fees and OOP as more profitable to them rather than the CHF memberships (Stoermer *et al*, 2011).
- ❖ **Adverse selection problem.** The CHF schemes are subject to adverse selection through features of the enrolment mechanism. Members can enroll in the CHF at health facilities and receive immediate access to health care. This feature does not encourage people to join before they fall sick. This also allows members to drop out each year and only re-enroll when they need to use the services (Stoermer *et al*, 2011).
- ❖ **Access for the poor.** Although the CHF Act states that the power to issue an exemption from CHF payment is vested with the Ward Health Committee upon receiving recommendations from the Village Council, such exemptions are hardly ever issued. This is not an unusual phenomenon which can be observed worldwide in cost sharing schemes, that exemption mechanisms work poorly and do not effectively protect the poor. This leaves the poor in an even more vulnerable situation as they are not recognized as exempted (Stoermer *et al*, 2011; Later Veer *et al*, 2004; Burns and Mantel, 2006).
- ❖ **Drop out in years is higher.** In years of drought and resulting crop failures the rural population gives higher priority to food expenses for



ensuring the survival of family during such difficult years. (Re-) enrolment into a prepayment scheme receives less priority (Stoermer *et al*, 2011). In a study done by Shaw (2002) in Igunga and Singida showed that the overall dropout was high. The overall dropout might have an implication on the revenue generation for the CHF as most of the people in the village depend on agriculture. In a drought we expect the enrollments to be down.

- ❖ **Poor staff's attitudes.** Since the scheme is mainly found in the rural areas where there is wide evidence that Tanzania faces a challenge of staff (MOHSW, 2014). Moreover, health sector staffs are not always properly motivated, especially those working in remote areas; and, with little motivation, service delivery in facilities in rural areas is undermined and therefore members might not want to enroll any more with such staff and perceive low quality (Mtei and Mulligan, 2007).

#### 4.2.6.2. CHF design.

- ❖ **Overburdening of current office bearers.** Currently in many districts one member of the council health management team is appointed as a CHF coordinator. This person, together with the District Medical Officer performs other activities like practicing health profession (Stoermer *et al*, 2011).
- ❖ **Limited/inappropriate benefit package.** The benefit package of CHF in most districts includes all services provided by primary level health care and excludes hospital care. When a person who is need of referral at the district hospital the only option is OOP which can lead to catastrophic health expenditure (Mtei and Mulligan, 2007; Macha *et al*, 2014).
- ❖ **Insufficient Insurance Management Information System.** An MS Excel tool has been developed to support data management of CHF; the tool however is perceived as dysfunctional and thus is hardly being used. Most information is captured in paper format and compiling data is often incomplete and inaccurate. This leads to problems in data collection and analysis, and therefore management decisions are ill-informed (Stoermer *et al*, 2011).

#### **4.2.6.3. CHF servicing issue.**

- ❖ **Insured identification.** A number of problems are also related to unclear identity card documents and difficulties in identification of family members on the joint family card. This leads to an unclear verification system for health facilities and inconvenient accessibility processes for the policy holders due to the shared card (Stoermer *et al*, 2011).
- ❖ **Insufficient feedback mechanism.** Members are not provided with an effective feedback mechanism to voice their concerns with the system. The system is thus not harvesting feedback to improve its operations (Stoermer, 2011). A study which was done by Chee *et al*, 2002 in Hanang showed that there is little involvement of the community in management of the scheme. Members are not invited in the meeting to discuss about the scheme and the funds.
- ❖ **Use and management of CHF.** There is weakness in the use and management of funds in some district (Mtei and Mulligan, 2007) especially in the ward health committee. This has been contributed by lack of knowledge/training on the financial management. In some district according to Later Veer *et al* (2004) about 27% of the districts, the funds were found idle in accounts without being utilized due to the district not being clear on the procedures. 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. In their literature review Mtei and Mulligan (2007) found that not all districts conducted regular auditing.

### **4.3. National Health Insurance Fund (NHIF).**

#### **4.3.1. Background.**

The National Health Insurance Fund is a statutory health insurance scheme which was established by Parliamentary Act No. 8 of 1999, in order to facilitate access to health services by the principal members and their dependents (NHIF, 2012). The management of the fund is under the Board of Directors that is appointed by Minister of Health and Social Welfare.

#### **4.3.2. Memberships.**

Membership is mandatory for public employees. The 6% contribution for the scheme (NHIF, 2012) is shared between the employer and the employee and

deducted from payroll each month. The national health insurance fund currently has 3.0 million members which is approximately 7.0% of the population of Tanzania (NHIF, 2013). In 2011/2012 the National health insurance fund collected amount of TZS 199.1 billion (~ US\$ 122.2M) of which 80.8% was from contribution from the members, 19.0% from investments and 0.1% from other sources (Bultaman *et al*, 2013). In the same year the NHIF spent TZS 78.1billion (~US\$ 47.9M) in which about 62% (TZS 48.4billion~ US\$29.7M) was used to pay the beneficiaries, 28%(TZS 21.9 billion ~ US\$ 13.4 M) was used for administration expenses and 11% (TZS 8.6 Billion ~ US\$ 5.3M) was miscellaneous expenses (Bultaman *et al*, 2013).

In order to complement and guarantee improved access to quality health care services to NHIF beneficiaries, the Fund has introduced the NHIF outreach program which is conducted on quarterly basis by involving medical specialists of different disciplines. The objective of program is to ensure that the vulnerable community in underserved areas is accessing specialized quality healthcare services. By the end of June 2013 of NHIF accredited strategic health facilities countrywide stood at 5,840 equivalents to 80% of available health facilities in Tanzania. (NHIF, 2013). **(See table 9).**

<b>Table 9. Trends in the memberships in NHIF.</b>					
<b>No.</b>	<b>Description</b>	<b>2001/02</b>	<b>2005/06</b>	<b>2011/12</b>	<b>2012/13</b>
1.	Number of Members	164,708	275,865	474,760	559,829
2.	Beneficiaries	694,774	1,268,979	2,502,794	2,963,296
3.	Number of Identity card distributed	184,764	1,029,211	1,857,172	2,346,590
4.	Accredited Health facility	3,197	3,967	5,426	5,840
<b>Source: Fact sheet inside NHIF, 2013.</b>					

From this table members have been increasing each year and beneficiaries are increasing. Therefore the revenues have been increasing enabling to finance health services to improve the access to the community.

#### **4.3.3. Benefits packages.**

The National Health Insurance Fund's benefits package consist registration and consultation fees, outpatient services, medicines, diagnostic tests,

inpatient services, surgical services, physiotherapy, optical services, orthopedics and dental services (**See annex 3**). The providers issue medicines based on the National Essential Medicines List and an additional list drawn by NHIF regarding the regulation of using generic formulations and adherence to the mutually agreed NHIF medicines price schedule. The price schedule is prepared after taking into account macroeconomic changes such as price index (inflation) and any other relevant economic indicators. Members of national health insurances funds can receive medical care services provided at dispensaries, health centers, district hospitals, regional hospitals and referral hospitals (NHIF, 2012).

The following table shows the income and reimbursements for a trend of five years.

<b>Table 10: NHIF income and reimbursements (Millions TZS).</b>						
<b>No.</b>	<b>Description</b>	<b>2006/07</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/211</b>
1.	Contributions	45,516	55,472	73,282	90,084	134,891
2.	Total income (including income from investments)	56,884	72,168	76,512	108,845	164,146
3.	Percentage of funds paid out to health services against total income of NHIF	14.4%	14.1%	18.4%	23.0%	27.0%
4.	Actual spending including administration	23,950	26,719	34,325	39,782	68,048
5.	Unspent balance as % of total income	58%	63%	55%	63.0%	59%

**Source. Health sector Public expenditure Review 2010/2011, MOHSW (2012)**

From the above table, premium contributions account for the largest proportion of total revenue and have been increasing over time, in line with the increase in membership. Investment return is another significant source of revenue. Income has been growing strongly since the start of the scheme due to membership growth, and members' income growth. On the other hand there is huge unspent reserve balance but in the last two years the reserve has decreased from 63% to 59%. Due to the presence of this huge reserve it enhances financial stability of the NHIF and at the same time it raises questions about whether NHIF is delivering value for members' money (Musau *et al*, 2011). Holding very large reserves defeats the whole purpose of collecting these funds. The NHIF is facing some challenges which will be discussed on later to explain this huge reserve of funds.

The benefits payments (reimbursements) in the four years take a large proportion of the share followed by administrative expenses as shown in the table below.

<b>Table 11: NHIF expenditure by component (Million TZS).</b>						
<b>No.</b>	<b>Description</b>	<b>2001/02</b>	<b>2005/06</b>	<b>2011/12</b>	<b>2012/13</b>	<b>%</b>
1.	Benefits Payment	247.36	4,204.62	48,190.19	82,862.51	<b>66</b>
2.	Administration	738.93	3,225.97	21,699.92	26,375.15	<b>21</b>
3.	Member services	-	321.79	6,096.31	4,046.11	<b>3</b>
4.	Others	466.98	4,572.7	2,126.68	12,339.53	<b>10</b>
5	Total expenditure	1,453.27	12,325.08	78,113.10	125,623.30	<b>100</b>
<b>Source. Fact sheet Inside NHIF, 2013</b>						
<b>Remarks.</b> The proportion (%) expenditure is only by 30 <sup>th</sup> June, 2013 which is the last column.						

By 30<sup>th</sup> June, 2013 government facilities received 30% of total reimbursement according to fees for service. The Faith Based health facility received 36.2% of the total because Faith-based health facilities are important actors in health service delivery, especially in marginalized areas. The table below summarizes the benefits payments according to the health facilities. (**See table 12**).

<b>Table 12: Reimbursement by health facility ownership, 2010/11 (Millions TZS).</b>						
<b>No.</b>	<b>Description</b>	<b>2001/02</b>	<b>2005/06</b>	<b>2011/12</b>	<b>2012/13</b>	<b>%</b>
1.	Government Facilities	225.06	2,213.58	16,083.20	24,858.06	<b>30.0</b>
2.	Faith Based Organization	22.3	2,091.98	24,530.62	29,988.80	<b>36.2</b>
3.	Private Facilities	-	396.1	8,720.62	18,335.36	<b>22.1</b>
4.	Pharmacies	-	-	5,267.93	9,497.07	<b>11.5</b>
5	ADDO's -	-	-	163.30	183.22	<b>0.2</b>
6.	Total	<b>247.36</b>	<b>4,701.66</b>	<b>54,765.67</b>	<b>82,862.51</b>	<b>100.0</b>
<b>Source. Health sector Public expenditure Review, 2010/2011, MOHSW (2012).</b>						
<b>Remarks:</b> The proportion (%) expenditure is only by 30 <sup>th</sup> June, 2013 which is the last column						

#### 4.3.4. Equipment and Facility Improvement Loans.

The Fund has started to facilitate equipments and facilities improvement loans as an intervention aimed at the provision of better services to its beneficiaries (NHIF, 2013). The loans provided to these facilities are used mainly for improvement of health services in terms of purchasing new medical equipments. Usually the loans are paid back after a period of time and the community benefits from those equipments. **(See table 13).**

<b>Table 13. Amount approved and issued loans up to June, 2013 (TZS millions).</b>								
<b>Item</b>	<b>Government facilities</b>		<b>Faith based organization</b>		<b>Private Facilities</b>		<b>Total loans</b>	
	No.	Amount issued	No.	Issued	No.	Issued	No.	Issued
Medical equipment loan	56	1,283,775,690	32	668,807,639	7	156,809,000	95	2,109,392,329
Facility equipment loan	11	583,669,740	4	314,471,024.19	0	0	15	898,140,764
Total Facility of loan	67	1,867,445,430	36	983,278,663	7	156,809,000	110	3,007,533,093
% to the total		<b>62%</b>		<b>33%</b>		<b>5%</b>		<b>100%</b>
<b>Source: Fact sheet inside NHIF, 2013.</b>								

#### 4.3.5. Challenges with National Health Insurance Funds.

In Tanzania the NHIF is facing some challenges in the implementation of the activities and some time remains with huge amount of reserves as shown in the previous section. These challenges according to Musau *et al* (2011) are:

- ❖ Many facilities especially public do not claim reimbursement, citing cumbersome reimbursement procedures.
- ❖ The time taken between re-claiming reimbursement and the actual payment is considered unjustifiably long by service providers.
- ❖ Some facilities have problems submitting claim forms to the NHIF that are incorrectly filled in, over invoicing, reporting false admission,

missing patient signature, Non adherence to the National essential Medicine Lists and Standard Treatment Guidelines which delays reimbursement, and possible discourages future claims.

- ❖ Frequent stock-outs of medicines in most accredited health facilities.
- ❖ Negative attitude by some health providers towards NHIF members on the use of cards versus cash due to immediate need of cash by health facilities.
- ❖ Under spending of the funds generated by the NHIF.

#### **4.4. Donor funds. /External support.**

Donor funds in Tanzania are major source of health sector financing. From the national health account (WHO, 2013) the external support has been fluctuating which means it has been going up and down but in the recent years it has been going down. Donor funding usually evolves according to set project plans and set budgets with some of their own contributions (e.g. technical assistance). The recent trend is that donors increasingly channel funds into General Budget Support for the whole country and not directly into the health sector, which has an implication for sector in terms of securing an increasing share of government budgetary resources because the funds may not be earmarked for health (TGPSH, 2007).

##### **4.4.1. Trends in Donors funds/external support.**

In Tanzania the donors' funds are in the form of pooling mechanism which is health basket fund that are deposited at the Ministry of Finance and then disbursed to the Ministry of Health. The health expenditure in Tanzania decreased in nominal terms from US\$ 97 million in 2009/2010 to US\$ 90 million in 2012/2013. The main funders for the health basket funds in financial year 2012/2013 to 2013/2014 were Canadian, Danish, and Irish Governments (West-Slevin and Dutta, 2015). U.S. government support for HIV and malaria is very large compared to all other external resources. The U.S President's Emergency Plan for AIDS Relief (PEPFAR) contributed US\$295 million in 2012/2013 (October–September) and the President's Malaria Initiative committed US\$49 million, averaging about one-third of overall. Within the HIV response, PEPFAR resources accounted for an estimated 80% of all specified HIV resources in 2012/2013, and an estimated 92% in 2013/2014 (West-Slevin and Dutta, 2015).

The stability of funding for vertical programs depends on the continued USG and Global Fund support. With the move to Global Fund's New Funding Model, Tanzania has been issued an overall funding envelope of US\$633 million, which includes both new and existing money for AIDS, tuberculosis, and malaria for fiscal 2014–2016 (West-Slevin and Dutta, 2013). About 61% of this amount is allocated for HIV. All other formal external donor support on-budget represented 18–21% of the total (West-Slevin and Dutta, 2013). Some bilateral donors such as United Kingdom Department for International Development provide general budget support and project support to NGOs and other organizations.

#### **4.4.2. Challenges with donors/external funds.**

- ❖ Flows of external resources tend to be unpredictable and prone to fluctuations and the gap between commitments and actual disbursements continues to be a problem for project financing as well as for program support. A study done by Save the Children showed that foreign expenditure in terms of actual release of funds has averaged 33% of total health expenditure since 2005/2006 which was less than the budgetary commitments that averaged 37.62%. For example in 2009/2010 the funds release was 89.4% of the budget, creating a gap of 47.6 billion TZS an amount which could implement the road map to accelerate reduction of maternal and child death in Tanzania (Save the Children, 2011).
- ❖ Delays or even complete non- disbursement of committed funds undermines the integrity of budget management and implementation schedules, reducing the effectiveness of entire projects and programs. The risks of non- disbursement or untimely disbursement are particularly acute for direct budget support where government may have committed funds in good faith, based on agreed expectations of disbursements (MOFEA. 2003).
- ❖ A large proportion of funds still flow outside the government budgeting system and it is therefore difficult to integrate external finance within government plans and also to be able to account for such expenditures.
- ❖ Some funds come with conditions on how to use.



## 4.5. Tax

In general the purpose of the country taxation system is to raise revenues in order to fund public good services and activities that will help the government to achieve policy objectives. Financial resources for health-care services can be raised through taxation. Tanzania has moved in a positive direction in domestic revenue collection attributed to wide ranging reforms including operationalization of Tanzania revenue authority (TRA) in 1996 and the review of the key tax legislation including income tax act and value added tax (VAT) act. Tax revenue has been increasing significantly by 20% on average each year since the establishment of Tanzania revenue authority (Sogema, 2013; ADB, 2010). Different types of taxes can be collected.

### 4.5.1. Direct tax.

Direct taxes in Tanzania are dominated by personal income taxes of salaried employees (Pay-As-You-Earn, withholding taxes on employee income) and corporate taxes. Both the share of P.A.Y.E. and corporate income taxes in direct taxes have increased slightly since 2000-01, from 43% to 46% for P.A.Y.E., and from little over 20% to 32% for corporate taxes (Sogema, 2013). The withholding tax on goods and services supplied between taxpayers is next but fairly far behind, with a share of about 8% in 2011-12. Other direct taxes, namely the Skills and Development Levy, individual income taxes for small and medium individual traders, and the rental tax, each account for less than 10% of direct taxes in 2011-12 (Sogema, 2013).

**Table 14. Direct tax: Revenues, Share of the Total tax and Average Annual Growth.**

	<b>Revenues 2011/2012 TZS Millions</b>	<b>Share of Total Tax revenue 2011-2012</b>	<b>Average Annual Growth 2001 to 2011/2012</b>
P.A.Y.E	1,129,469	16.9%	26%
Individual	65,768	1.0%	16%
Skills and development levy	138,901	2.1%	22%
Corporate Tax	779,855	11.7%	30%
Withholding tax	279,426	4.2%	22%
Rental tax	57,371	0.9%	25%
Others	20,719	0.3%	32%

**Source: Tanzania Revenue Authority (TRA), 2011.**

From the above table PAYE and corporate income tax are strong performers growing by 26% and 30% respectively on average per year between 2000-2012 and 2011/2012. Together both taxes account for little less than 30% of the total tax revenue (Sogema, 2013). This strong performance is the result of both sound policies and strong economic growth (ADB, 2010). Net receipts from withholding taxes have also increased strongly over the period, growing by 22% on average each year, while individual income taxes have increased on average by 16% per year. Finally, while it yields fairly small amounts (less than 60 billion of TZS in 2011-12), the rental tax has been generating a stable stream of revenue, growing on average by 25% each year (Sogema, 2013).

#### 4.5.2. Indirect Tax.

Indirect tax revenue accounts for two thirds of total tax revenue in Tanzania and is heavy dependent on the international trade: import and excise duties as well as VAT on imports. Together taxes on the importation of goods in Tanzania accounted for 62% of the indirect tax in 2011/2012 (Sogema, 2013). Of all indirect taxes, VAT on imports is the levy that contributed the most to Tanzania's Treasury in 2011-12, with receipts of 1,082,918 million TZS. The domestic VAT accounts for a slightly smaller percentage of total revenues (15.1%). Altogether, VAT revenues (both domestic and on imports) stood at 2,062,000 in 2011-12, or 31.8% of total tax revenues in that year. Import and duties levied at Tanzania's borders amounted to 1,129,941 in 2011-12, or a little over 17% of total tax revenues. Adding the fuel levy to this amount brings the total of excise and duties levied on imports (excluding VAT) to 1,520,440, or 23.4% of total tax revenues. (**See table 15**).

<b>Table 15. Indirect Taxes: Revenues, Shares of the total tax and Average Annual Growth.</b>			
	<b>Revenues 2011/2012 TZS Millions</b>	<b>Share of Total Tax revenue 2011/2012</b>	<b>Average Annual growth 2001 to 2011/2012</b>
Excise (Domestic)	449,959	6.9%	19%
VAT (Domestic)	979,082	15.1%	19%
VAT (Domestic Goods)	383,816	5.9%	18%
VAT (Domestic services)	595,267	9.2%	22%

Imports duties	546,335	8.4%	19%
Excise duties	583,606	9.0%	24%
VAT on imports	1,082,918	16.7%	18%
Fuel levy	390,500	6.0%	25%
Others	164,734	2.5%	19%

**Source: Tanzania Revenue Authority, 2011/2012.**

Revenue Management in Tanzania assumes critical importance. Better revenue realization can go a long way in making Tanzania less aid dependent as well as make available more funds for development expenditure (MOFEA, 2013). The table below summarizes the main tax indicators.

**Table 16. Performance Indicator for Tax collection In Tanzania.**

No.	Performance Indicator	2009/2010	2010/2011	2011/2012	2012/2013
1.	Revenue as proportion of GDP	14.6%	15.2%	15.7%	16%
2.	Na of Registered Taxpayer -TIN registered	617,877	845,737	1,035,281	1,611,520
	-VAT registered	13,253	16,848	17,860	21,362
3.	Tax exemption as a proportion of total revenue collection	15%	19%	27%	-

**Source: MOFEA, 2013**

On this account, Tanzania has made significant progress in recent years. Between 2001 and 2011/12, revenue receipts grew eight times at a compound average growth rate of 21%; as a result the revenue yield in 2012-13 stood at 16% compared to 14.6% in 2009-10. At the same time the cost of revenue collection has declined from 3.8% in 2008-09 to 2.1% in 2012-13. The tax base has also increased by more than 150% for TIN-registered tax payers and 60% for VAT-registered tax payers between 2009-10 and 2012-13. However, tax exemptions continued to increase significantly. From 15% of total revenue collection in 2009-10, they increased to 27% in 2011-12 (MOFEA, 2013). The increase in exemption can be explained by many reasons according to Sogema (2013) are: (i) attract

foreign direct investments (ii) rises its income (iii) benefits transfer of technology (iv) also given as an incentives for investors (v) and Political will.

During the first half of the year 2014/15, total revenue collection was TZS 5,390.2 billion which is 86% of the estimate of TZS 6,261.4 billion. Tax revenue collections amounted to TZS 4,965.5 billion or 89% of the estimated TZS 5,591.8 billion. Non-tax revenue continued to perform significantly below the estimates during this period whereas the actual revenue collection from this category was TZS 275.1 billion against the estimates of TZS. 440.3 billion (MOFEA, 2014).

Government taxation though not sufficient offers sustainability in terms of mobilization as it ensures that government will have the funds to address the health challenges the country is facing (Chibuye, 2010). Payments to health care through general taxation (direct and indirect taxes) are progressive, implying that it is mainly the rich who incur a higher burden of this source of health care financing (Mtei *et al*, 2014).

Despite of all these tax collection by the government of Tanzania the share of the health budget in the total government budget still had remained below the 15% which is recommended by the Abuja declaration (MOHSW, 2012). Therefore government of Tanzania should now consider increasing the share of the health budget to reach 15% of the total government budget as a move to achieve universal health coverage in Tanzania.

## **CHAPTER 5. CHALLENGES FOR EXEMPTIONS AND WAIVER SYSTEM IN TANZANIA.**

### **5.1. Pro-Poor Policy in Tanzania.**

The vision of the National health policy of Tanzania is “to improve health and well-being of all Tanzanians with a focus on those most at risk and encourage the health system to be more responsive to the needs of the people” (NHP, 2007). This vision is further emphasized in the National Strategy for Growth and Reduction of Poverty (NSGRP) which states as one of its major goals an “improved quality of life and social well-being, with particular focus on the poorest and most vulnerable population groups and, reduced inequalities (e.g. education, survival, health) across geographic, income, age, gender and other groups.” (URT, 2005).

### **5.2. National Exemption Policy.**

The policy was launched with the aim of guaranteeing equal access to health services by exempting those groups in the society who have major difficulty in paying for health services (Mtei and Mulligan 2007. When the Tanzania government introduced the user fees policy in the early 1990’s the exemption was also introduced to protect the poor and most vulnerable from incurring catastrophic health expenditures (Rohregger, 2014). Examples of the targeted groups in this policy are pregnancy mothers, children under five, prisoners, elderly and above 60 years, patients with mental disorders, chronic diseases like TB/Leprosy, HIV/AIDS and other chronic illness that would drain a substantial income if such patients were asked to pay (Rohregger, 2014; Babbel, 2012; Mubyazi, 2004). Cancer may be exempted but the resources will not be sufficient to cover expenses of everyone. The services package includes all types of preventives and curatives care except for some special care like plastic surgery, glasses etc.

### **5.3. Waivers policy.**

Waivers are guaranteed to those patients who do not automatically qualify for statutory exemptions but are in need of the same and classified as unable to pay (Burns and Mantel, 2006; Rohregger, 2014; Mubyazi, 2004). The waivers policy gives a patient a temporary relief for those who prove to be very poor and unable to pay.

## **5.4. Implementations challenges for the exemptions and Waivers policy in Tanzania.**

The exemptions and waivers mechanisms meant to protect the poor and most vulnerable groups in Tanzania have remained ineffective and do not function as stipulated in the policy and are prone to misuse. The available literature shows that the policy in theory appears to sound well but in practice the policy does not function well (Mubyazi, 2004; Idd *et al*, 2013; Kamuzora and Gilson, 2007; Maluka, 2013). The poor do not receive the benefits that are intended for them while the rich receive the benefits that are intended for the poor. A study by Macha *et al* (2012) showed that about 43% of those qualified for exemption were paying. A household survey conducted by the SHIELD project estimated that 44% of those who were eligible for exemptions pay user fees for outpatient care and 70% pay inpatient care (Borghetti *et al*, 2011). Several challenges have been identified during the implementation of the exemptions and waivers policy as discussed below.

### **5.4.1. Targeting.**

Targeting is a welfare concept and strategy for identifying any group of person in a population that eligible for an intervention or assistance. This usually arises from the resources constraints or some distributive objectives that demand exclusion of some individuals from a program/intervention (Grosh, 1996).

According to this when the exemption and waiver policy was started there was no criteria set for targeting the poor and this has been regarded as the most ineffective for implementation of the policy in Tanzania. The policy lacks clear eligibility criteria for who is the poor as a results the health workers and community leaders implement the waiver system at their own style which renders the waiver highly arbitrary and non transparent (Rohregger, 2014; Mamdani and Bangser, 2004; Burns and Mantel, 2006).

In targeting two types of errors usually occur which are (i) error of exclusion: that means excluding those intended to benefits from program which is under coverage and (ii) error of inclusion: including those not intended to benefit from the program which is leakage. (**See table 16**).

<b>Table 17. Errors in targeting.</b>		
Person identified as Poor?	Person really poor?	
	<b>Yes</b>	<b>No</b>
<b>Yes</b>	Effective targeting	Inclusion of the non- poor "leakage"
<b>No</b>	Exclusion of the real poor "low coverage of the poor"	Effective targeting

**Source: Morestin et al, 2009.**

**Methods for targeting in Tanzania.**

The village council or its committee identifies eligible receivers of waivers. A list is then presented to the ward health committee for further scrutiny and once endorsed; the list is forwarded to the Council Health Services Board (CHSB), which issues a CHF membership card for those people to access health care services. However the criteria vary from district to district with no specific criteria (Maluka, 2013).

Similarly Witter (2005) in her study concluded that exemptions and waivers system are complex and difficult to understand, frequently do not reach the intended targeted groups hence it is difficult to implement patients with chronic illness are likely to become more poor.

Maluka (2013) in qualitative study on the exemption and waiver in Iramba and Lindi, Tanzania found that there was a confusion in the eligibility criteria for the elderly as the policy does not say which elderly are to be exempted. In his study he quoted two respondents as shown below.

*"The policy is blind and the government has been silent on this despite its importance. The government has just said elders above 60 years should be granted exemption" (In-depth interview (IDI) with CHMT in Lindi).*

**Source: Maluka, 2013.**

*"There is confusion. The policy says exemption should be granted to elders who are 60 years and above and are unable to pay. But the policy is interpreted differently. People think that all elders, regardless of their economic status, deserve free services. So, there are two things: policy and politics. To a large extent, politics seem to be stronger than the policy". (IDI with CHSB member in Iramba district).*

**Source: Maluka, 2013.**

Idd *et al* (2013) in his qualitative studies in Lindi showed that analysis with some respondents indicated that lack of clarification of the exemption eligibility criteria made policy implementers at different levels implement the policy in their own style. One of the respondents said that (**See the quote**).

*"Policy makers are giving us a hard time to define clearly who is poor. They say that the poor who are not able to pay memberships contribution should be exempted but is true that all who cannot pay CHF contributions are poor? The word poor is vague. Policy makers should clearly define who is poor and this will make it easier for us to implement this policy"(IDI with village Leader).*

**Source: Idd *et al*, 2013.**

The failure of the central government to define eligibility criteria for waivers, compounded with limited technical support, exacerbated problems and contributes to the variation in the implementation of the pro-poor exemption policy between districts. Likewise, poor dissemination of policies can lead to confusion and variations in what is implemented. Improving communication strategies to inform the policy implementers and the general population has been identified as one of the key points in the implementation of any policy (Idd *et al*, 2013).

In Zambia the criteria that were set up by the Ministry of Community Development and Social Services included both income and non income indicators. A person's economic status is categorized into one of three groups. It is not explicit whether the person has to meet all or some of the indicators within the groups. In this group 1 and 2 are considered to be poor but only group 1 is considered to be very poor and destitute while group 3 are those who can afford to pay for the health services (Tien and Chee 2002). (**See table 18**).



<b>Table 18. Criteria for wealth group in Zambia.</b>			
<b>No.</b>	<b>Group 1</b>	<b>Group 2</b>	<b>Group 3</b>
1.	Per capita wage income not exceeding K. 15,000	Per capita wage income not more than K. 40,000	In stable employment
2.	Chronic food insecurity	Depends on peasant agriculture	Has regular income
3.	No land or productive assets	Occasional food insecurity	Runs business enterprise
4.	Unsupported aged widow, disabled, too old, etc.	Has inadequate income	Has food security
5.	Orphaned children	Runs small family business	Owns valuable and productive Assets
6.	Illiterate and no skills	Depends on relatively stable help from kin	
7.	Depends on erratic help from neighbors, etc	Semi-illiterate	
<b>Source: Masiye et al, 2000.</b>			

Therefore from the above table we can conclude that criteria in other countries may be slightly better but they are not very sharp and leave room for leakage.

Similarly in Ghana, the beneficiaries of the waivers are identified by the in charge of the health facilities. The health facilities in charge are responsible for the identifying and screening for the waiver and their dependent (Garshong et al, 2001). This decision was found that when waiver is made consistency by the same person the implementation of the waiver policy was more effective.

In Kenya, the waiver system allows each local institution to set criteria it will apply in granting waivers and chief executive at the facility has the authority in granting them. Social workers from the mission hospitals serve as impartial intermediaries to assess who received waivers. They would visit the patient's home and village chief before granting a waiver. This centralization of authority within health facilities made certain that the guidelines were implemented fairly and consistently within communities (New brander et al, 2000).

#### **5.4.2. Reimbursement shortfalls.**

This is another challenge in implementing the National exemption and waiver policy in Tanzania. A key successfully exemption and waiver policy for the poor is a concurrent mechanism to pay for the revenues foregone when providing services to the poor at no charge (Tien and Chee, 2002). Health staff who rely on the revenue cannot be expected to grant waivers consistently and fairly unless there is funding to reimburse (Munishi, 2010). In Tanzania people who are exempted and waived are supposed to be paid through by the government through tax. This in really does not work because the government does not reimburse the amount due for the exempted and waived patients at the health facilities.

The failure of government through the Ministry of Health to compensate for the revenue while they are exempting and waiving patient had an implication on the delivery of the health services (Munishi, 2010). Some health workers were reluctant to offer more exemption and waiver, shortages of drugs and equipments which might results in poor services. Kamuzora and Gilson (2007) reported that other districts were not giving exemptions and waivers because of the fear of losing revenues as the government was not compensating for the revenues.

Munishi (2010) in his qualitative study in Mtwara and Bagamoyo reported that lack of reimbursement of user fee revenue lost through exemptions and waivers by the MOHSW was also one of the key elements in changing health care workers attitudes **(See the quote below)**. They argued that the government was not serious in supporting the policy which has been implemented since 1993.

*"Think of the staff who does grant exemptions and waivers and there is no reimbursement..... and they do not know anything about the system..... It is discouraging to continue providing the service."*

**Source: Munishi, 2010**

The failure of the government to compensate for the revenues could be explained by many reasons such as insufficient funds to compensate those revenues, withdrawal of donors, or not budgeting.

In Zambia the Health Care Cost Scheme which was set up to ensure that the poor have access to health care through fee waivers, does not consistently receive funds to cover this segment of the population. This funding failure is partly due to insufficient funding, and partly due to lack of clarity in funding procedures. The district health management teams (DHMT) were to provide the number of poor treated to the Social Welfare Offices, who would remit funding to the DHMTs. This procedure was rarely followed (Tien and Chee, 2002). At the same time, the Social Welfare Office was to issue certificates to the poor, and allocate funding to the DHMT based on the number of certificates issued which was not followed (Masiye *et al*, 2000).

Available literature shows that in Uganda the exemption policy failed due to lack of adequate financing such as central/local to subsidies the exemption. The scheme was developed without putting in place the required resources for implementation (Kivumbi and Kintu, 2002). In Kenya, health facility staff were reluctant to pass on information about waivers and believed the patient's relatives should assume the burden of fees because staff did not want to lose revenue (Bitran and Giedion, 2001). Evidence from Bitran and Giedion (2003) from their study in Cambodia, Thailand and Indonesia where exemptions and waivers is practiced showed that they work due to the reimbursements done by the governments.

#### **5.4.3. Lack of awareness.**

Lack of awareness is another implementation challenges in implementing the exemption and waiver policy in Tanzania. It has been stipulated that for an exemption and waiver to work in proper way awareness among the health workers and community is needed, as it will help them to work accordingly (Kapinga, 2012). Available evidence from literature shows that there is low awareness among the health workers and community making the matters worse on implementing the policy (Mubyazi, 2004; Stoermer *et al*, 2013). Many patients are not able to demand the exemption because they do not have enough information about the exemptions and waivers and who is eligible (Mamdani and Bangser, 2004).

Similarly Mubyazi (2004) reported that the low awareness level regarding entitlement to exemption on the beneficiary side and the lack of clear targeting criteria on the supply side is used as a loophole by health care providers for not implementing the exemption policy by simply ignoring it.

As a result, potential beneficiaries continue to pay user-fees directly or indirectly through under table payments in order to get services. Due to lack of awareness some poor people in Tanzania were discriminated and shown a lack of respect as reported by Mamdani & Bangser (2004) in their evaluation study on poor people's experience of health services in Tanzania.

Similarly awareness is needed by the patients to be able to demand their rights. Rohregger (2014) in a study done in Lindi, Tanzania showed that villagers, village executive officers and Ward executive officers were un aware on such policy that existed in the country. However there was an increase of the people claiming exemption and waivers after a Canadian organization conducted sensitization campaigns and encouraged people to apply for the exemptions and waivers. This demonstrates to us that raising awareness increases the people who might benefit. Possible ways to raise awareness are education and information sharing by health care workers, health care events such as AIDS day, media (television, radio), community initiatives, local meetings, facility governing committees, council health services boards, on the job training (Munishi, 2010). Maluka (2013) also reports in his studies showed that a financial incentive is one of the strategies to raise awareness.

#### **5.4.4. Shortages of resources.**

In implementing the exemptions and waiver system in Tanzania there are certain resources that have to be observed like drugs, medical equipments and other necessary equipments for implementing the schemes (Kapinga, 2012). While the government is spreading information of improving affordability and access to the healthcare through exemption and waivers, at the same time it is not providing enough resources to implement the policy accordingly. Frequent out of stocks drugs in the health facilities in Tanzania that may necessitate buying drugs from the private pharmacies may affect the implementation of the exemptions and waivers system (Yohana *et al*, 2011). Although government policy dictates that drugs are free to those with exemption and waiver status, the reality of the drug supply situation at health facilities forces many people to buy drugs from private pharmacies (Kapinga, 2012).

According to the observations and comments made by service users during the study done in Tanzania by SIKIKA (2013) what is waived or exempted in accessing health care is that service users are not asked to pay for the bed whenever they are hospitalized but they find themselves in a situation where they are forced to buy other services like medicine from private facilities. These medicines are normally prescribed to the patients but are not provided in the hospital. Some expectant mothers are forced to buy some delivery kit items such as cotton, gloves and gauze with only 40.4% of interviewed expectant mothers reporting to be able to afford health care services. Despite claims of free maternal health services, the reality is that many poor expectant mothers cannot access quality health care if they cannot afford to buy appropriate equipment for delivery.

This discrepancy between theory and practice by the government seems to be the source of allegations made by some of service users that some service providers use resources provided by the government for personal gains. As a result service providers have started to develop a negative attitude towards exemption and waiver because the government does not provide enough support and hence they are blamed by their customers for substandard care provision (SIKIKA 2013). One way to improve frequent stock out of drugs as reported by Maluka (2013) in his study in Iramba district is the effective supervision to the health facilities by CHMT in order to control irrational prescription of drugs by the health providers.

Denial of exemption is a common practice in the windows of the outpatients of the hospitals and dispensaries in Tanzania. People who come for the services who are supposed to be exempted are not told that they are exempted. Rohregger (2014) in his study in Lindi found that one of the exemption and waiver policy failures was resources constraints in the implementation as demonstrated by the two quotes below from the health facility officers.

*"We treat around 20 people per day of which 15 are exempted, mostly the Under fives. The income from user-fees is therefore very low, sometimes it is not more than TZS 50,000 in three months. (...).The second biggest group are the pregnant women, but they mostly do not come. For the elders, they pay, because we do not tell them that they are exempted. Otherwise we will earn even less."*

**Source: Rohregger, 2014.**

*"Poor people are not exempted. They do not get access to free services, even if they come with a letter. (...) We have a small budget and cannot provide free services to these people. We only have a small budget for 200-300 persons, which we reserve for people affected by chronically diseases. We do not provide treatment under any circumstances until the person pays. This is the official policy of the district".*

**Source: Rohregger, 2014.**

Therefore in any implementation of the policy without enough resources there will be failure of the policy. The presence of the resources facilitates easy implementation of the policy.

#### **5.4.5. Monitoring and Evaluation of the policy.**

Monitoring and evaluation is required in the implementation of any policy to determine whether it is moving in desired direction (Kapinga, 2012). The term "monitoring" is commonly used to describe the process of systematically collecting data to inform policymakers, managers and other stakeholders whether a new policy or program is being implemented in accordance with their expectations (Fretheim *et al*, 2009). In addition, Fretheim *et al*, 2009 concluded that periodic monitoring and evaluation is important for looking at what is being done periodically and quantifying what has been attained.

Information on the number of exemptions issued, categories and reasons for exemption, health facility information, area served, and background information on the patient contribute to a good evaluation system. Systems must be in place to record the volume of waivers and exemptions and their value (New brander *et al*, 2000). In his study Munishi (2010) found that there was no proper record keeping for who was granted exemption or waiver, no data base for the beneficiary of the exemption containing basic information such as age and sex to enable to compare the actual exemptions with the targets to be able to estimate the coverage and the leakage of the protection mechanism.

Monthly and quarterly supervision through Health Information Management System (HMIS) are means for monitoring exemptions and waivers at all health facilities. Munishi (2010) in his qualitative study in Mtwara and Bagamoyo reported that due to resource constraints monitoring and

evaluation was not done accordingly. One of the respondents at the policy level revealed that supervision is conducted when financial resources are available. (**see the quote**).

*"Sometime we take even a year without visiting the districts due to lack of financial resources". Respondent at MOHSW.*

**Source: Munishi, 2010.**

Therefore from this it is clear that lack of resources is one factor that could lead to policy failure.

A study of Zambia's exemption system found that 28% of individuals receiving exemptions did not meet the age or eligibility criteria (Diop *et al*, 1998). Further, the individuals wrongly given exemptions tended to be of higher income (Diop *et al*, 1998). Masiye and Odegaard (2000) study found that Zambia's health care cost scheme had limited impact on the poor and also produces substantial leakage of benefits. Thus, routine monitoring and evaluation is needed to identify problems or unintended outcomes, so modifications to design and implementation can be made to address the issues.

## **CHAPTER 6. CONCLUSION AND RECOMMENDATIONS.**

### **6.1. Conclusion.**

1. Based on this review and findings we have the evidence to believe that

- ❖ User fees and OOP are financial barriers for access to the health services for the poor and vulnerable groups.
- ❖ OOP payments for health are the major cause of catastrophic health expenditure which has an impact of impoverishment the family especially for the poor.

2. Based on the review and findings the major challenges for CHF are:

- ❖ The enrollments are far behind due to several reasons: (i) Poor quality services. (ii) Lack of information to the community (iii) High premiums (iv) High drop out in the year. (v) Poor staff's attitude. All of these facts points to a basic lack of trust from the side of the community.
- ❖ CHF design (i) Overburdening of the current staffs (ii) Limited benefits packages (iii) Lack of tool for data collections.
- ❖ CHF issues (i) No proper identity card for the members (ii) Insufficient feedback to the beneficiaries (iii) Weakness in the use of the CHF in the district.
- ❖ Contribution to the overall financing of the health financing is very low even after 10 years of performance.
- ❖ The CHF is highly regressive which means it's the poor who contribute relatively more.

3. Based on these we have the evidence that the NHIF have several challenges:

- ❖ Huge reserves of funds due to: (i) Many facilities do not claim due cumbersome procedures (ii) The long waiting time between claim and reimbursements (iii) Some facilities submit incorrectly filled forms which takes long time to correct it and discourage them to claim again(iv) The way the NHIF is functioning with a higher overhead and continuous under spending.
- ❖ Frequent out of stock of medicine in the health facilities.



3. Based on this the donor funds are the best source of funds. The major challenges with the donor funds are:

- ❖ The flows of the donor funds are unpredictable and tend to fluctuate.
- ❖ Delays in the disbursements and sometime even completely non disbursements due to several reasons including conditions.
- ❖ Large proportion of funds still flows outside the Government budgeting system and it is therefore difficult to integrate external finance within Government.
- ❖ Funds are not disbursed 100% as they were committed which affects the implementations of the various project in the health sector.

4. Based on this review the tax collections has shown a positive direction in the collection of funds which can be used to finance the health sector. The share of government expenditure for health as % of general government expenditure has remained fairly constant since the last 4 years.

5. Based on this we have evidence that exemption and waiver system in Tanzania does not function as stipulated. The challenges are:

- ❖ There is no clear mechanism for targeting for the poor as waiver system beneficiaries, leading to under coverage and leakages.
- ❖ Non-reimbursement by the government to the health facilities for the exempted and waived patients.
- ❖ Lack of awareness by both the community and health workers as result the policy is not implemented accordingly.
- ❖ Lack of the resources like drugs, equipments and other necessary equipments to implement the policy.
- ❖ Lack of clear monitoring and evaluation of the policy hence difficult to evaluate whether the policy is in the right directions or not.

## **6.2. Recommendations.**

### **6.2.1. General recommendations.**

Based on the above conclusions the following are the recommendations which can be drawn:

1. Strengthen the pre payments schemes in Tanzania as the move from OOP payment for health. This will prevent the family from the barrier of accessing

the health services and from incurring catastrophic health expenditure and impoverishments. The following can be done.

**(A) For CHF**

- ❖ Improve the quality of health services by making a constant availability of the drugs and other diagnostic equipments at the health facilities which can be achieved through effective supervision by the CHMT and buying buffer stocks.
- ❖ Conduct regular community sensitizations to increase enrollments into the CHF. This can be achieved in which village councils and ward development committee involve actively themselves in the sensitizations through various methods.
- ❖ Improve the morale of the health facility staff through paying some allowances, training, effective supervision by the CHMT. This will improve the enrollments at the health facilities.
- ❖ Employ a dedicated staff apart from the existing staff to improve the accountability and performance of the scheme and also improve the benefit package by including the district hospital.
- ❖ Build up the functioning insurance management information system for the routine analysis, member tracking, claim tracking. This will improve the monitoring and evaluation of the community health fund.
- ❖ Conduct quarterly community meeting so as to give feedbacks on the progress of the CHF and every members be given a portable identity card.
- ❖ Training on the financial management of the health facilities and the health facilities governing committee in order to improve the financial flow of CHF from the district.

**(B) For NHIF.**

- ❖ Simplify the NHIF claim procedures in order to avoid the cumbersome procedures that discourage to claim the reimbursements and build capacity of the health workers to submit claim in completely and timely manner.
- ❖ Harmonize the NHIF in order to cross subsidization with the CHF to reduce fragmentation since the NHIF is having a huge reserve. This will help the poor to enjoy the benefit packages and protect them from catastrophic health expenditures.
- ❖ Review the capacity and performance of the NHIF and start capacity building to the NHIF staff.

2. Harmonize with the donor to keep their commitments and release of the funds as per commitments and timely.
3. The government of Tanzania should increase the share of the government expenditure for health as % of general government expenditure to meet the Abuja commitment as the tax collection has shown positive trends.
4. In order for the exemption and waiver to work properly the MOHSW should put clear the targeting mechanism for the poor in order to avoid confusions for the implementers.
5. The MOHSW should introduce reliable reimbursement of revenue lost through exemptions and waivers in public facilities which will improve the attitude of health care providers in providing exemptions and waivers. This can be done through donors or NGO's to fund the reimbursements or using vouchers.
6. For the poor, exemption and waivers the government of Tanzania should consider to fund them using earmarked tax (Innovative financing) from cellular phone, tobacco etc in order to protect them.

**6.2.2. Plan of Action.** (See table 19 below).

<b>Table 19. Plan of action for the recommendations.</b>			
<b>No.</b>	<b>Recommendation</b>	<b>Priority time line for action.</b>	<b>Responsible person</b>
1.	To improve the quality of care by making a constant supply of medicine through effective supervision and buffer stocks	Short term	<b>MOHSW/DMO/Pharmacist</b>
2.	To conduct regular sensitization to increase enrollments to the CHF using the Village leaders, Media such as radio	Short term	<b>DMO/Village leaders/ CHF coordinators.</b>
3.	To motivate the health workers through paying allowance, effective supervision as a means to increase enrollments of the CHF and recognition.	Short term	<b>District Director/DMO/CHMT.</b>
4.	To employ a dedicated staff to manage the CHF	Short term	<b>District Director/DMO.</b>
5.	To improve the benefits package of the CHF by including the district hospital in case of referral.	Short term	<b>MOHSW/DMO.</b>
6.	To put a functioning insurance management information system for data collection on the CHF	Medium term	<b>MOHSW/DMO.</b>
7.	To conduct regular quarterly meeting with the community for the feedback on the progress of the CHF	Medium term	<b>DMO/CHF coordinator.</b>
8.	To make a single and portable identity card for each member in the CHF to make easy identification	Short term	<b>DMO/CHF coordinator.</b>
9.	To train the health facility staffs and facility governing committee to improve the financial management.	Medium term	<b>MOHSW/DMO.</b>
10.	Harmonize NHIF to cross subsidize with CHF	Medium term	<b>NHIF/CHF/MOHSW.</b>
11.	Review the capacity of NHIF and start capacity building for the staffs	Medium term	<b>MOHSW.</b>
12.	Build capacity to the health workers on the claim procedure and proper filling of the forms for claiming.	Short term	<b>DMO/NHIF.</b>
13.	The government of Tanzania should to increase the share of the public health fund to reach 15% of the Abuja commitment.	Medium term	<b>MOHSW/MOFEA</b>

14.	To review the guideline for criteria for targeting to avoid confusion on the identification of the poor	Medium term	<b>MOHSW</b>
15.	The MOHSW should put a clear monitoring and evaluation system of the exemption and waiver policy	Medium term	<b>MOHSW</b>
16.	The MOHSW should introduce reliable reimbursement of revenue lost through exemptions and waivers in public facilities.	Medium term	<b>MOHSW</b>
17.	The government of Tanzania should now consider to start financing the poor, exemption and waiver using earmarked tax (Innovative financing)	Medium term	<b>TRA/MOHSW/MOFEA</b>

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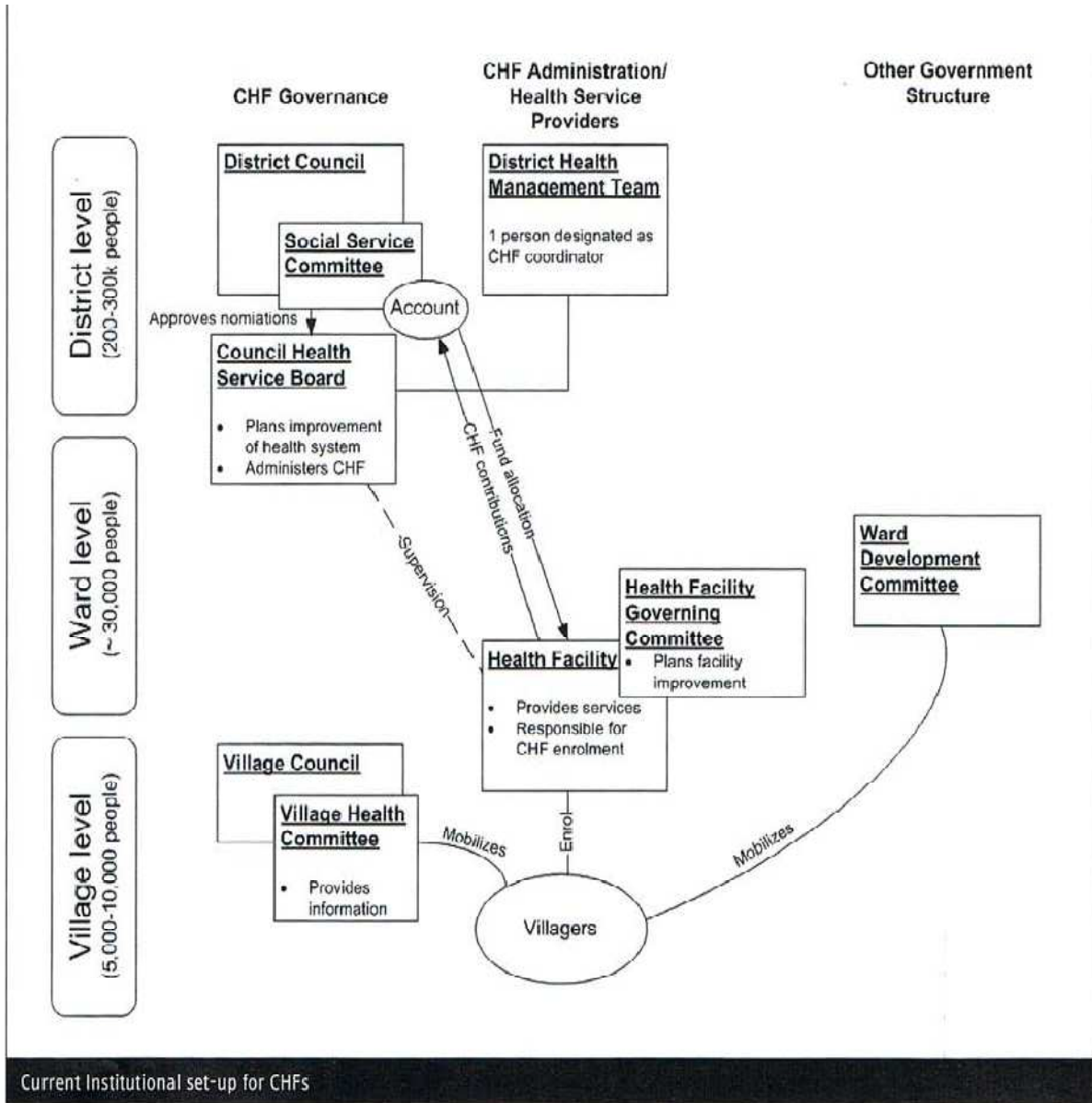


**Annex 1. Map of Tanzania.**



**Source: Burns and Mantel, 2006.**

**Annex 2. Institutional set up and their responsibilities for the community health fund in Tanzania.**



**Source: Stoermer et al, 2011.**

### **Annex 3. Preventive and curative services in CHF benefit packages.**

<b>No.</b>	<b>Description</b>	<b>Benefits offered</b>
1.	<b>Maternal services</b>	<ul style="list-style-type: none"> <li>❖ Pre delivery care</li> <li>❖ Delivery care</li> <li>❖ Post delivery care</li> <li>❖ Nutritional supplementary to pregnancy women and lactating women</li> </ul>
2.	<b>Well baby services</b>	<ul style="list-style-type: none"> <li>❖ Expanded program on Immunization</li> <li>❖ Micronutrient supplementation</li> </ul>
3.	<b>Curative care</b>	<ul style="list-style-type: none"> <li>❖ Basic trauma</li> <li>❖ Malaria.</li> <li>❖ Diarrhea</li> <li>❖ Opportunistic infection</li> <li>❖ Other local infection</li> </ul>
4.	<b>Limited chronic care</b>	<ul style="list-style-type: none"> <li>❖ Tuberculosis treatment</li> </ul>
5.	<b>Sexual transmitted diseases services</b>	<ul style="list-style-type: none"> <li>❖ Counseling and limited testing.</li> </ul>
6.	<b>Family planning</b>	<ul style="list-style-type: none"> <li>❖ Contraceptive</li> </ul>
7.	<b>Information, education and communication materials.</b>	<ul style="list-style-type: none"> <li>❖ Nutrition</li> <li>❖ Family planning</li> <li>❖ HIV/AIDS</li> </ul>

**Source: Shaw, 2002**

#### Annex 4. Benefits packages in National Health Insurance Fund.

No.	Description	Benefit package
1.	<b>Registration</b>	<ul style="list-style-type: none"> <li>❖ Cost of registration</li> <li>❖ Cost of consultation</li> </ul>
2.	<b>Outpatient care</b>	<ul style="list-style-type: none"> <li>❖ Medicine and consumables</li> <li>❖ Consultation</li> </ul>
3.	<b>Investigations</b>	<ul style="list-style-type: none"> <li>❖ Diagnostic test</li> <li>❖ Echo cardiograph</li> <li>❖ Computed Tomography</li> <li>❖ Magnetic Resonance Imaging</li> <li>❖ Ultrasound</li> </ul>
4.	<b>Surgical services</b>	<ul style="list-style-type: none"> <li>❖ Minor surgery</li> <li>❖ Major surgery</li> <li>❖ Specialized surgery</li> </ul>
5.	<b>Inpatient services</b>	<ul style="list-style-type: none"> <li>❖ Admissions</li> <li>❖ Medicines &amp; Consumables</li> <li>❖ Investigations</li> </ul>
6.	<b>Physiotherapy</b>	<ul style="list-style-type: none"> <li>❖ Outpatients &amp; Inpatients</li> </ul>
7.	<b>Optical services</b>	<ul style="list-style-type: none"> <li>❖ Treatment of eye diseases</li> <li>❖ Treatment of refraction errors</li> </ul>
8.	<b>Spectacles</b>	<ul style="list-style-type: none"> <li>❖ Corrective spectacles for 3 years.</li> </ul>
9.	<b>Dental services</b>	<ul style="list-style-type: none"> <li>❖ Dental fillings</li> <li>❖ Dental extractions</li> <li>❖ Root canal treatment</li> </ul>
10	<b>Medical/orthopedic appliances</b>	<ul style="list-style-type: none"> <li>❖ Neck, thoracic &amp; spine collars</li> <li>❖ Hearing aids</li> <li>❖ Walking clutches.</li> <li>❖ Leg Orthopedic support</li> </ul>

Source: NHIF, 2013.

## Annex 5. Some indicators in progress to Universal health coverage by 2014.

No.	Indicator	progress	Target/Benchmark	Progress relative to the target/benchmark
1.	Measles immunization	100.0%	100.0%	100.0%
2.	DPT-HB3 Immunization	95.0%	100.0%	95.0%
3.	Vit A coverage 2doses	60.0%	100.0%	60.0%
4.	TT2 Immunization coverage	88.0%	100%	88.0%
5.	ANC at least 4 visit	36.0%	100.0%	36.0%
6.	Delivery in health facilities	58.0%	100.0%	58.0%
7.	Skilled Birth attendants	62.0%	100.0%	62.0%
8.	Postnatal care	31.0%	100.0%	31.0%
9.	Contraceptive prevalence	27.0%	100.0%	27.0%
10.	ITN use children/pregnant	73.0%	100.0%	73.0%
11.	ART coverage	65.0%	100.0%	65.0%
12.	Doctors/Nurses /10,000	5.7	23	24.8%
13.	OPD visit per capita	0.8	4.0	20.0%
14.	Hospital per 100,000 people	0.5	1.0	53.0%
15.	Health centre/50,000 people	0.6	1.0	65.0%
16.	Dispensary /10,000	1.2	1.0	119.0%
17.	% of population within 6km to health facility	75.0%	100.0%	75.0%
	<b>Financial protection (Kakwani index)</b>	<b>Progress</b>	<b>Target bench mark</b>	
18.	OOP	-0.07	+	
19.	Direct tax	+0.41	+	
20.	Indirect tax	+0.14	+	
21.	NHIF (Formal sector)	+0.42	+	
22.	CHF (informal sector)	-0.49	+	

Source: Mtei *et al*, 2014.