

A WORLD BANK STUDY



Making Health Financing Work for Poor People in Tanzania



THE WORLD BANK

Dominic Haazen

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Abbreviations, Acronyms, and Currencies

BMI	Basic Medical Insurance
CAG	Comptroller and Auditor General
CFS	Consolidated Fund Services
CHF	Community Health Fund
CMS	Cooperative Medical Scheme
CSMBS	Civil Servants' Medical Benefit Scheme
CSSC	Christian Social Services Commission
DHS	Demographic and Health Survey
FBO	faith-based organization
FCFCU6	Free Care for Children under 6
FNG	National Guarantee Fund
FSD	District Solidarity Fund
FY	fiscal year
GBS	general budget support
GDP	gross domestic product
GNI	gross national income
HCFP	Health Care for the Poor
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HSS	health systems strengthening
HSSP	Health Sector Strategic Plan
IDRC	International Development and Research Centre
ILFS	Integrated Labour Force Survey
IMSS	Mexican Social Security Institute
ISSSTE	Social Security Institute for Government Workers
M&E	monitoring and evaluation
MA	Medical Assistance
MHI	medical health insurance
MHO	mutual health organization
MMAM	Primary Health Care Development Program (in Kiswahili)
MMI	military medical insurance
MoDLA	Ministry of Decentralization and Local Affairs
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NAO	National Audit Office
NBS	National Bureau of Statistics
NGOs	nongovernmental organizations
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NHSO	National Health Security Office
NRCMS	New Rural Cooperative Rural Medical Scheme

NSSF	National Social Security Fund
OOP	out-of-pocket
PBF	performance-based financing
PEPFAR	(U.S.) President’s Emergency Program for AIDS Relief
PHC	primary health care
PIN	personal identification number
PIT	personal income tax
PMI	(U.S.) President’s Malaria Initiative
PMO-RALG	Prime Minister’s Office, Regional Administration and Local Government
RAMA	Rwanda Health Insurance Company (Rwandaise d’ Assurance Maladie)
RC	contributory scheme (Régimen Contributivo)
RHMT	regional health management team
RS	subsidized scheme (Régimen Subsidiado)
SCHIP	Strategis Community Health Insurance Plan
SHI	Statutory Health Insurance
SHIB	Social Health Insurance Benefit
SHIELD	Strategies for Health Insurance for Equity in Less Developed Countries
SISBEN	Selection System of Beneficiaries for Social Programs
SP	Seguro Popular
SSF	Social Security Fund
SSRA	Social Security Regulatory Authority
SSS	Social Security Scheme
TB	tuberculosis
TC-SWAP	Technical Committee-Sector Wide Approach
THE	total health expenditure
TIKA	Tiba kwa Kadi, the urban form of the CHF
TPH	Tropical and Public Health (Swiss Institute for)
UC	universal coverage
UMASITA	Tanzania Informal Sector Community Health Fund
USAID	U.S. Agency for International Development
VAT	value added tax
VHI	Voluntary Health Insurance
VIBINDO	umbrella organization of informal sector operators in Dar es Salaam region
VSS	Vietnam Social Security Agency
WHO	World Health Organization
Currencies	
B	Thai baht
T Sh	Tanzania shilling
US\$	U.S. dollar

Executive Summary

This policy note is designed to support the development of the health financing strategy in Tanzania. It is directed at decision makers in the areas of health and social policy as well as the Ministry of Finance, which will play a crucial role in integrating the financial implications of this note into the overall fiscal situation in Tanzania. It is also hoped that this note will stimulate debate among interested stakeholders on the best funding modalities for health and the most appropriate ways to integrate those modalities. On the basis of the data and options described in this policy note, the World Bank will work with authorities and other interested stakeholders to develop a financing program to support the needed reforms in these sectors.

The health financing system in Tanzania is highly fragmented, with many financiers and modes of financing. Out-of-pocket payments account for about half of total health spending, with an increasing portion of that total being channeled through various public and private prepayment schemes. Table 1 provides an overview of current health financing approaches. Public financing includes a large proportion of external financing, with a significant part of that being off-budget. This fragmentation results in substantial inefficiencies in the use of resources and often-conflicting incentives for the various actors in the health system. Given the limited funding that is available, it is clear that a rationalization of these various modes of financing must take place to ensure improved access to services, improved quality, and ongoing sustainability. Moreover, the existing public financing mechanisms must be reviewed to ensure that they promote access to services for the poor and vulnerable.

Table 1: Summary of Current Health Financing Approaches in Tanzania

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	NHIF	NSSF-SHIB	CHF/TIKA	TIKA	CHF
Coverage (number)	2.0 million	51,300	1.7 million		
Coverage (% of population)	4.6%	9.2%	3.9%		
Source of revenue	6% payroll contributions, half employer, half employee	Part of 20% NSSF contribution through payroll; SHIB not differentiated	Councils pay premium for poor	Individual contribution of T Sh 5–15,000 matching grant from Health Basket Fund	
Revenue collection method	Payroll deduction and submission to NHIF	Payroll deduction and submission to NSSF	Collected at health facility level, remitted to district		
Number of risk pools	One	One	One per district, but funds held at facility level so they are effectively the risk pool		
Payment methods	Fee-for-service	Capitation, some fee-for-service	Essentially capitation, as there is no payment for services; facilities use CHF revenue to support service delivery		
Benefit package	Full range of services	Broad range of services	Mostly public primary health care and some hospital services, within district		

(Table continues on next page)

Table 1: Continued

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Facility coverage	Extensive network of over 5,500 health facilities	Smaller network of 264 facilities			
Regulatory oversight	Separate Board of Directors	Social Security Regulatory Authority	MoH and NHIF		
Other financing methods	Government and nonprofit facilities available upon payment of user fees (some exemptions); however, problematic availability of drugs and medical supplies				
Other insurance schemes	Private insurance purchased by employees	Private insurance, including purchased by employers	Not applicable	Urban-based micro-insurance schemes	Rural and FBO micro-insurance schemes

Source: Author.

Notes: CHF = Community Health Fund; FBO = faith-based organization; MoH = Ministry of Health; NHIF = National Health Insurance Fund; NSSF = National Social Security Fund; SHIB = Social Health Insurance Benefit; TIKA = Tiba kwa Kadi, the urban form of the CHF.

Because the various parts of the system are closely connected, a comprehensive and sustainable health financing strategy must address each part of the system. Specific attention must be focused (a) on the regulatory system for both insurers and providers and (b) on specific strategies to attract and enroll the poorest in prepayment schemes. The analysis of the approaches in different countries suggests a number of recurring and reinforcing themes:

- Special efforts are required to reach the poor because they cannot afford services and often cannot afford prepaid health insurance.
- Such special efforts to serve the poor and other members of the informal sector require incremental subsidies.
- Such incremental subsidies can increase public spending by as much as 1.0 to 1.8 percent more than existing levels expressed as a share of gross domestic product (GDP), although this increase can be largely offset by reductions in out-of-pocket payments.
- Capped, capitation, case-based, or a combination approaches are essential for cost control, and fee-for-service should be avoided if at all possible.
- If one is to maintain a sustainable system, it is critical to match benefits to revenue, even if this approach means starting with a small benefit package or different packages for different groups.
- The fiscal transfers required and the redistributive effects of major health financing reforms make political leadership essential, as shown in the Thailand and Ghana examples.
- The need for cost controls makes a strong regulator essential for reform, as shown in the Thailand and Rwanda examples.
- Although small risk pools can enhance community ownership, the Ghana and Rwanda examples show that those pools can also create sustainability problems

and administrative capacity issues, unless explicit cross-subsidization or reinsurance mechanisms or support systems such as consolidated revenue collection or claims management are put in place.

It is clear that health reforms require trade-offs that must be acceptable to the majority of the population. For example, the goal of enrolling 45 percent of the population by 2015 must confront the costs of identifying, registering, and serving the informal sector and the poor. Increasing the enrollment in such groups will require raising the awareness and understanding of the concept of risk pooling and insurance generally, as well as building trust in the institutions that offer insurance so that those who sign up are confident that the benefits offered will be received when needed. It is also likely that a broader range of benefits will need to be offered, especially low-use and high-cost services such as inpatient care, because the attractiveness of the Community Health Fund (CHF) benefit package is limited by the relatively low cost of primary care.

A number of areas have been identified that should be pursued and could be included in the Health Financing Strategy. They are organized here along the lines of the health financing functions:

Service Provision

- Reduce existing inefficiencies and inequities in the health system.
- Recognize the need to review the management and governance structures of health facilities.
- Supply the improved mechanisms that are needed for the allocation of drugs and medical supplies to facilities.

Purchasing

- Evaluate how alternatives to fee-for-service could be implemented within the National Health Insurance Fund (NHIF), as well as other insurers, and then develop action plans for shifting to an alternative approach over time.
- Decide whether to use per diem or case-based reimbursement for inpatient hospital services, and develop an appropriate action plan.

Risk Pooling

- Change the NHIF to a scheme financed only by subscribers, thereby redirecting the government contribution toward improving social health protection for the poor.
- Work with the NHIF to use T Sh 250 billion of the estimated T Sh 300 billion in accumulated NHIF reserves to help strengthen the health system.
- Remove the Social Health Insurance Benefit (SHIB) from the National Social Security Fund (NSSF), and provide coverage through the NHIF with a total premium of 2.5 percent paid by employees.
- Have CHFs focus on community mobilization and revenue raising, and have the NHIF use its comparative advantage to act as the claims processor, card issuer, and funds manager.
- Establish uniform CHF rates at T Sh 30,000 for urban and T Sh 15,000 for rural.

- Set matching funds at 100 percent for urban and 150 percent for rural to recognize the higher poverty rates in rural areas, and use savings from the NHIF changes to provide the matching funds and to increase coverage for the poor.

Revenue Generation

- Recognize the need for flexible payment approaches for membership in the CHF and TIKA (Tiba kwa Kadi, the urban form of the CHF) to reflect the irregular income patterns of informal sector workers and subsistence farmers.
- Leverage existing budget resources to promote access to services, thus financing outputs rather than inputs.
- Look at other sources of sustainable financing for the health sector, such as an earmarked portion of value added tax (VAT) revenue.
- Examine the future role of user fees, and determine appropriate approaches for identifying the poor for the purposes of exemptions, waivers, or premium subsidies.

The Regulatory Framework and the Political Environment

- Put in place a comprehensive regulatory framework to govern the overall health financing system.
- Garner the appropriate political commitment for the Health Financing Strategy.

To assess the financial and economic effects of reform options, simulations were run using a model developed by the Ifakara Health Institute for the Strategies for Health Insurance for Equity in Less Developed Countries (SHIELD) project. The following options were simulated:

- A status quo option used no major changes in the parameters of health financing and no significant initiatives to encourage enrollment in prepaid health insurance schemes. This option involves current health systems strengthening (HSS) efforts, including investments in the development of health human resources, monitoring and evaluation (M&E), and infrastructure.
- A 45 percent target option (Option 1) simulated the effect of reaching the stated objective of covering 45 percent of the population with prepaid health insurance by 2015. The option includes various changes to the NHIF, SHIB, and CHF/TIKA coverage and premium levels, as well as utilization changes for CHF/TIKA and NHIF members to reflect a changing benefit package and a higher number of accredited facilities. HSS efforts are intensified to keep pace with increasing service demand.
- A universal coverage option (Option 2) used the same basic parameters as Option 1 but assumed (a) that the entire informal sector be covered through either the CHF (rural) or TIKa (urban) scheme and (b) that 77 percent of the private formal sector be covered through either private insurance or the NHIF. HSS investments are also scaled up in this option.

The simulations show that the extension of prepaid health insurance coverage to a larger segment of the population should not cause significant increases in either the percentage of GDP spent on health services or the proportion of the total government

budget devoted to such services, as long as robust economic growth continues. A lower growth assumption results in health expenditures as a percentage of GDP increasing from 4.5 percent to 5.0 percent in the universal coverage option and increasing as a percentage of the government budget from 9 percent to 13 percent, still well below the Abuja target. It would take a substantial slowing in economic growth (to 4 percent annually throughout the projection period) to push health expenditures to 6 percent of GDP and 15 percent of government expenditures.

Even in the absence of any reforms, there will be a significantly increased demand for health services as a result of population growth, with about 53 percent more services projected by 2025 than are currently being provided. This forecast underscores the need for continued attention to health system strengthening, especially in terms of health human resources. It also highlights the fact that efficiently using the human and financial resources that are already available will become increasingly important. The simulation results indicate that efficiency improvements can help to mitigate the cost implications of scaling up prepaid health insurance coverage.

Given the strong commitment of a number of development partners to improving social health protection, it should be possible to generate interest in helping to finance the transition and perhaps other costs associated with this expansion of coverage. Of course, a credible, sustainable action plan and detailed costing will be needed to garner such support, not just from development partners, but also from the government, which will likely bear the greatest proportion of any cost increases. The health financing strategy and the accompanying action plan should provide the basis for these types of discussions.

This policy note provides background information, cross-country examples, and policy options, which can all be incorporated into the development of a comprehensive health financing strategy. It also provides a framework for looking at the various elements of the health financing system, and it explores the financial, economic, and health system implications of a number of the options.

A key aspect in moving forward is to determine the acceptability of the options from a political economy perspective, as well as to consider in depth their feasibility and expected costs. This effort should assist in finalizing the health financing strategy and should lead to the identification of specific policy actions and reforms that will be needed to set into operation the strategy and its various components. Given the nature of such policy actions and the reforms they would support, it may be possible to consider them for inclusion in future development policy operations, either at the general budget support (GBS) level or as a separate sectoral development policy operation. Drawing on this analysis, specific support could be targeted to assist with the transition costs to universal coverage, notably in the following areas:

- Set in place an appropriate regulatory framework to monitor and provide oversight to prepaid health insurance operations (both public and private), bearing in mind the evolving role of the Social Security Regulatory Authority (SSRA).
- Address the role and future of the SHIB, which should be consistent with the pension reforms that are also being pursued.
- Make substantive changes to the financing framework for the NHIF, along the lines described in this note.

- Focus on the organizational and operational changes required for the CHF/TIKA to enable them to play the role envisioned in this policy note.
- Address the need for increased efficiency and provider autonomy.

Health financing reform of any significance will create major changes in the way in which the health sector operates. Those changes make it important to fully discuss with all relevant stakeholders the overall vision for health financing, its effect on the health sector, and the specifics of any proposed changes before proceeding. The experience of other countries, most notably Kenya, shows that such reforms can be doomed to failure if proposed changes are not fully explained and discussed. It is recommended, therefore, that consultation and advisory mechanisms be put in place immediately to facilitate this essential dialogue. The explicit signaling of high-level support for health financing reform is also a critical next step in the process.

Introduction

The vision of health policy in Tanzania is to improve the health and well-being of all Tanzanians, especially those at risk, and to enable the health system to be more responsive to the needs of the people. To achieve this vision, the health sector seeks to facilitate the provision of equitable, quality, and affordable basic services that are gender sensitive and sustainable and that are aimed at achieving improved health status. Tanzania's latest Health Sector Strategic Plan (HSSP III, 2009–15) focuses on the need for effective partnerships—with public and private health facilities, development partners, and other stakeholders—to contribute to the achievement of the Millennium Development Goals.

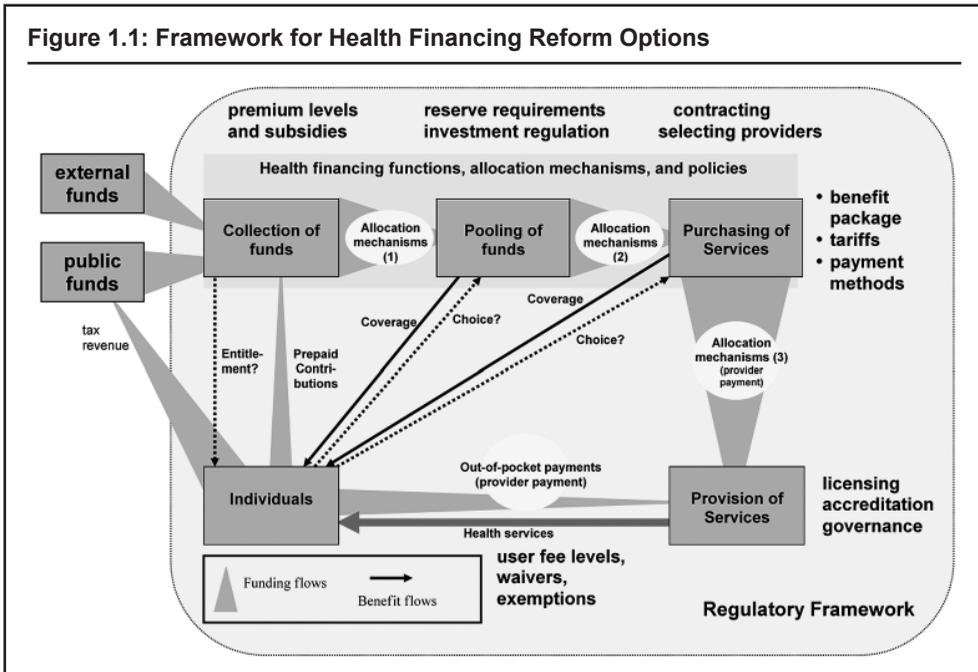
An emerging goal of a national health financing system is to provide universal coverage and social health protection. The objective is to improve access to services by removing barriers to care—especially for poor people and those in rural and remote areas—and to ensure that sufficient resources exist to enable health care providers to deliver a basic package of high-quality health care services. A key component of this effort is measuring and shaping the performance of this system. An important prerequisite for this is a comprehensive health financing strategy, which will help Tanzania (a) analyze the adequacy, organization, distribution, and effects of its health investments on its overall health goals; (b) plot a path for sustainable health financing into the future; and (c) guide future mobilization, allocation, pooling, and use of resources.

This note is designed to serve as a key input to the development of this financing strategy by highlighting the key parameters and issues in the health financing system and suggesting options that might be pursued during the implementation of the strategy. It is directed at decision makers in the areas of health and social policy and at the Ministry of Finance, who will play a crucial role in integrating the financial implications of this note into the overall fiscal situation in Tanzania. It is also hoped that this note will stimulate debate among interested stakeholders on the best funding modalities for health and the most appropriate ways of integrating these modalities.

Reform options must address key aspects of revenue generation and expenditure management, as well as provider organization and service delivery arrangements. Such options also need to take into account the critical issues of service quality (and the mechanisms for ensuring it) and regulation of the system (including both insurers and providers).

Figure 1.1 provides a framework for looking at health financing reform options. It shows the interrelationship of the revenue collection, pooling, purchasing, and provision functions within the overall health system. The system itself operates within a regulatory framework (the shaded blue area), the most salient features of which are shown next to the applicable functions.

Because the various parts of the system are closely connected, a comprehensive and sustainable health financing strategy must address each part of the system. This framework can be applied to any type of system, from a totally tax-based system to fully premium-based social health insurance, although in the former model, the central government is essentially responsible for revenue collection, pooling, and purchasing and may provide services as well.



Source: Adapted from Kutzin 2000.

HSSP III expresses the view that implementation of cost-sharing and prepayment schemes has a great potential for raising additional revenues for the health sector and providing flexible funding to health facilities. The government of Tanzania prefers to improve health insurance schemes rather than increase out-of-pocket expenditure by patients, and it would like to increase social health insurance coverage to eventually reach universal coverage. To this end, the government has set a target of enrolling 45 percent of the population in prepayment schemes by 2015.

However, to do this, policy makers must put regulatory and financing mechanisms and specific strategies in place to attract and enroll the poorest in prepayment schemes. Such strategies will need to be carefully developed, and the potential financial effects must be closely studied. Effective regulatory mechanisms to guide and supervise health insurance schemes must also be established.

On the expenditure side, sustainable approaches must promote the use of funds received by health care facilities to ensure that facility managers—with increased community input—are able to make the decisions necessary to allow them to provide high-quality services. In practical terms, all resources a facility receives should be free of specific conditions or encumbrances, and a common budgeting and approval process

should be established. Moreover, to the extent possible, health facilities should be able to retain and use the revenue that they generate from prepayment schemes and user fees.

The structure of the note is as follows. Chapter 2 describes the socioeconomic context in Tanzania. Chapter 3 provides a diagnosis and evaluation of the current health financing system, focusing on the overall health financing situation, the trends in health financing, and the contribution of the major financiers within the system. It also includes a specific examination of the various prepayment schemes that currently exist. Chapter 4 describes the efforts of other countries in reforming their health financing systems to provide examples of what can be done given proper planning and political will. Finally, chapter 5 discusses a number of potential reform options and assesses the financial and health system effects of each option, as well as the implications of each option relative to the framework described in this chapter.

Socioeconomic Context

The Tanzanian Economy and Poverty Reduction¹

Tanzania experienced economic growth of between 5 and 7 percent per year during the period from 2000 to 2008, until the global financial crisis hit the economy in 2009 (table 2.1). Sustained economic reforms and macroeconomic stability, coupled with a favorable external environment, contributed to this growth. Although the government had carried out an expansionary fiscal policy since 2000 with a fast rise in government expenditures, the fiscal environment was overall on a prudent track, sustained by strong growth in tax revenues, large debt relief, and significant growth in foreign aid. Inflation was initially kept in check but accelerated starting in 2005, and it reached double digits in 2008, driven by adverse regional food supply shocks and challenges in managing large liquidity coming from public and private capital flows.

The real effective exchange rate converged to a more competitive level after being overvalued at the beginning of the decade but it has started to appreciate again in real terms, mainly because of higher domestic inflation. The current account balance has deteriorated since 2006, driven by high imports (high imported oil prices and capital import growth). It is now no longer fully covered by foreign aid and, therefore, is more dependent on foreign direct investment flows.

Table 2.1: Key Economic Indicators

	Actual			Estimated			Projected		
	2005	2006	2007	2008	2009	2010	2011	2012	2013
GDP (US\$ million, current prices)	14,251	14,797	17,305	19,017	21,628	23,724	25,738	27,980	30,586
GNI per capita (US\$, Atlas method)	378	383	387	442	460	475	490	510	550
GDP growth (%)	7.4	6.7	7.1	7.4	6.0	6.0	6.0	6.0	7.4
Annual inflation (% CPI, end of year)	5.0	7.2	7.0	10.2	11.9	9.9	9.0	8.5	7.5
Current account deficit (% of GDP)	6.8	8.8	7.8	12.5	10.6	9.1	9.3	10.0	10.3
Exchange rate (T Sh/US\$)	1,165	1,261	1,132	1,280	1,320	1,440	n.a.	n.a.	n.a.

(Table continues on next page)

Table 2.1: Continued

	Actual			Estimated			Projected		
	FY05/ 06	FY06/ 07	FY07/ 08	FY08/ 09	FY09/ 10	FY10/ 11	FY11/ 12	FY12/ 13	FY13/ 14
Domestic revenue to GDP	12.4	14.1	15.9	16.2	15.4	16.1	16.3	16.5	16.7
Overall budget balance to GDP (after grants)	-4.8	-4.9	0.0	-4.5	-6.4	-6.5	-6.0	-5.2	-4.1
Domestic borrowing to GDP	1.5	1.2	-1.5	1.0	1.8	1.0	1.0	1.0	1.0

Source: World Bank 2011a, 7, 58, 59.

Notes: n.a. = not applicable; FY = fiscal year; GNI = gross national income.

The global financial and economic crisis has led to a growth slowdown in Tanzania. Real GDP growth in 2009 was estimated to have dropped to about 6 percent from 7.4 percent in 2008. The crisis has affected Tanzania through the export channel (mainly tourism, cash crops, and regional manufacturing exports) and through lower capital flows (foreign assistance and private investment flows).

Manufacturing, wholesale and retail trade, transport, communication services, and construction are the most affected sectors. The decline of international commodity prices and the reduction of food shortages in the subregion have yet to result in lower inflationary pressures. Inflation has been mainly driven by food prices and reflects the impact of the drought in parts of northern Tanzania and neighboring countries.

Despite the solid growth record, findings from 2009 analysis of the *Household Budget Survey 2007* by the National Bureau of Statistics (NBS) show a mixed picture of the country's progress in poverty reduction over the past eight years (NBS 2009). Lower relative prices from imported goods and increased government spending led to tangible improvements in some areas, including ownership of consumer durables, housing quality, and some social indicators, (such as mortality of children under five years of age and enrollment in primary education). Nevertheless, progress was rather limited in terms of basic needs income poverty, ownership of productive assets in rural areas, and some other social indicators (such as maternal mortality and access to safe water).

Between 2001 and 2007, the incidence of income poverty fell slightly in mainland Tanzania, as did the depth and intensity of poverty. However, the size of those decreases is small. Per capita consumption measured through the Household Budget Survey increased by only 5 percent in real terms between 2000–01 and 2007. With such a small change in consumption, the poverty head-count ratio dropped only slightly, from 35.6 in 2001 to 33.6 in 2007. Because the head count fell by only a little while the population continued to grow rapidly, the absolute number of poor people increased by 1.3 million in the period. In rural areas, the change in poverty was not statistically significant. Even though relative inequality remained more or less unchanged, consumption declined for a small fraction of households at the very bottom of the income distribution. There was also a marked urban-rural gradient in poverty incidence, with the poverty headcount ratio in Dar es Salaam calculated at 16.4, compared with 24.1 in other urban areas and 37.6 in rural parts of Tanzania.

Population Dynamics and Demographic Changes

Changes in population numbers and demographics are important because they indicate the changing requirements for various types of services and infrastructure, even if there is little or no change in living standards. With a population of approximately 43 million in 2010, Tanzania is the seventh most populous country in Africa. At 2.9 percent, the annual population growth rate is high, and it is projected to remain high into the foreseeable future, dropping to only 2.73 percent by 2025. According to the National Bureau of Statistics Population Projection, this relatively stable growth rate is the result of a significant decline in the total fertility rate, from 5.1 to 3.4, as well as a reduction in the crude death rate, from 13.3 to 9.7. The expected decline in the infant and under-five mortality rates contribute to the overall decline in the death rate.

Despite the expected decline in the total fertility rate, the significant (almost 50 percent) increase in the number of women of childbearing age means that the total number of babies born each year will remain more or less constant over the projection period. As a result of those dynamics, Tanzania's population is projected to almost double from 33.7 million in 2000 to 65.3 million by 2025. This projection is important for policy making and planning for future health financing options, because the size and structure of the population has an effect on what might be feasible. Table 2.2 shows the historical and potential future characteristics of the population.

Table 2.2: Population and Demographic Indicators and Projections

	Historical		NBS Projection			
	1980	2000	2010	2015	2020	2025
Total population (million)	18.67	33.71	43.19	49.86	57.10	65.34
Women (aged 15 to 49)	4.15	7.74	10.37	11.82	13.44	15.45
Percent	22.2	23.0	24.0	23.7	23.5	23.6
Children (aged 0 to 14)	8.78	15.48	19.17	22.23	25.27	28.18
Percent	47.0	45.9	44.4	44.6	44.3	43.1
Working age population (aged 15 to 59)	8.83	16.77	22.02	25.43	29.31	34.18
Percent	47.3	49.7	51.0	51.0	51.3	52.3
Older population (aged 60 or more)	1.06	1.46	2.00	2.20	2.52	2.97
Percent	5.7	4.3	4.6	4.4	4.4	4.5
Dependency ratios (%)						
Young	0.99	0.92	0.87	0.87	0.86	0.82
Elderly	0.12	0.09	0.09	0.09	0.09	0.09
Total	1.11	1.01	0.96	0.96	0.95	0.91
Population growth rate	3.03	3.00	2.51	2.92	2.75	2.73
Number of births (thousands)	896.1	1,396.0	1,678.3	1,704.8	1,697.9	1,660.2
Number of deaths (thousands)	360.6	555.9	573.2	589.1	621.7	636.7
Crude birth rate (per 1,000 population)	48.01	41.41	38.86	34.19	29.73	25.41
Crude death rate (per 1,000 population)	19.32	16.49	13.27	11.81	10.89	9.74
Total fertility rate (births per woman)	6.84	5.74	5.10	4.50	3.90	3.40
Infant mortality rate (per 1,000 births)	128.6	82.2	80.5	72.2	64.7	56.8
Life expectancy (years)	47.3	46.3	55.0	57.0	58.0	61.0

Sources: Historical data are from the U.S. Census Bureau International Database (1960 population is 10.26 million); projections are from the Tanzania National Bureau of Statistics.

The impact of population growth on the need for infrastructure and staffing will be considerable because by 2025, health services will need to be delivered to more than half again as many people as in 2010. As will be shown, the system is already having difficulty coping with the current service needs, so gearing up for such a large increase in just 15 years will be a significant challenge. It is worth noting that the relatively stable number of births projected from the NBS model means that maternity and obstetrical care will need to focus on ensuring that services are available for current levels of delivery and that those services are, in fact used.

Other factors are also important when evaluating health financing reform options. Dependency ratios are particularly important, because they reflect the ability of the workforce to cover the costs of those who are not economically active. Overall, there will be a slight decline in the dependency ratio, mostly as a result of a reduction in the percentage of young people in the overall population, as those currently under 15 years of age enter the workforce. Changes in household size are also important. Overall household size dropped from 5.7 in 1991/92 to 4.9 in 2001/02 and 4.8 in 2007. At an average of 5.1 adult equivalents in 2007, household size in rural areas is considerably higher than in urban areas; the decline in size in those areas has not been as great (the average size in 1991/92 was 5.9). In contrast, there has been a continuing drop in household size in Dar es Salaam, from 4.6 in 1991/92 to 4.3 in 2000/01 and 3.7 in 2007. The change in household size in other urban areas has not been quite as dramatic, going from 4.9 in 1991/92 to 4.4 in 2007. The proportion of female-headed households also increased considerably, from 18 percent in 1991/92 to 23 percent in 2000/01 and 25 percent in 2007. Note that these figures are taken from the 2007 Household Budget Survey and are expressed in terms of "adult equivalents," not just the number of family members.

Another important element is the extent to which jobs will be available for these new workers. According to the Integrated Labour Force Survey (ILFS 2006), labor force participation rates for women and men are high (88.8 percent and 90.5 percent, respectively) even though there is a high degree of informality in the workforce and a substantial proportion of the total workforce is engaged in agriculture. In 2006, 40 percent of all households engaged in informal sector activities, with the proportion reaching 57 percent in Dar es Salaam and 54–55 percent in urban areas (NBS 2007: 43). The proportion in rural areas was 33 percent. Between 2001 and 2006, the level of informal activities decreased in urban areas but increased in rural areas, growing overall from 35 to 40 percent. The overall number of households estimated to engage in informal sector activities grew by 65 percent, from 2.0 million to 3.3 million households.

About three-quarters of all employed individuals work informally in agriculture and fisheries, with this proportion increasing to almost 80 percent for women and decreasing to 70 percent for men. Naturally, the proportion in rural areas is much higher than in the cities: 88 percent versus 13 percent in Dar es Salaam and 43 percent in other urban areas (ILFS 2006, 26). An important consideration for any health financing option is the fact that the incomes of those engaged in agriculture are considerably lower than incomes in other occupations. For example, paid employees in agriculture, hunting, and forestry have a mean monthly income of just T Sh 39,731 (T Sh 44,896 for men, T Sh 25,009 for women), while self-employed individuals in the same sector have a slightly better mean income of T Sh 56,186 (T Sh 67,457 for men, T Sh 43,896 for women), although they may also receive additional income in kind. Median incomes are even lower, at T Sh 14,000

for paid employees and T Sh 20,000 for self-employed workers (ILFS 2006, 82, 85). Such low levels of cash income for such a large proportion of the workforce severely constrain the potential options for health financing, especially in terms of revenue generation.

Table 2.3 highlights relevant labor force composition and income figures. It does not differentiate between the formal and informal sector, which is important because the formal sector has a higher likelihood of securing regular wage increases. For example, the imputed average wage of formal public sector workers was about T Sh 182,000 per month in 2006, based on NHIF premium revenue and enrollment data, which is consistent with the figures in table 2.3. This figure had increased to T Sh 312,000 by 2009. Also, the recently released Tanzania Pension Policy Note shows an imputed average monthly wage for formal private sector workers of more than T Sh 300,000 in 2009, implying significant wage growth in the formal sector as well.²

It is not known whether informal sector wages—especially for those working in the agriculture sector—have grown to the same extent, but with the volatility in many commodity prices this is unlikely and further disparities between formal/informal and urban/rural incomes can be expected when updated information becomes available. The table also shows quite a high labor force participation rate (85–90 percent), variable employment ratios (highest for rural areas, lower for other urban areas, and lowest in Dar es Salaam—owing to higher unemployment and lower female participation), and informal sector participation levels that are much higher in Dar es Salaam and other urban areas, and lower in rural areas.

Table 2.3: Employed Population Characteristics

	Currently Employed Population by Area (%)				Mean Monthly Income	
	Dar es Salaam	Other Urban	Rural	Total	Paid	Self- employed
Agriculture, hunting, forestry	13.6	43.6	88.7	75.3	39,173	56,186
Fishing	0.8	1.0	0.3	1.2	52,539	94,861
Subtotal agriculture and fishing	14.4	44.6	89.0	76.5	39,383	56,793
Mining and quarrying	0.3	0.9	0.4	0.5	70,609	108,492
Manufacture	7.7	6.3	1.3	2.6	87,085	62,700
Electricity, gas and water	0.6	0.3	0.0	0.1	284,592	61,826
Construction	4.0	2.5	0.5	1.1	78,925	99,858
Subtotal industry	12.6	10.0	2.2	4.3	87,675	77,510
Wholesale and retail trade	29.0	19.6	2.8	7.6	73,806	98,682
Hotel and restaurants	6.3	5.2	0.8	2.0	74,130	65,603
Transport, storage, communications	7.6	2.9	0.5	1.5	131,830	116,979
Financial Intermediation	0.7	0.2	0.0	0.1	294,582	63,690
Real estate	2.5	0.9	0.1	0.5	117,654	173,385
Subtotal services	46.1	28.8	4.2	11.7	85,061	98,267

(Table continues on next page)

Table 2.3: Continued

	Currently Employed Population by Area (%)				Mean Monthly Income	
	Dar es Salaam	Other Urban	Rural	Total	Paid	Self- employed
Public administration	5.1	2.9	0.3	1.1	194,294	98,545
Education	3.0	2.7	0.9	1.4	181,208	124,189
Health	1.8	1.6	0.3	0.6	158,738	75,191
Subtotal public sector	9.9	7.2	1.5	3.1	181,502	105,606
Other community	2.4	1.9	0.2	0.7	82,798	158,831
Private household	14.6	7.3	1.9	3.8	23,505	50,456
TOTAL	100.0	100.0	100.0	100.0	98,454	75,693
Labor force participation rate	85.8	87.2	90.8	89.6		
Current employment ratio	58.7	72.7	84.0	79.2		
Households with informal sector activities	57.0	54.0	33.0	40.0		

Source: Integrated Labor Force Survey 2006.

Notes

1. This section is based largely on the Tanzania Country Assistance Strategy (World Bank 2011a).
2. See World Bank (2011b, 17) and author's calculations.

Diagnosis and Evaluation of Current Health Financing System

Overview of the Health System and Health Financing in Tanzania¹

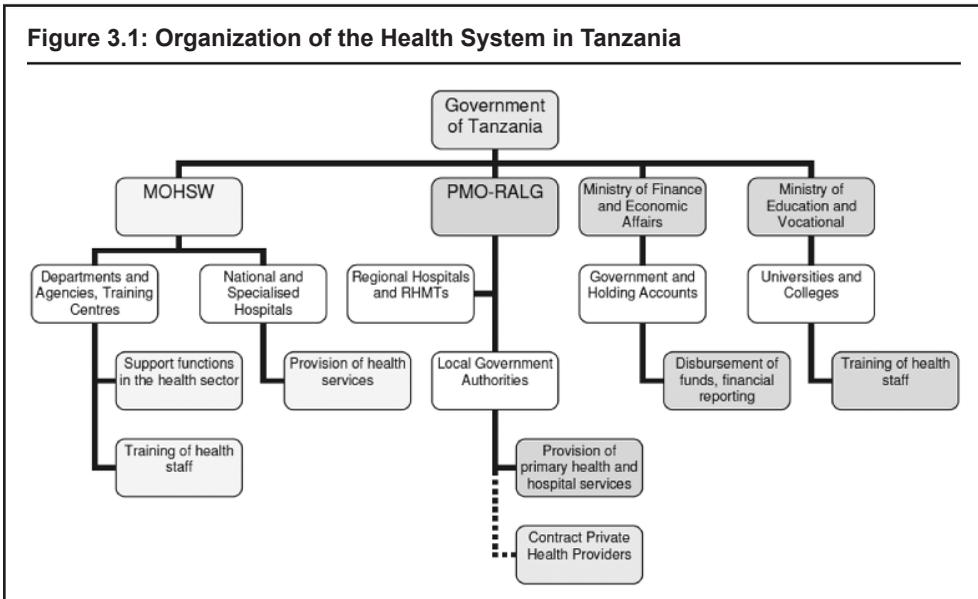
Before trade and economic liberalization in the 1980s, the Tanzanian health care system was solely in the hands of the central government and was financed through the national budget. There was some recognition of religious and other nonprofit facilities, which were financed through donations from their sponsoring institutions and some service fees from clients. Those facilities were heavily concentrated in areas where government facilities were not well established, especially rural and remote areas.

Mainland Tanzania is divided into 21 administrative regions and 113 districts, which are represented in 133 councils. There are about 10,342 villages. Services are organized in a pyramidal structure with dispensaries and health centers at the base, followed by district hospitals, regional hospitals, and national referral hospitals as one moves toward the apex. Both public and private providers operate dispensaries, health centers, and at least one hospital at the district level. There are 4,679 dispensaries and 481 health centers throughout the country. About 90 percent of the population lives within 5 kilometers of a primary health facility (Tanzania MoHSW 2008a).

The 55 district hospitals are owned by the government, and 13 designated district hospitals are owned by faith-based organizations (FBOs). There are also 86 other hospitals at the first referral level (owned by the government, parastatals, and the private sector), as well as 18 regional hospitals, which function as referral hospitals for the district hospitals, plus 8 consultancy and specialized hospitals. Compared to the existing government staffing norms, only 35 percent of positions are filled with qualified health workers. Although the staffing norms are being revised to take into account the increased density of health facilities under the Primary Health Care Development Program (“MMAM” in Kiswahili), there is no doubt that significant human resource shortages exist.

It is generally perceived that the quality of care in FBO facilities is relatively better than that in public facilities, although there is little empirical evidence to substantiate this perception. The government is revising its support to the Christian Social Services Commission (CSSC) and other FBOs through formal public-private partnership arrangements, including the introduction of service agreements that will specify contractual obligations in return for government funds and will put the relationship between CSSC facilities and the government on a more businesslike basis (Tanzania, MoHSW 2008 (a), 25, 34, 41).

The Tanzania Mainland health system is administered by the Ministry of Health and Social Welfare (MoHSW)—which provides overall policy direction and quality control, and runs regional and national referral hospitals—and by the Prime Minister’s Office, Regional Administration and Local Government (PMO-RALG), which oversees the district system of district hospitals and primary health care centers and dispensaries. Those facilities are owned and operated by local government authorities. The organization structure for the publicly financed health sector is shown in figure 3.1.



Source: Tanzania, MoHSW 2008, 12

Notes: MOHSW = Ministry of Health and Social Welfare; PMO-RALG = Prime Ministers Office, Regional Administration and Local Government; RHMT = regional health management team.

A series of HSSPs have been produced to guide the development of the health system in Tanzania. The latest, HSSP III, was launched by the president of Tanzania on June 30, 2009. It outlines 11 strategies and six cross-cutting issues that encompass the three main levels of care in the health sector (district, regional, and national), and the five types of services (dispensary, health center, district hospital, regional hospital, and national hospital). The 11 strategies focus on the following areas:

- District health services
- Referral hospital services
- Central support
- Human resources for health
- Health care financing
- Public-private partnerships
- Maternal, newborn, and child health
- Disease prevention and control
- Emergency preparedness and response
- Social welfare and social protection
- M&E and research

The health care system is still run under the implicit assumption that a major part of the financing of health care facilities runs through the national budget (financed partly by taxes and partly by money from development partners). In fact, as will be shown, a significant portion of total health care financing comes from other sources. The proportion of total funding provided by development partners is also growing, in both on-budget and off-budget financing. The largest portion of the off-budget financing is for HIV/AIDS and malaria programming.

Although the MoHSW is responsible for licensing health facilities, there is no formal mechanism for accreditation, except by the NHIF and the SHIB of the NSSF. The NHIF mechanism is explained the later section describing prepayment mechanisms.

Because public financing for health care providers in 1993 was not sufficient to maintain existing health care structures, the financing system was overhauled and user fees were introduced as an additional financing source to the national budget. User fees were generally conceived as a means to increase the financial resources available for the health care system, but they were also intended to (a) reinforce the notion that there is no free health care, (b) reduce informal payments, and (c) help to avoid unnecessary visits to health care facilities. The user fees made access to health care services relatively more expensive for poorer people than for richer people. Such regressive effects were accepted as a precondition for improving the quality of health care services, which had been deteriorating significantly under previous budget financing mechanisms.

Although exemptions and waivers were put in place to ensure access to essential health services, especially by the poor and vulnerable, several reviews of those policies indicate that they are not having the desired effect (Mtei and Mulligan 2007, 47–48). The reviews found that exemption systems favor the better-off people more than the poor because most of those exempted belong to households that are able to pay the CHF membership fees. A household survey conducted by the SHIELD project estimated that 44 percent of those who were eligible for exemptions pay user fees for outpatient care; 70 percent pay for inpatient care. For those not eligible for exemptions, 89 percent pay for outpatient care and 86 percent for inpatient care (Borgh, Mtei, and Ally 2011, 39). Thus, exemptions are somewhat effective in reducing out-of-pocket payments. With respect to waivers, the poorest often do not have access because of a lack of information, denial of the waiver by a provider, loopholes that allow misuse and sometimes abuse of the system, and a lengthy and cumbersome identification process that often deters people from applying for waivers (Mtei and Mulligan 2007, 6). Identification of the poor is a major problem, because there are no clear guidelines and because no money is set aside to compensate facilities for waivers.

In addition to exemptions and waivers, other systems were developed to address the highly regressive aspects of user fees, thus enabling people to access medical treatment when needed through prepayment and risk pooling. The mechanisms included voluntary public community health funds organized at the district level, voluntary micro-health schemes organized at the community level, private health management organizations, private health insurance, public mandatory social health insurance through the NHIF, and voluntary health benefits through the NSSF. Whereas the NSSF itself is mandatory, members must sign up separately for the SHIB health benefit, but most do not.

Voucher schemes have also been implemented in a limited way, although the scheme for anti-malaria bed nets has been found to be very effective. This scheme was superseded to a large extent by the “under-five” and “universal” bed-net campaigns

that were funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the U.S. President's Malaria Initiative (PMI); Switzerland; and the World Bank. Vouchers were also examined by the NHIF to encourage facility-based delivery, although the current thinking is to provide insurance cards rather than vouchers.

In summary, the health financing landscape in Tanzania is quite fragmented, with a large number of funding sources covering different aspects of the costs of health services. The HSSP III has as a major priority the development of a comprehensive health financing strategy to determine the appropriate mix of financing modalities and to develop a road map for improving financial and physical access to health services by all Tanzanians. The next section reviews the trends in health financing, both in total and in different areas.

Trends in Health Financing

Overall Health Expenditure

Health expenditures involve central government budgets through the MoHSW, local government budgets through PMO-RALG, off-budget payments from development partners, cost-sharing revenue, revenue from public and private insurance, and household out-of-pocket expenditures. Although a new National Health Accounts report is under development, the latest comprehensive figures are from 2005/06.

Table 3.1 shows that there were significant changes in both the size and the composition of health expenditures between 2002/03 and 2005/06, with total health expenditure more than doubling over the three years in question. The greatest increase (in both absolute and percentage terms) was seen in donor funds, and significant increases were also seen in public funding. Although the proportion of private expenditure on health decreased considerably, from 47.1 percent to 27.8 percent, actual private spending still increased by T Sh 88 billion, or 38 percent, with most of this increase coming from household out-of-pocket payments.

Table 3.1: Total Health Spending by Source of Funds

	T Sh million		Distribution (%)		Increase T Sh million	Increase (%)
	2002/03	2005/06	2002/03	2005/06		
National expenditure on health	496,030	1,159,217	100.0	100.0	663,187	133.7
Distribution by financing source (%):						
Public	126,140	325,740	25.4	28.1	199,600	158.2
Donors	136,061	511,215	27.4	44.1	375,154	275.7
Private	233,829	322,262	47.1	27.8	88,434	37.8
Household out-of-pocket	201,388	267,779	40.6	23.1	66,391	33.0
Household other	6,944	17,388	1.4	1.5	10,444	150.4
Private nonhousehold	25,496	37,095	5.1	3.2	11,599	45.5

Source: Tanzania National Health Accounts 2008.

Both donor and public financing have continued to increase since 2005/06, so the results of the current National Health Accounts round will be quite important, especially in determining whether private funding has increased again as a share of total health expenditure or has continued its downward trend. Those figures will have a significant effect on the assessment of potential future policy options for health financing.

Public Financing

This section examines public financing, which includes government spending and on-budget spending by development partners. Table 3.2 shows funding from public sources by year, including per capita spending and the proportion of government spending. As can be seen, total public health sector spending more than tripled between 2004/05 and the 2010/11 estimates. The largest increase has been in foreign non-basket funding, although a substantial part of this increase is the result of Global Fund grants (included in “non-basket” financing) moving from off-budget to on-budget. The table also shows that there are considerable problems with budget execution for non-basket funds.

A considerable amount of off-budget foreign funding (most notably funding from the U.S. government) is not shown in the table. With the emergence of the U.S. President’s Emergency Program for AIDS Relief (PEPFAR) and the PMI, significant off-budget resources have started flowing into the health sector. For example, PEPFAR funding in 2006/07 amounted to US\$205.5 million and increased to US\$356.2 million by 2008/09. The latter figure represented 72 percent of total HIV/AIDS funding in fiscal 2009 and was greater than the actual expenditures by the MoHSW for that year.² The PMI accounted for another US\$35 million in fiscal 2009 and increased its contribution to US\$52 million in fiscal 2010.

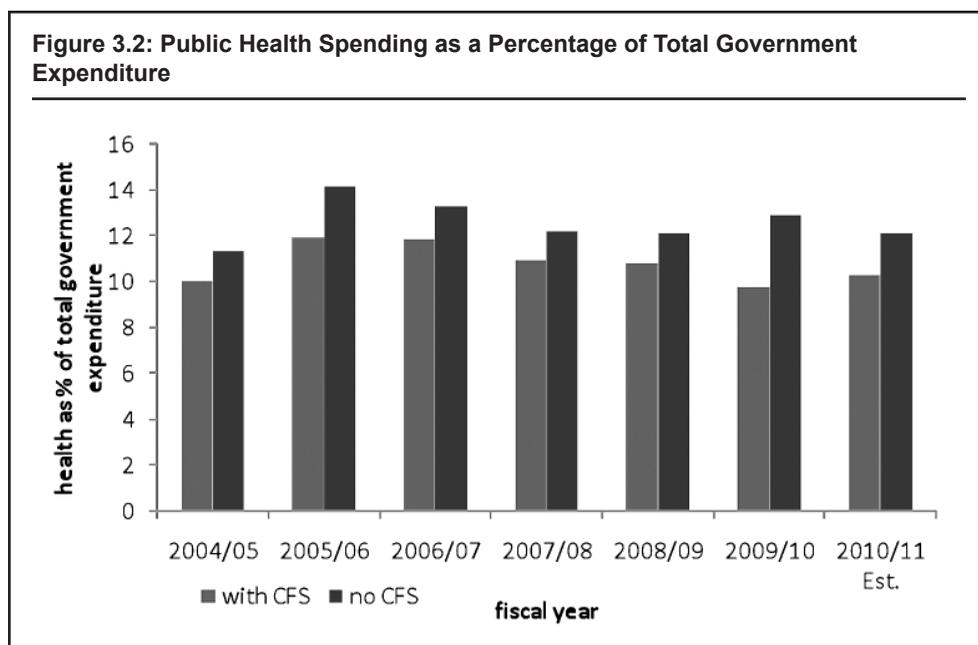
Table 3.2: Public Health Spending by Financing Sources

Source of funds (T Sh million)	2004/05	2005/06	2006/07	2007/08	2008/09		2009/10		2010/11
	Actual expenditure	Actual expenditure	Actual expenditure	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates
Government funds	206,554	296,819	348,890	378,113	459,496	461,504	548,658	578,682	643,011
Foreign funds									
Basket	91,777	68,299	103,204	80,956	99,730	85,401	121,640	128,796	161,804
Non-basket	2,896	61,257	61,512	112,003	204,368	154,168	254,801	200,049	387,908
Total Foreign	94,673	129,555	164,716	192,959	304,098	239,569	376,441	328,845	549,712
Off-budget	3,384	3,363	2,964	15,289		5,858		10,784	
Total	304,612	429,738	516,570	586,361	763,594	706,931	925,099	918,311	1,192,723
Real spending (FY05=100)	304,612	403,693	460,825	478,347	566,980	524,907	640,851	636,148	791,153
Real per capita (T Sh)	8,328	10,707	11,856	11,939	13,728	12,709	15,052	14,941	18,074
Real per capita (US\$)	7.51	8.98	9.49	9.46	10.40	9.63	11.34	11.26	12.31
Total as % GoT (excl. CFS)	11.3	14.1	13.3	12.2	11.1	12.1	11.6	12.9	12.1
Total as % GoT (incl. CFS)	10.1	11.9	11.8	11.0	10.0	10.8	9.7	9.8	10.3
Percentage of total									
Government funds	67.8	69.1	67.5	64.5	60.2	65.3	59.3	63.0	53.9
Basket	30.1	15.9	20.0	13.8	13.1	12.1	13.1	14.0	13.6
Non-basket	1.0	14.3	11.9	19.1	26.8	21.8	27.5	21.8	32.5
Total foreign	31.1	30.1	31.9	32.9	39.8	33.9	40.7	35.8	46.1

Sources: Tanzania Ministry of Health and Social Welfare, Public Expenditure Review, 2010; WDI (for GDP deflator).

Government financing is decreasing as a proportion of total funding—from 69.1 percent in 2005/06 (actual) to 53.9 percent for 2010/11 (estimated). However, the large absolute increases in both government and external financing over this period suggest that there may be not be a large amount of additional room for further significant increases in health financing from these sources. By contrast, at the recent United Nations Millennium Development Goals summit in New York, the president of Tanzania reaffirmed his government’s commitment to achieving the Abuja target of 15 percent of total government spending going to health.

Figure 3.2 highlights the recent experience in relation to this target. It shows that actual expenditures in 2009/10 reversed the general downward trend since 2005/06 and that the 2010/11 estimates seem to continue this reversal. The previous trend appears to have resulted from a combination of robust growth in general government revenue and several other high priorities for government, such as agriculture, education, and infrastructure. The 2010/11 estimates include major increases in Global Fund grants (currently on-budget), which more than doubled from T Sh 152.7 billion (or 31.9 percent of the total MoHSW budget) in 2009/10 to T Sh 333.7 billion in 2010/11 (or 49.3 percent of the budget). Excluding the Global Fund, the overall development budget increased by just 6.3 percent, from T Sh 107.9 billion to T Sh 114.7 billion, while the total budget increased by just 5.0 percent, from T Sh 326.3 billion to T Sh 342.5 billion. In addition, the recurrent budget increased by just 4.3 percent, which is barely above population growth.



Sources: Tanzania MoHSW 2008, 2009, and 2010.
 Notes: CFS = Consolidated Fund Service; Est. = estimated.

Those figures emphasize that the amount of government revenue available for the health sector has been limited. It is not likely that this limitation will change in the foreseeable future, especially if external financing continues to be available and if the other demands on government revenue continue to increase. The combination of shrinking

pledges to global health initiatives and the rapid use of the funds from existing Global Fund grants could result in an absolute decrease in the health sector budget in fiscal 2012, thereby raising questions about the extent to which the government will step in to keep the overall level of health financing stable. However, the scope for increased financing is limited by the other pressures mentioned earlier, as well as the current fiscal situation, in which an overall budget deficit of 6.1 percent of GDP (12.1 percent before external financing) is expected in 2009/10, up from 4.5 percent (9.4 percent) the previous year. This finding suggests that the fiscal space in terms of budget resources is very limited.

Global Fund grants, as well as most external financing other than the Health Basket Funds, are earmarked for specific purposes, which results in extremely limited discretionary funding for the health sector. This limitation means that significant increases in those funds are not translated into general increases in health service delivery. To have such an effect, either the Health Basket Funds or the allocation from the government's resources would need to increase.

So the question may be asked, "What has been achieved by the significant increase in the overall level of health sector financing?" The Annual Health Sector Performance Profile Reports give some indication of the answers to this question. Table 3.3 shows some of the key performance indicators that are tracked as part of the HSSP process.

Table 3.3: Changes in Key Health Sector Indicators

Indicator	1999	2004/05	2009/10	Change, 2004–09 (%)	Change, 1999–2009 (%)
Infant mortality rate	99	68	51	-25.0	-48.5
Under-five mortality rate	147	112	81	-27.7	-44.9
Maternal mortality ratio	529	578	454	-21.5	-14.2
Births in health facilities (%)	36	46	51	+10.9	41.7
TB treatment completion rates (%)	81.0	82.6	88.0	+6.5	+8.6
Outpatient visits per capita	0.71	0.78	0.74	-5.1	+4.2
Clinical staff per 10,000 population ^a	4.30	4.60	4.93	+7.1	+14.7

Source: Annual Health Sector Performance Profile Report, various years.

Note: TB = tuberculosis.

^a Includes physicians, assistant medical officers, nurses, and nurse-midwives.

These data show that although there have been impressive improvements in key health outcomes, the progress on process indicators has been relatively modest. In the case of outpatient attendance, visits per capita have actually declined over the past five years. This result is consistent with the recent performance audit by the Comptroller and Auditor General (CAG, the government's independent auditor), which concluded that—at the local level—health facilities “are not efficiently managed and are funded without proper consideration of service demands and performance” (NAO 2008, 2). Specifically, it found that 80 percent of clinical staff members of the selected sample of health centers and dispensaries see fewer than 10 patients per day. Further, it found that health centers often tended to have the same allocation of drugs, even though there might be a 20-fold difference in the number of patients seen. This disparity clearly indicates that there is substantial room for efficiency improvements to make the maximum use of the available funds, regardless of the level of funding. There are also significant regional variations in the allocation of funds, with the highest-resource regions getting 2.6 times

the amounts per capita of those with the least resources. All of these data suggest that improving efficiency and equitable allocation of resources should be a major thrust of any health financing strategy.

NHIF Expenditure

Another important source of funding for the health sector is the NHIF. Fortunately, current data are available for the NHIF expenditure, which is a relatively small proportion of total health expenditure although the contributions collected represent more than 10 percent of total public resources.

As shown in table 3.4, while there has been significant growth in contributions and expenditure, the proportion of total income paid out as benefits had been persistently less than 15 percent until 2007/08, after which it increased to 15.6 percent in 2008/09 and then jumped to almost 20 percent in 2009/10. However, a collective 20 percent return on investment for NHIF members may still represent a relatively poor value proposition, which will need to be addressed if the government is to realize its growth goal of enrolling 45 percent of the population in prepayment schemes.

Table 3.4: NHIF Income and Reimbursement, 2001/02 to 2009/10

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Income (T Sh million)									
Premium revenue	11,388	13,866	20,310	24,700	29,847	45,516	55,472	73,283	85,826
Investment income	36	577	1,568	3,501	6,800	10,333	16,343	16,317	16,997
Total income	12,240	14,535	21,938	28,610	37,256	56,884	72,178	89,943	102,884
Premium income as % total	93.0	95.4	92.6	86.3	80.1	80.0	76.9	81.5	83.4
Investment income as % total	0.3	4.0	7.1	12.2	18.3	18.2	22.6	18.1	16.5
Paid amounts for claims (T Sh million)									
	247	1,346	3,808	4,072	4,918	8,269	10,188	14,052	20,057
% of premium income	2.2	9.7	18.8	16.5	16.5	18.2	18.4	19.2	23.4
% of total income	2.0	9.3	17.4	14.2	13.2	14.5	14.1	15.6	19.5

Sources: NHIF Annual and Statistical Reports.

Table 3.4 shows a large absolute increase in revenue from premiums, increasing from T Sh 11.4 billion in 2001/02 to T Sh 85.8 billion in 2009/10. This revenue growth is a function of the increase in the number of beneficiaries—from 692,000 people in 2001/02 to 1.97 million in 2009/10—as well as more than a three-fold increase in the premium per subscriber.

The overall revenue composition has also changed considerably over time, with the revenue from premiums dropping from 95 percent in 2002/03 to just 77 percent in 2007/08, and then increasing again to 83 percent in 2009/10. There has also been significant growth in investment income, from just 4 percent of total income in 2002/03 to 23 percent in 2007/08, although it declined to 17 percent in 2009/10. In 2008/09, this investment income exceeded the amount spent on benefits. If this income stream can be maintained, it could be used to help improve the level of benefits for NHIF members.

NSSF and CHF

The SHIB program, which has been operating since January 2006, is one of the seven benefits of the NSSF. It is financed through the combined social security contribution of

20 percent of wages, shared between the employer and the employee. In the year ending June 30, 2010, the SHIB paid out T Sh 1.2 billion, which is a 30 percent increase over the T Sh 923 million paid out the previous year. However, it is important to note that only 9.2 percent of the NSSF members are registered with the SHIB, and major initiatives to increase this percentage are under way. If all 348,000 NSSF members joined the SHIB and used benefits in the same proportion as those currently enrolled, the total SHIB expenditure could be as much as T Sh 13 billion, representing 6.4 percent of total NSSF contributions. Of course, it is unlikely that all members would be registered, because many have private health insurance that is provided through their employers.

As of April 30, 2010, 99 councils from 20 regions had established a CHF. Another 9 new councils from 8 additional regions had been sensitized for CHF establishment; 38 councils from 16 regions had established a CHF but were not currently active. A total of 18 municipal and town councils from 18 regions had been sensitized to start operating TIKAs.

Data on the total amount of funding made available through the CHF are not readily available, but a rough calculation can be made. According to the 2009 Public Expenditure Review, CHF revenue accounted for an average of 18.7 percent of the complementary financing for the 12 councils sampled. If those councils can be taken as a representative sample, this finding implies that CHFs collected a total of T Sh 3 billion in 2008/09. It is not clear, however, whether this revenue would include the T Sh 1 billion that councils received as matching contributions. It is important to note that the matching funds resulted from applications by just 34 councils (23 were approved), which suggests that significant matching grant revenue is being left on the table.

Another way to calculate the amount of funding is through the number of people enrolled in CHFs (currently 1.68 million), although this calculation is complicated somewhat by the fact that the annual payment ranges from T Sh 5,000 to T Sh 30,000 per household, depending on the district. However, if an average household size of 5 people is used and an average payment of T Sh 10,000 is assumed, the total revenue would be T Sh 3.3 billion, which is close to the Public Expenditure Review estimate. Table 3.5 summarizes the coverage of publicly administered prepayment mechanisms. It shows that despite the progress that has been made, population coverage is still less than 9 percent, although the revenue collected is less than 10 percent of total publicly financed health spending and the actual benefits paid are about 2.5 percent of that amount.

Table 3.5: Summary of Prepayment Plans, 2010

Plan	Number of beneficiaries	Share of pop. (%)	Revenue collected (T Sh, million)	Revenue per beneficiary (T Sh)	Benefits paid (T Sh, million)	Benefits per beneficiary (T Sh)
NHIF	1,971,251	4.6	85,826	43,539	20,057	10,175
CHF ^a	1,678,734	3.9	3,009	1,792	2,106	1,792
SHIB ^b	51,306	0.1	1,200	23,389	1,200	23,389
Total	3,701,291	8.6	90,035	24,325	24,266	6,556

Source: Author's calculations.

^a Revenue collected is kept and used at the district; there is no direct payout of benefits; 30 percent is assumed to be used for administration (per CHF guidelines).

^b SHIB is funded out of the general NSSF contribution, so no revenue is specifically attributed to the program.

Summary of the Key Issues and Problems in Health Financing

Although the total resources available for health have increased considerably over the past number of years, many issues remain. For on-budget financing (government and donor), the level of discretionary funding is low, with most of the funds earmarked either for salaries or for specific donor programs such as activities financed by the Global Fund. Because the overall budget envelope for health is fixed, increases in earmarked donor funds tend to reduce the discretionary budget even further. In addition, there is a significant amount of off-budget funding; the ability of the government to influence spending priorities for this funding is even more limited.

The public consistently expresses concerns about access to quality services, citing absence of staff members, medical supplies, drugs, and equipment, as well as the high cost of out-of-pocket payments. The poor quality of services provided by accredited health facilities is also a key complaint of those enrolled in various health insurance schemes (NHIF, SHIB, and CHF). Members of those schemes feel that the benefits they receive are not commensurate with their contributions. The data generally support this contention, although the situation has improved in recent years for the NHIF.

By contrast, health care providers feel that they are not adequately reimbursed for the level of expected care, despite the increased money from user fees and insurance schemes. This perception is exacerbated by the lack of understanding within medical facilities about payment methods; that lack of understanding leads to facilities not submitting insurance claims and not requesting the resulting funds from the local authorities who are paid by the insurers. Similarly, the resources from CHF contributions (which are matched by MoHSW/Health Basket Funds) remain unused or are used unevenly by different local authorities.

Specifically with respect to the CHF, a study by the Swiss Institute for Tropical Medicine and Public Health (described later) found a lack of payment to providers for services rendered (Swiss TPH 2010). Another key issue is the lack of feedback that members of the NHIF can provide: often the only recourse left to them is voting with their feet by switching providers or discontinuing service.

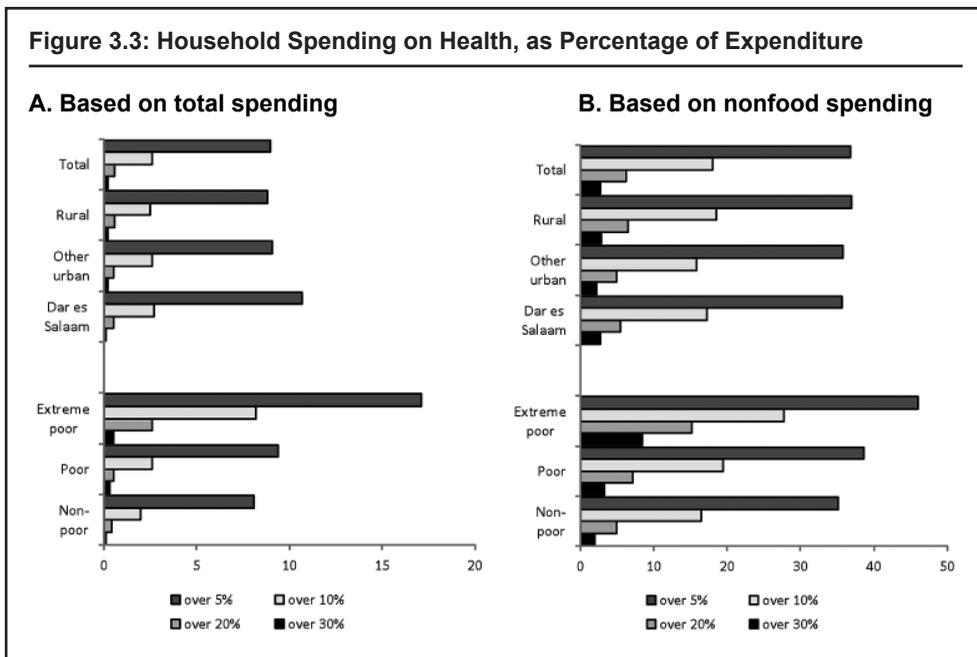
The NHIF has a very high level of unused reserves. According to its latest annual report, the NHIF has more than T Sh 300 billion in investments and reserves, representing about 15 years worth of claims at current expenditure levels. Because this funding is tied up and cannot be used to improve services or benefits to subscribers, it represents a significant opportunity cost to the health system as a whole. The issue of investing reserves prudently also needs to be addressed and regulated.

The issue of regulation needs significant attention. Each prepayment scheme operates under its own enabling legislation and regulatory authority. An overall regulatory framework is needed to define the rules for all players, thereby enhancing transparency regarding the roles, rights, and responsibilities of each stakeholder and, in turn, ensuring that stakeholders are held accountable for their actions. Such a regulatory framework should extend to private sector insurers as well. To this end, a Social Security Regulatory Authority (SSRA) has been established, but it is not clear which aspects of the health insurance market, other than the NSSF, it will be able to regulate. To date, the SSRA Act and regulations are silent on critical areas such as tariff definitions, determination of the benefit package, financial solvency, governance and organization, and contribution rates.

Medical equipment such as microscopes and drugs is often in short supply or lacking altogether at public health facilities. This is a common complaint among both NHIF and CHF members; however, this problem adversely affects CHF members more because their health insurance in most cases offers treatment only at public primary facilities within their home district. In rural areas, it is often necessary to travel long distances to reach a referral hospital. For the majority of the rural population, especially those working in the informal sector (primarily in subsistence agriculture), it is difficult to cover the transport cost. As a result, rural dwellers do not access referral facilities even if they are members of financing schemes that offer this benefit.³

According to the Household Budget Survey of 2007, average household spending on health services was just 1.9 percent of household expenditure for Tanzania as a whole, with relatively little variation between the poor (2.1 percent) and nonpoor (1.8 percent). However, because of the nature of health expenditures, averages are a poor way to measure their effect. The Household Budget Survey data provides two other ways to look at these data.

One way is to calculate the incidence of catastrophic health expenditures. There is no generally accepted definition of the level of spending that is considered catastrophic, so this analysis looks at various levels: 5 percent, 10 percent, 20 percent, and 30 percent of total household spending. The results are shown in figure 3.3. The graph in panel A shows that overall, health-related spending accounts for more than 5 percent of total spending for 9 percent of households, with a higher proportion of households in Dar es Salaam spending 5 percent or more of their income on health than those in rural areas. The proportion of the total population that spends more than 10 percent of income on health is about 2.6 percent, with little variation between areas; the proportions spending more than 20 percent and 30 percent of their income on health are 0.4 percent and 0.2 percent.



Source: Special tabulations from the Household Budget Survey (2007) data set.

However, when one looks at the bottom graph, it is clear that the burden on the poor and extreme poor is proportionately greater than on the nonpoor. Health expenditures account for at least 5 percent of total household spending for more than 17 percent of the extremely poor (those beneath the food poverty line), with 8 percent spending 10 percent or more, 2.6 percent spending 20 percent or more, and 0.5 percent spending 30 percent or more. Clearly, health spending is a significant burden for the one-sixth of the population who are extremely poor.

The negative impact is even more dramatic when nonfood spending is used as the basis for the analysis (panel B). Health-related items make up 5 percent or more of nonfood spending for 37 percent of all households and 46 percent of extremely poor households. About 18 percent of households allocate 10 percent or more of their nonfood spending to health, increasing to almost 28 percent for the extremely poor. More than 15 percent of the extremely poor spend 20 percent or more, and 8.4 percent spend more than 30 percent on health. For the population as a whole, 6.2 percent allocate 20 percent or more and 2.8 percent allocate 30 percent or more of their nonfood spending to health.

Another way of looking at the poverty impact of health expenditures is to examine the poverty head count with and without health spending. The results of this analysis are shown in table 3.6.

Table 3.6: Poverty Impact of Health Expenditures

	Poverty head count	Poverty without health expenditure	Poverty head count due to health expenditure	Percent due to health expenditure
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

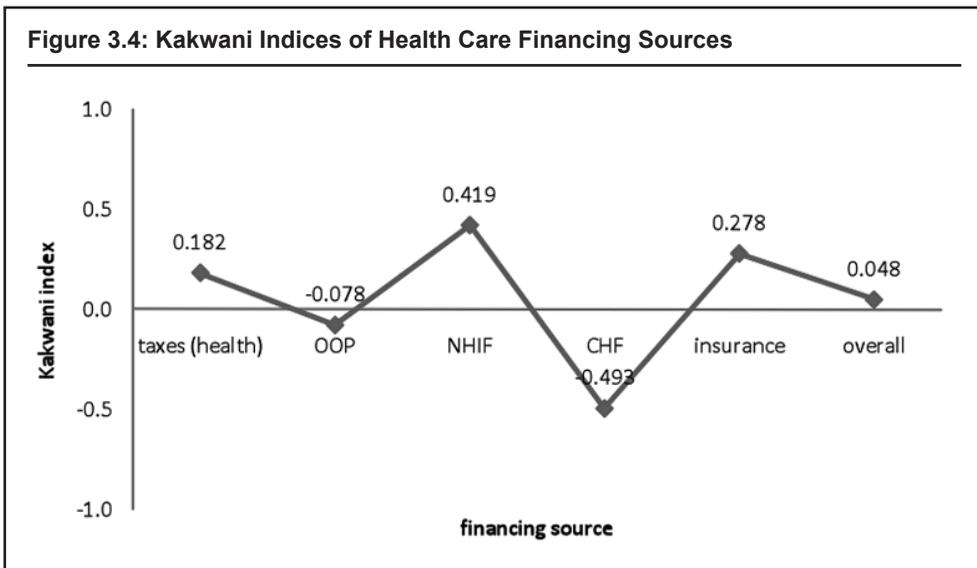
Source: Household Budget Survey (2007), special tabulation by World Bank.

This table shows that health expenditures are a major contributor to poverty in Tanzania, accounting for 4.2 percent of the poverty head count. Even more important and perhaps surprising, health expenditures account for 7.6 percent of the total poverty headcount in Dar es Salaam and 4.3 percent in other urban areas. Those figures suggest that improving access to prepaid health insurance and reducing out-of-pocket spending could have a major effect on poverty, especially in Dar es Salaam and other urban areas.

As part of the SHIELD project—which is financed by the International Development and Research Centre (IDRC) and the European Commission and is looking into health insurance options and experience in Tanzania, Ghana, and South Africa—the Ifakara Health Institute has been systematically looking at various aspects of the health financing situation in Tanzania. Two particular aspects have been examined: (a) the financial effect of health expenditures on different income groups and (b) the benefits of health expenditures on these income groups.

In terms of financial effect, the project evaluated the level of progressivity of various types of health financing mechanisms, including taxes, direct out-of-pocket payments, the NHIF, and the CHFs. It used the 2000/01 Household Budget Survey as well as a SHIELD-financed survey in 7 districts in Tanzania, which covered 2,234 households and 12,201 individuals in 4 rural districts and 3 urban councils.

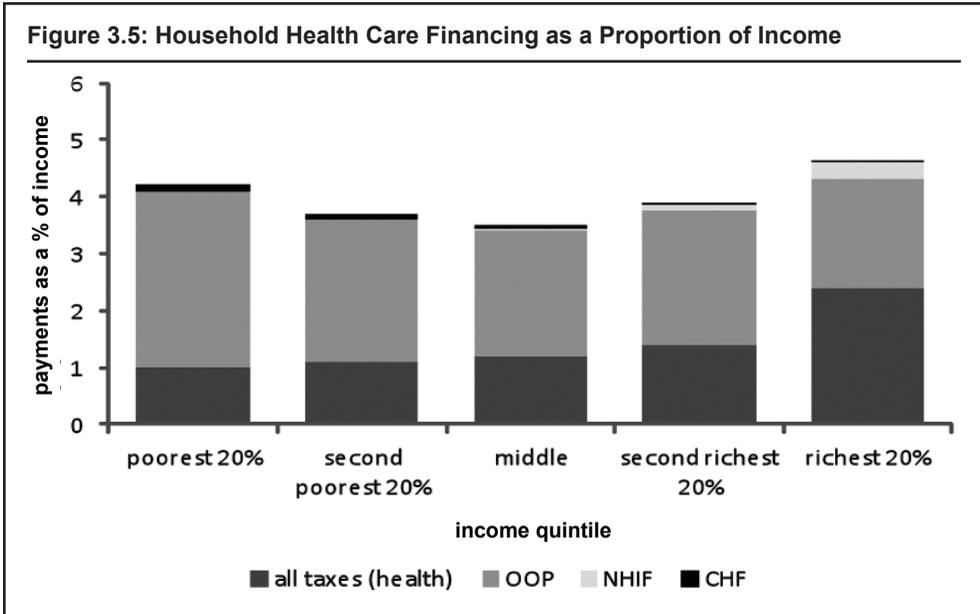
Figure 3.4 summarizes the results of the progressivity analysis using the Kakwani index, which is defined as the difference between the concentration index of health care payments and the Gini index of income distribution. The index is negative if the financing source is regressive, positive if it is progressive, and equal to zero if it is proportional. The Gini index is a measure of income/wealth inequality. A low Gini coefficient indicates a more equal distribution while a zero value indicates a proportional distribution (Mtei and Borghi 2010, 5). Figure 3.4 also shows that the health financing system overall is marginally progressive, with taxes and the NHIF being progressive and with a Kakwani index of 0.419. The CHF and out-of-pocket payments are both regressive, with indices of -0.078 and -0.493.



Source: Mtei and Borghi 2010, 30.

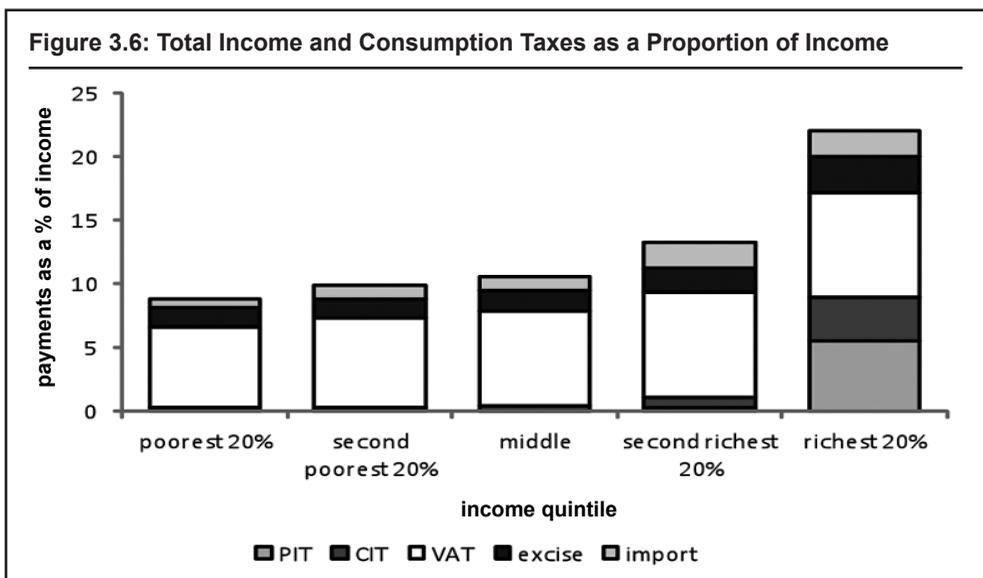
Note: OOP = out-of-pocket.

Figure 3.5 shows the effect by income group. The richest 20 percent of the population pay the highest proportion of their income to finance health care, while the poorest 20 percent bear the second highest proportion. The middle-income quintile bears proportionally the smallest proportion of the health financing burden.



Source: Mtei and Borghi 2010, 28.
 Note: OOP = out-of-pocket.

If one is looking at income and consumption taxes as a whole, figure 3.6 shows the extent to which they are progressive. The lowest burden is borne by the poorest quintile, with just under 9 percent of income paid as taxes; larger shares are paid by each successive income quintile, reaching almost 22 percent of income paid as taxes for the richest quintile. The major reason for the jump in the richest quintile is that this group is the only one that pays any significant level of personal income tax.



Source: Mtei and Borghi 2010, 27.
 Notes: PIT = personal income tax; CIT = corporate income tax.

After it examined the sources of financing for the health system and how much the various income groups paid relative to each source, the SHIELD project also looked at the incidence of benefits for the system as a whole and its component parts for different wealth quintiles. Again the special survey was used, supplemented by cost information from the NHIF, the National Health Accounts, and the MoHSW Health Management Information System. In the core analysis, NHIF costs were used because using other cost estimates produced little difference in the results. Figure 3.7 shows the relative share of health services for various types of care across income groups.

Although public primary health care facilities are pro-poor, the pro-rich orientation of outpatient care (panel B) at district and referral hospitals leads to the lowest and highest income groups getting a proportionately smaller share of the benefits, while the middle-income group gets the largest share. Similarly, publicly provided hospital care (panel D) is skewed toward specific income groups, such as the second poorest quintile for health centers and district hospitals and the middle quintile for regional and referral hospitals. Private inpatient care is predictably skewed toward the rich, while the inpatient distribution for FBOs is much more evenly distributed.

The study concludes (as shown in panel A) that “When combining benefits from outpatient and inpatient care from public providers, the overall distribution is more or less even, although the poorest 20 percent are getting less than 10 percent of all benefits.... Overall benefits from private for-profit providers, including drug shops, are strongly pro-rich, with the richest 20 percent getting more than 45 percent of the benefits. Overall benefits from faith-based providers are evenly distributed ...” (Makawai and others 2010, 24).

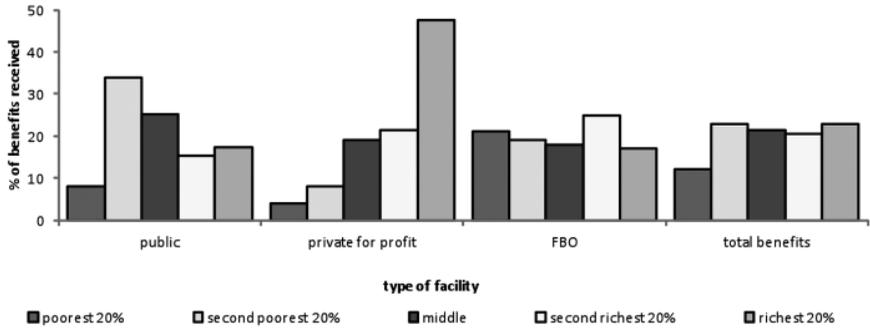
A final area examined by the SHIELD study produced a comparison of the benefits received versus need, with need being defined on the basis of responses to the survey with respect to self-assessed health status. Figure 3.8 shows that the poorest quintile has the greatest share of need but receives the lowest share of total health care benefits. All other quintiles receive a larger share of benefits than their share of need, and all—except the poorest 20 percent—get more than 20 percent of the total benefits.

Both the Financial Incidence Analysis and the Benefit Incidence Analysis need to be borne in mind in developing any health financing options. Further, a recent study by the Ifakara Health Institute looked at the use of health services by people who did and did not have prepaid health insurance. Figure 3.9 shows that although outpatient health care use (that is, using any outpatient services in the previous month) among the insured relative to the uninsured increases across all wealth quintiles, the percentage growth in the poorest groups is greater, with 87 percent and 83 percent growth in the first and second quintiles, compared with 44 percent, 51 percent, and 56 percent respectively for the upper-income quintiles. Further, the ratio of health care use between the highest and lowest quintiles shows a significant decline: from 1.57:1 for the uninsured to 1.32:1 for the insured group. This finding clearly shows that health insurance can have a pro-poor effect.

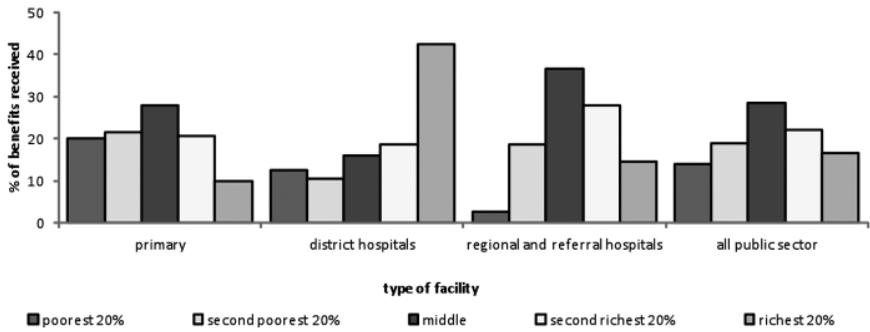
As a result of this and similar studies, as well as the commonly held view that prepayment plans can potentially play an increasingly important role in improving social health protection, the next section delves deeper into the key prepayment schemes that are currently in place in Tanzania.

Figure 3.7: Benefit Incidence for Various Health Interventions

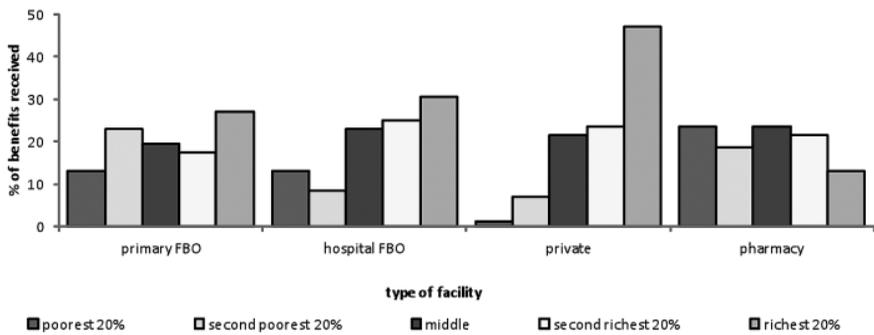
A. Total benefits



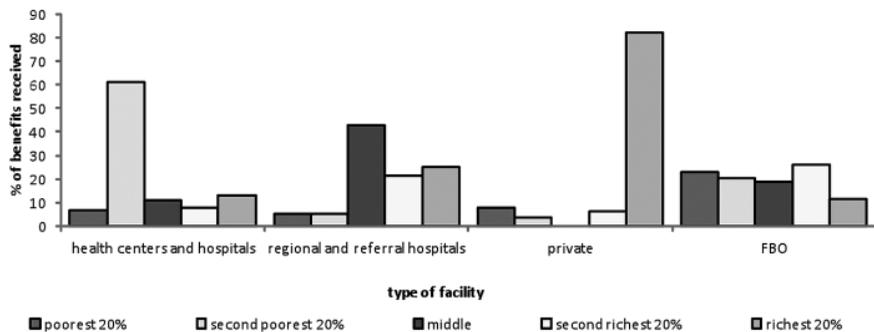
B. Public outpatient



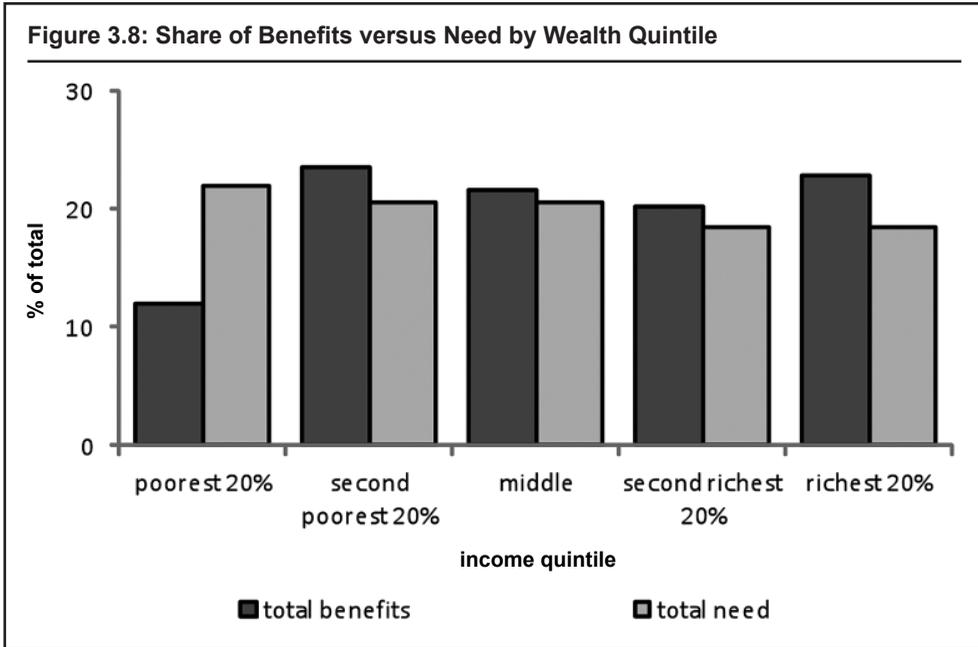
C. Private outpatient care



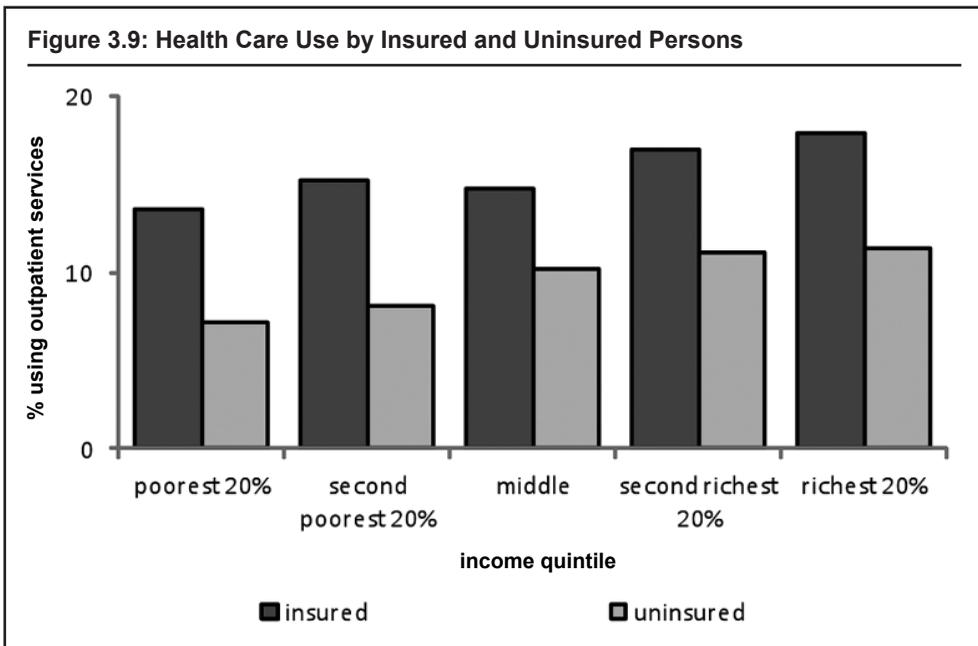
D. Inpatient care



Source: Makawai and others 2010, 21–25.



Source: Makawai and others 2010, 26.



Source: Tanzania MoHSW 2010, presentation by Ifakara Health Institute.

Overview of the Functioning of Current Prepayment Mechanisms

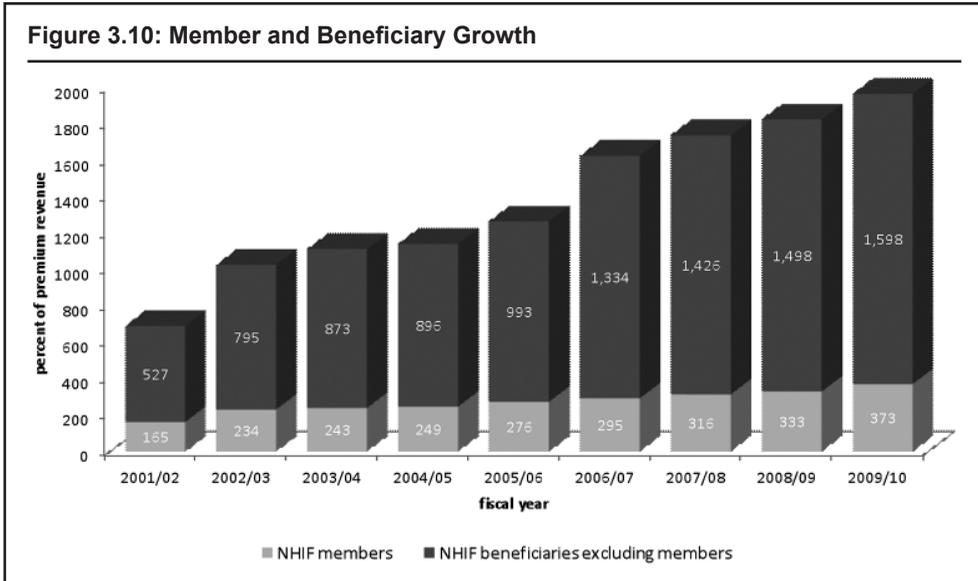
*National Health Insurance Fund (NHIF)*⁴

The NHIF began operations in July 2001 and, aside from out-of-pocket payments, is currently the main source of health service financing after the government funds. As shown in table 1, the NHIF covers the health insurance costs of public servants. It covers spouses and up to four children or legal dependents or a combination thereof per member. Membership is compulsory.

NHIF premiums are 6 percent of members' income and are deducted from the employees' salary and remitted to the NHIF. This premium is split 50/50 by the member and employer (the government in the case of public servants). About 2 million people are currently covered, which is substantial but still less than 5 percent of the 38 million Tanzanians. There is only one risk pool to cover all NHIF members. To increase membership, the NHIF has extended coverage to pensioners, police, prison staff, immigration officers, and fire and rescue service staff members, and it has allowed subscribers to pay extra for insuring family members beyond the numbers included in the basic package. NHIF is also exploring mechanisms to enroll the private formal sector and the "organized" informal sector.

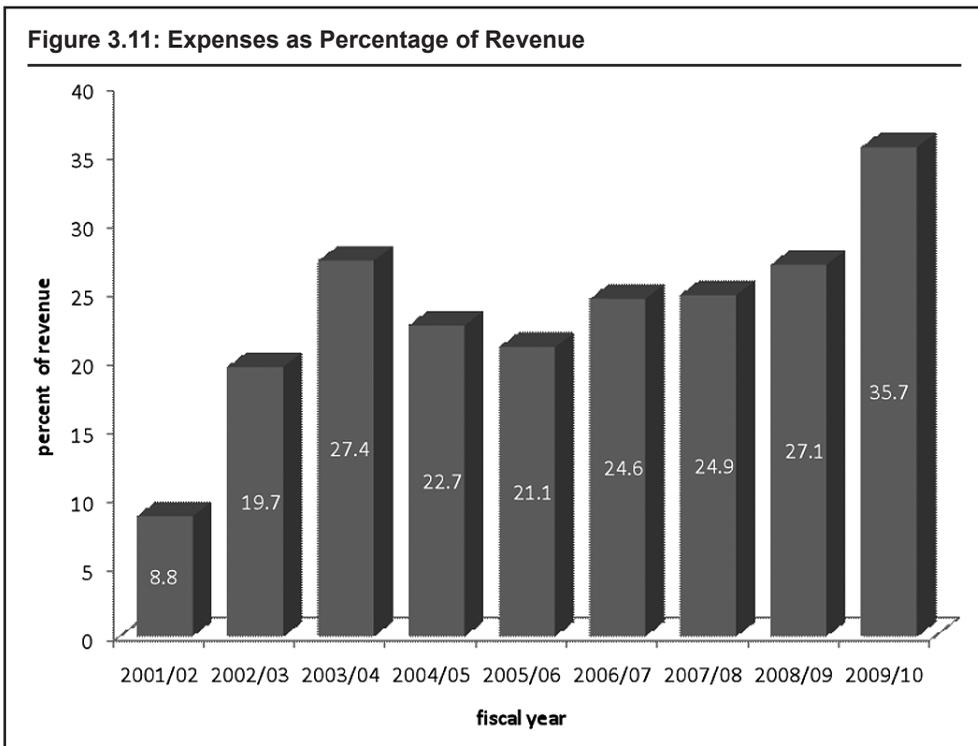
Providers are paid on a fee-for-service basis. Members must go to an accredited public or private health facility or provider to receive health services. The NHIF requires accreditation for health care providers who want contracts. All public providers are accredited regardless of quality; thus selective accreditation applies only to FBO and private facilities. Private pharmacies are also accredited. The accreditation process uses predetermined criteria and is based on MoHSW standard guidelines, which include the following: (a) availability of human resources, equipment, and facilities in accordance with MoH guidelines; (b) acceptance of a formal program of quality assurance prescribed by the NHIF; (c) acceptance of NHIF standard payment mechanisms and fees; (d) adherence with NHIF referral guidelines; (e) acceptance of reporting requirements; and (f) recognition of the rights of the patient. As of June 30, 2010, a total of 5,576 health facilities—68 percent of all health facilities in Tanzania—were accredited by the NHIF to provide services. Of the total, public facilities accounted for 91 percent of the dispensaries, 77 percent of the health centers, and 53 percent of the hospitals. The scheme is managed by a board of directors appointed by the government.

The NHIF offers a wide range of benefits, including basic diagnostic tests, drugs, outpatient services, inpatient services, and minor and major surgery. The NHIF currently reimburses 90–95 percent of the claims presented to it by providers, which is a significant increase over the 50 percent reimbursement rate paid when the NHIF was launched. At the same time, the expenditure of the NHIF is quite low. Despite continuing efforts, claim reimbursements still account for less than 23 percent of total NHIF income. Those claims account for about 2 percent of the total national health expenditure.



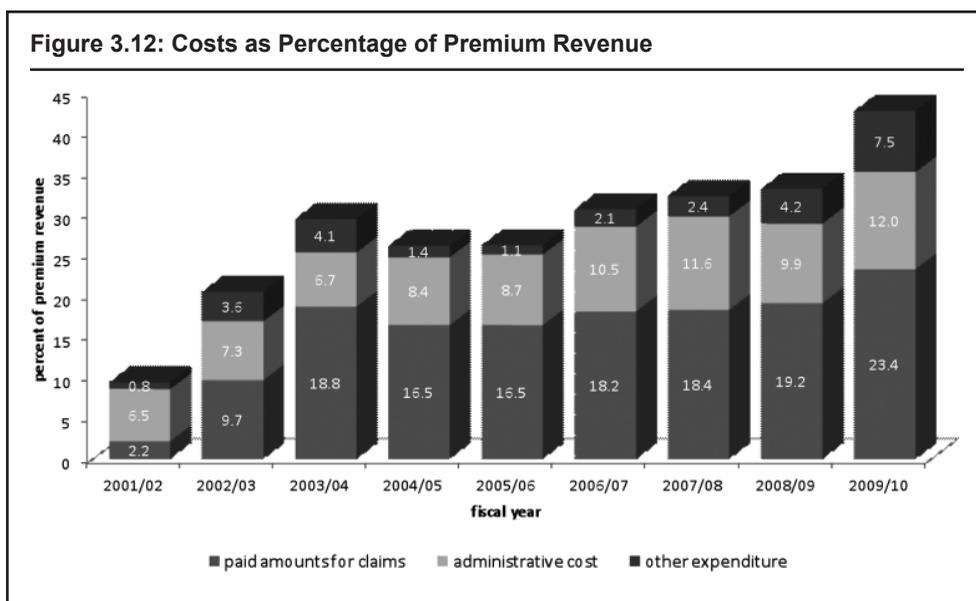
Sources: NHIF Annual Reports and Statistical and Actuarial Bulletins, various years.

Figure 3.10 shows the significant growth in NHIF membership over the past 10 years: increasing from 691,714 (164,708 members with 527,006 dependents) in 2001/02 to 1,971,251 (373,326 members with 1,597,925 dependents) in 2009/10. Although this increase is still a small percentage of the total population (5.2 percent, based on a population of 38 million), it is encouraging to see such growth.



Sources: NHIF Annual Reports and Statistical and Actuarial Bulletins, various years.

Figure 3.11 shows that expenses as a percentage of total revenue are increasing. Starting in 2005/06, there has been steady growth, to 27.1 percent of revenue in 2008/09 and a sudden jump to 35.7 percent of revenue in 2009/10. This increase is a result of higher reimbursement, increased administrative cost, and a significant increase in other expenses (see figure 3.12).



Sources: NHIF Annual Reports and Statistical and Actuarial Bulletins, various years.

In figure 3.12, the amounts paid out for claims compared with premium revenue show a slight increase from 16 percent to 19 percent between 2004/05 and 2008/09, followed by a jump to 23.4 percent of premium revenue in 2009/10. The 2009/10 result is a change from the previous trend of relatively little change in the benefits paid out year over year when compared with premium revenue. Although this trend is a very positive, it must be noted that the better-performing health insurance schemes in Eastern Europe (for example, Estonia and Romania) spend about 95 percent to 98 percent of their premium revenue on benefits to their members (Estonian Health Insurance Fund 2010, 9; CNAS 2010, 1).

Another trend to watch closely is the increase in the administration cost and other expenditures as a percentage of premium revenue; such figures increased from 8.4 percent and 1.2 percent in 2004/05 to 12.0 percent and 7.5 percent in 2009/10. Although some of this increase is the result of NHIF funding of medical equipment and facility rehabilitation—which arguably should not be funded by a health insurer—the costs must be closely tracked to ensure that they remain within acceptable levels for a national health insurance program.

A study by the World Health Organization (WHO) indicated that the average spent on administration for mature health insurance systems is 4.2 percent, with a range of 2 percent to 6.6 percent. Estonia spends 0.96 percent and Romania spends 1.7 percent of premium revenue on administrative expenses (WHO 2004, 40). Even when one allows for the challenges of communications and overall capacity within Tanzania, it should be

possible to keep administrative and other expenses to significantly less than 10 percent of premium revenue.

The “other expenses” for 2009/10 include T Sh 1.84 billion provided for medical equipment to accredited facilities, as well as T Sh 906 million provided for facility rehabilitation. Although these are necessary expenses, they do not fall within the types of expenditures that should normally be incurred by a health insurer. The fact that the NHIF is being called on to fund such items highlights the significant funding pressure on the system from the central MoHSW, which would usually be expected to provide the funds. Recently, the NHIF has been tasked with providing administrative, coordination, and technical assistance support to CHFs. This support has included the development of a CHF action plan and inclusion of CHF issues in the second NHIF Strategic Plan (2010–15).

National Social Security Fund⁵

The SHIB of the NSSF was established in July 2006 for the benefit of private sector workers. SHIB members benefit from health services through the financing of their 20 percent contributions to the NSSF, which are collected through payroll deduction (Mtei and others 2007, 35).

Health insurance is one of seven benefit categories under the NSSF, although the main benefit is pensions. All benefits are funded out of a single risk pool. Health insurance operations commenced 10 years after the NSSF began operating, and the SHIB is a standard component of the overall NSSF benefit package. However, enrollment into the SHIB requires a separate procedure that results in SHIB beneficiaries representing just 9.2 percent of total NSSF membership. This proportion translates into roughly 31,000 individuals. There are also about 20,000 dependents, which amounts to a much lower rate of dependents than as part of the NHIF (0.66 dependents per subscriber for SHIB compared to 4.28 dependents per subscriber for the NHIF).

Various factors can contribute to the low enrollment rate into the SHIB. They include private sector employers providing their own health benefits separate from the NSSF to employees, as well as lack of public knowledge about the health scheme. NSSF representatives believe the Fund’s single contribution rate, which covers all categories, may lead members to fear that other benefits such as pensions could be decreased if they take advantage of health insurance. Finally, in some areas, there is a lack of accredited health facilities, which leads members not to enroll because they would not be able to access health services. Overall, 264 hospitals, health centers, and dispensaries are accredited to the SHIB, which is a small proportion of the total health facilities in the country.

NSSF pensioners are also entitled to membership in the SHIB, but the contribution rate is 6 percent of the gross pension. To boost membership, the NSSF is reviewing its health care strategy and examining approaches for increasing the uptake of the SHIB. In contrast to the NHIF, the SHIB makes capitation payments to accredited health facilities and health providers for health services rendered to members. Using this approach, the member must select a single facility, and the facility is then paid a flat amount per year to provide health services to that member. The capitation amount is not based on any specific information because the SHIB does not collect information on the costs incurred by members or on utilization rates. Some facilities, especially in Dar es Salaam, refuse to take capitation, and the NSSF makes special fee-for-service arrangements with those facilities.

Health benefits provided by NSSF include a broad range of services, among them the following:

- Outpatient services: consultations, basic and specialized diagnostics, simple and specialized procedures, and drugs on the National Drug List
- Inpatient services: admission (overnight stay), consultations, simple and specialized procedures, and referrals to a higher level and specialized hospitals

CHF/TIKA (Community Health Fund and TIKA [Tiba kwa Kadi])⁶

The CHF was established as an alternative to user fees at the point of service. The idea is that district residents (usually informal workers and farmers) can join a CHF on a voluntary basis and can get access to health care without paying user fees. Currently, 1.7 million people are registered with CHFs, representing 3.9 percent of the population. The contribution is paid by the member; those who cannot afford the membership fee can theoretically benefit from an exemption policy (Kamuzora and Gilson 2007, 4). Contributions are between T Sh 5,000 and T Sh 15,000 per household per year. The funds raised are doubled by a “matching grant” from the national budget (Health Basket Funds), subject to a particular district CHF raising T Sh 5 million or more in annual contributions. Currently, 72 of 132 districts have a functioning CHF.

The goal is to enroll 85 percent of employees of the informal sector and of those living in rural areas (Kamuzora and Gilson 2007, 1). However, districts are at different phases of implementation. According to reports, members in only 29 of 72 districts had access to services in 2007. Of the 29, enrollment varied between 4 and 20 percent of the population (Sendro 2007, 12). The trend of enrollment differs from district to district. Some districts are slow to register new members and are poorly motivated. CHFs have the problems of many voluntary health insurance schemes, including a poor provider structure. Membership cards are typically honored only in the district where the CHF is located, and members are typically restricted to the facility where they registered. People tend not to re-enroll. CHFs also suffer from limited management capacity and a lack of proper data management, although since the NHIF got involved, this problem has improved. A recent situation analysis by the Swiss Institute for Tropical Medicine and Public Health found that CHFs had issues in the areas of design, enrollment, services, and sustainability. It also found that the district medical officer played a key role in determining the viability of a fund (Swiss TPH 2010).

Studies have identified issues regarding a lack of accountability at both the district and the ward levels, with managers interpreting policy on an individual basis. This issue is exemplified by households that would normally qualify for an exemption being denied such exemptions owing to either (a) the interpretation of the exemption policy by individual managers or (b) a complete lack of a defined exemption policy or of earmarked funds to finance the exemptions (Kamuzora and Gilson 2007; Mtei and Mulligan 2007, 6).

Kamuzora and Gilson (2007) found that “inability to pay membership contributions was the most important barrier, whereas poor quality of care, non-acceptance of the need to protect themselves against the risk of sickness, and lack of trust in CHF managers mattered more to average and wealthy community members” (Mtei and Mulligan 2007; Kamuzora and Gilson 2007, 8). A study by Kuwawenaruwa, Macha, and Borghi (2010, 16) on willingness to pay for voluntary health insurance found that “People are

willing to join and pay for health insurance if they are made aware of the principles of insurance and properly understand the concept of risk pooling.” The study also found that there is a general unwillingness to pay more than a minimal amount for health insurance coverage. Willingness to pay was higher for those districts with a higher benefit package, although few indicated that they were prepared to pay more for increased benefits (Kuwawenaruwa, Macha, and Borghi 2010, 14–15). Clearly, such issues would need to be addressed in any potential scaling up of CHF/TIKA.

The Swiss study also found issues with respect to access for the poor, as mentioned earlier, as well as adverse selection and high dropout rates during drought seasons. It also found a policy of letting potential applicants sign up at their leisure rather than active enrollment seeking. This study, as well as the review by Mtei and Mulligan, did find a number of best practices that could help to increase enrollment. They include improving the benefit package, clearly determining the ability or willingness of potential members to pay, strategically using sensitization, and promoting flexibility in membership fees in terms of both payment timing and contribution rates.

For example, councils could consider two payments per year, monthly payments, or seasonal payments (based on harvest times) or even payments for multiple years (for example, following good harvests). Enrollment could also be increased through collaboration with micro-finance institutions to help fund the premiums. At the facility level, district drug buffer stocks could be established for supplementary drug supply (financed through cost-sharing funds) to ensure that services are available when CHF members need them, bank accounts could be established at the health facility level to allow facilities to access CHF funds, and the emphasis on supporting pro-poor funding mechanisms within districts could be encouraged in order to enroll more people from vulnerable groups. Support to CHF management was also mentioned as being critical (Mtei and Mulligan 2007, 11–13).

Both the MoHSW and the NHIF provide regulatory oversight to CHF/TIKA. The NHIF has developed a CHF Action Plan (2009–12) that outlines how the newly established linkage between the NHIF and CHF/TIKA is going to work. This plan notes several advantages of this linkage, including (a) providing an entry portal for wider health insurance coverage, (b) providing a cost-effective coordination mechanism for CHF/TIKA at the national level, (c) promoting the harmonization of services and claims mechanisms, (d) facilitating the extension of coverage to the informal sector, (e) providing professional management of CHF/TIKA revenue, and (f) facilitating the portability of services (Tanzania Nation Health Insurance Fund 2009a, 13–14). Specific interventions mentioned in this plan include reviewing CHF benefit packages, registration, and collection mechanisms; introducing claims management and information systems at the CHF level; undertaking capacity building of CHF operations; promoting increases in user fees to encourage CHF membership; and establishing a Risk Equalization and Reinsurance Fund (Tanzania Nation Health Insurance Fund 2009a, 17–18).

*Nongovernment Nonprofit (Micro-Insurance)*⁷

Health micro-insurance schemes in Tanzania are typically sponsored by religious groups, informal groups, and associations. Micro-insurance schemes in the Mainland, such as UMASITA (Tanzania Informal Sector Community Health Fund) and VIBINDO (the umbrella organization of informal sector operators in the Dar es Salaam region), seek to strengthen informal sector communities by providing better access to health care,

improved quality of care, and ways to promote comprehensive health care services at affordable prices. Micro-insurance for health care is still in its infancy. Most of the schemes enroll groups rather than individuals (for example, all market vendors are required to join), but each group operates as a separate risk pool, causing potential financial sustainability problems.

Dar es Salaam has three major initiatives. The first, organized under VIBINDO, was facilitated by the International Labour Organization through small business operators in the second half of the 1990s. This initiative has remained small, with a very low rate of registration and renewal of membership.

The second initiative, registered by UMASIDA, is now known as UMASITA. This scheme, like VIBINDO, is facing the challenge of registering new members. UMASITA members include small-scale market retailers, tinsmiths, cobblers, stone crushers, and food vendors. VIBINDO covers about 1,102 people out of about 40,000 VIBINDO society members. UMASITA had up to 40,000 people enrolled, although it recently stopped functioning as a result of issues related to revenue collection and management, service utilization, and continuity of enrollment.

Together the micro-insurance schemes covered substantially less than 1 percent of the total population. The UMASITA benefit package included maternal and child health; voluntary counseling and testing; and treatment of common diseases such as malaria, pneumonia, diarrhea, and sexually transmitted infections. Surgical services are provided at government facilities, and the user fee is paid by the scheme. The VIBINDO benefit package includes primary health care services, reproductive health care services, some referral services, minor surgery, and limited hospitalization. Neither scheme required a copayment (McIntyre and others 2008, 24–25).

The third type of initiative is the church-based initiatives led by the Catholic Church, Lutherans, and other denominations in different parts of Tanzania. A new initiative that started in September 2010, sponsored by the Anglican Health Network, had a goal of registering 40,000 people within the first six months of operations and going nationwide within three years. Although the various churches have differing reasons to start such initiatives, there are two underlying themes. First, they seek to help alleviate the financing problems of the existing church-run health facilities; second, they seek to help the poor access health care by creating risk-pooling mechanisms. This approach has seen membership problems similar to those experienced by other initiatives.

One of the key problems contributing to the low uptake by the population is the general lack of knowledge of the fundamentals of insurance operations. As well, there is a failure to explain these fundamentals in the local, simplified context where the majority of target groups that would be interested exist. Another major issue is financial sustainability because such schemes operate separate risk pools and suffer from cost escalation (Jamu and others 2009, 32).

*Private Health Insurance*⁸

As health sector reform took place in the mid- to late-1990s, private health insurance became popular with most private companies. According to company representatives, approximately 120,000 people are covered by private health insurance. This number represents only a small percentage of the overall population of Tanzania. On average, premiums represent an estimated 8 percent of payroll.

Less than 1 percent of the total expenditure within the national health system comes from the private health insurance market. In 2002, T Sh 7.2 billion was the total amount of private insurance premiums paid (other than for life insurance, but including health coverage). It is to be hoped that the new National Health Accounts process that is under way will provide more up-to-date information on this sector.

These private insurance premiums indicate that the degree of health protection offered by private insurance companies is quite small. Interviewed representatives noted two factors for the lack of growth of private health care in Tanzania. First, the growth of private health insurance is difficult because of the poor level of health care in many parts of the country. Second, the bureaucracy surrounding private insurance is overwhelming and keeps companies from developing new initiatives. Private health insurance companies do not report to the MoHSW but— together with other forms of private insurance— are supervised by the Insurance Supervisory Department.

A private micro-insurance initiative was recently started in Tanzania, financed in part by the government of the Netherlands through PharmAccess and The Health Insurance Fund. The scheme is directed at entrepreneurs who receive micro-credit from the Pride Bank. Pride has partnered with the Tanzanian insurer Strategis to provide the entrepreneurs with a health insurance package. Called the Strategis Community Health Insurance Plan (SCHIP), participants pay approximately 10 percent of the premium as a copayment. The other part of the insurance premium is provided by The Health Insurance Fund, which is an international organization based in the Netherlands. The Fund works with a grant from the Dutch government; other funders such as the U.S. Agency for International Development (USAID) are also reported to have joined in the program. The longer-term sustainability of this approach— once the primary funders leave the sector— will be an important element in the evaluation of these approaches.

Notes

1. This section draws heavily from Lankers and others (2008, 12–13).
2. For additional information, see TACAIDS (2010).
3. See Jamu and others (2009, 33–37) and Makawia and others (2010, 28–29).
4. The text in this section draws heavily from Lankers and others (2008, 21–22).
5. This section draws heavily from Lankers and others (2008, 22–23).
6. This section draws heavily from Lankers and others (2008, 23–24).
7. This section draws heavily from Lankers and others (2008, 24–25).
8. This section draws heavily from Lankers and others (2008, 25–26).

Experiences from Other Countries

Experience gleaned from looking at other countries can suggest what might be possible and the types of challenges that can be expected. The key is to carefully determine whether what worked in other countries is applicable in the local context. The comparison countries were selected for the following reasons:

Thailand, Vietnam, and China were visited by a Tanzanian delegation as part of a Southeast Asia study tour organized by the World Bank.

Ghana and Rwanda have had great success in increasing coverage and face different sustainability challenges.

Kenya has gone through the process that Tanzania is just starting, although discussions continue. It is interesting to see the results of the discussions thus far, and there are also similarities in the organization of health services.

Mexico and Colombia have made significant progress in expanding health insurance coverage from the formal sector to the informal sector (including farmers) and have established effective mechanisms for identifying and reaching the poor.

Each of the following sections contains a summary table of the key aspects of health financing in the country (similar to table 1 in the Executive Summary), focuses on financial protection for the informal sector, and ends with some key messages that are important for Tanzania. Further details on each country appear in appendix A.

Thailand¹

The move to universal coverage in Thailand followed campaign promises during the 2001 general election. Known as the “30 baht” scheme (representing the amount of the copayment, equivalent to US\$0.75), it used existing health budgets and some additional financing to expand coverage to virtually all people not covered through the Civil Servants’ Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS) for formal private sector workers.

Transition toward universal coverage started in April 2001. Door-to-door approaches were used to sign up beneficiaries, reaching 44.5 million people by April 2002. There was some resistance from health care providers, but this resistance did not hold up the implementation of the scheme.

The major design principles include (a) getting to universal coverage as quickly as possible for those not already covered by existing schemes; (b) ensuring that cost control mechanisms are built into the universal coverage scheme; and (c) a minimal payment toward each patient’s care (30 baht per visit; note also that Thailand is a middle-income country), although this minimum has since been dropped with minimal effect on utilization. Table 4.1 shows the key characteristics of health financing in Thailand.

Table 4.1: Summary of Health Financing Approaches in Thailand

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	CSMBS	SSS	Universal coverage scheme		
Coverage (number)	5.7 million	10.1 million	47.2 million		
Coverage (% of population)	9	16	75		
Source of revenue	Government budget	1.5% each from employer, employees, and government	Government budget		
Revenue collection method	General taxation	Payroll contribution	General taxation		
Number of risk pools	One	One	One		
Payment methods	Fee-for-service for inpatient and outpatient	Capitation contract for inpatient and outpatient	Capitation for outpatient care, global budget capped diagnostic-related groups for inpatient care		
Benefit package	Extensive inpatient and outpatient services (average US\$400/person/year)	Extensive inpatient and outpatient services	Broad benefit package for inpatient and outpatient, not as extensive as CSMBS or SSS (average of US\$60/person/year)		
Facility coverage	Free choice of facilities	Extensive coverage	All public and private providers willing to accept the agreed tariff		
Regulatory oversight	Run by Ministry of Finance	Run by Ministry of Labor, Social Security Office	Scheme run by National Health Security Office (NHSO)		

Source: Author.

It is important to note the different provider payment methods for each scheme. The SSS uses a capitation contract model for both inpatient and outpatient care, while the CSMBS uses fee-for-service reimbursement extensively. The use of this payment method is felt to be a contributor to the high cost of this scheme (the cost of benefits for CSMBS is equivalent to about US\$400 per person while benefits for universal coverage are about US\$60 per person). The universal coverage scheme uses capitation for primary care and global budget-capped diagnostic-related groups for hospital care. Originally, there was a copayment of B 30 for each service under the universal coverage scheme, although this copayment was subsequently eliminated. This elimination has resulted in no discernible long-term increase in utilization. There are no deductibles for any of the schemes.

The poor are automatically eligible for the universal coverage scheme. Research has shown that the scheme is particularly effective in targeting the poor, with 44 percent of the enrollees in this scheme belonging to the first two income quintiles. It has also been successful in improving access to health services and in reducing impoverishment resulting from illness, which has declined by about 75 percent for families in the first income quintile and by about 64 percent overall.

Impressively, the results have been achieved without any significant increase in total health expenditure, indicating that—to a large extent—universal coverage benefits have replaced out-of-pocket payments, and the costs have been accommodated within GDP growth. However, sustainability is an ongoing concern, especially with the recent

expansion of the universal coverage benefit package, and increased financial access to services has strained the ability of the health system to cope with increasing service demand. The payment methods for the CSMBS scheme have led to continuing financial pressure. Box 4.1 highlights the key takeaway messages for Tanzania from the Thailand experience.

Box 4.1: Key Messages from Thailand

- Political will and popular support are essential.
- Rapid scale-up is possible if planned properly.
- Plans should avoid fee-for-service payment methods if possible.
- It is essential to plan for resulting utilization growth.
- Additional government (or development partner) financing will be needed in order to cover the poor.

Vietnam²

Health financing reform in Vietnam was driven by the rising costs of health care and by decreasing accessibility of the population, especially those in rural areas and the poor. The consolidation of the various schemes into a single administrative arrangement under the Vietnam Social Security Agency (VSS) and risk pool resulted in administrative efficiencies and increased solidarity between the Statutory Health Insurance (SHI) and Voluntary Health Insurance (VHI) programs. A high level of enrollment has been achieved by explicitly targeting the poor for coverage.

Table 4.2 provides details on the keys aspects of health financing in Vietnam. The main design principles appear to be (a) to sign up as much of the population as possible, (b) to provide the same level of coverage for both SHI and VHI (with cross-subsidization if necessary), and (c) to focus on administrative efficiency by merging existing arrangements into just two programs and by having both programs administered by the same organization, that is, the VSS. About half of the population (48 million people) is now covered by either SHI or VHI.

Providers are mostly reimbursed using fee-for-service, although some districts are experimenting with capitation arrangements. The fee-for-service approach is leading to concerns about financial sustainability. Providers are mostly public, although private providers are able to participate if they are willing to accept the VSS tariff. Referral requirements are enforced so that if people go to a higher-level facility without a referral letter, they have to pay the cost themselves.

Since 2001, there have been moves to increase hospital autonomy, giving more control over staffing, organization and management, and financial management. Copayments of 20 percent are standard, although there are exemptions for the poor. There are no deductibles, but there are maximum payments for high-tech procedures (US\$1,250 equivalent). The Ministry of Labor and Social Welfare does an assessment to determine who is poor.

Table 4.2: Summary of Health Financing Approaches in Vietnam

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	SHI		SHI, criteria US\$11/month rural, US\$14/month urban	VHI	
Coverage (number)	11.8 million		18.2 million	12 million	
Coverage (% of population)	14		21.7	14.3	
Source of revenue	2% paid by employer, 1% by employee—total 3%		3% of minimum salary paid by government	Subscribers, local government subsidy for near-poor	
Revenue collection method	Payroll deduction		General taxation	VSS contracts with local collection agents (10,000)	
Number of risk pools	Single risk pool with allocations to regional and county branches of VSS			Single risk pool with allocations to regional and county branches of VSS	
Payment methods	Mostly fee-for-service, some districts experimenting with capitation arrangements				
Benefit package	Same package: inpatient, outpatient, diagnostics, rehabilitation, drugs, transport for the poor and those in rural areas; standard copayment of 20%, exemptions for the poor				
Facility coverage	Mostly public, but private can participate if they will accept the VSS tariff				
Regulatory oversight	Both schemes run by VSS				

Source: Author.

A number of issues and challenges have been identified: (a) controlling abuse of the system; (b) dealing with adverse selection (people take coverage only when they are sick); and (c) dealing with the deficit, which reached 33 percent of SHI/VHI revenue in 2008 through both revenue and expenditure measures. There is a need to make VHI more affordable, especially for the “near poor” (those just above the poverty line); to sign up the other 50 percent of the population; and to improve the quality of health services. Box 4.2 provides the key takeaway messages from Vietnam.

Box 4.2: Key Messages from Vietnam

- There are potential efficiencies from shared administration.
- Plans should avoid fee-for-service payment methods if possible.
- It is essential to match the benefit package to available revenue.
- There is a place for both public and nonpublic providers within a national health insurance arrangement.
- The reach of the formal national health insurance organization can be extended by employing community-based contractors to collect premiums.

China³

A number of initiatives were put in place in China to address declining social health protection—especially for the poor—and poor resource allocation. Table 4.3 highlights the various initiatives.

Table 4.3: Summary of Health Financing Approaches in China

Dimension	Formal public sector	Formal private sector	Poor	Formal sector, rural	Informal urban	Informal rural/farmers
Prepayment scheme	Basic Medical Insurance (BMI)—Urban		Medical Assistance (MA)	New Cooperative Rural Medical Scheme (NRCMS)		
Coverage (number)	223 million		51.9 million	830 million		
Coverage (% of population)	16.8		3.9	62.7		
Source of revenue	6% employer, 2% employee		National government	Payment per person per year, shared between individual (20%), local (40%), and national government (40%)		
Revenue collection method	Paid by employers to Social Security Department		General revenue	Respective levels of government, NRCMS county level offices, or local agents		
Number of risk pools	One risk pool at each county or prefecture, also employee health accounts (4.2% of payroll) at discretion of employee		National risk pool	One risk pool at each county or prefecture (large counties)		
Payment methods	Plan that pays a portion of medical expenses Plan that allows subscriber to use saving account to pay copays or other costs		As SHI	Global budget for outpatient services, inpatient per bed-day, reimbursement rate that varies by type of service (considering appropriate referral patterns)		
Benefit package	Better than NRCMS			Started relatively small, expanded as client and district or region demand increased		
Facility coverage	All contacted service providers to be eligible		As SHI criteria	All contacted service providers to be eligible		
Regulatory oversight	General oversight by national and provincial governments					

Source: Author.

The major success factors included (a) having the highest-level political commitment to these programs at all levels (national, provincial, local); (b) piloting to prove the concepts but not waiting to achieve perfection in the pilots before scaling up; and (c) beginning with a small premium and benefit level that would quickly demonstrate the value of the scheme, thereby leading to both consumer demand and increased political and financial commitment by governments to improving the level of benefits.

The central government sets rules and provides overall leadership, while local governments implement. BMI workers are part of risk pooling at the county or prefecture level, but each employee is also his or her own risk pool. A “debit card” is issued that can be used at the employees’ discretion to pay some or all of the deductible or copayment portions for which employees are responsible for when they receive care.

Management of all funds is at the county level (Social Security Department for BMI, and Health Authority for the NRCMS). There is some discussion about pooling at the prefecture level as a result of variations in county revenue-raising capability and the problems of smaller risk pools.

All schemes pay only a portion of the total medical expenses (30–70 percent based on the type of services), with deductibles, copayments, and ceilings on the maximum amount of reimbursement. The levels of deductibles, copayments, and ceilings are set at the local level in accordance with local conditions and financial availability, and they are revised on a regular basis. Reimbursement rates encourage the use of local medical facilities.

The Civil Affairs agency conducts annual poverty level assessments. Income levels of US\$100–150 equivalent per person per year are considered poor, and income levels under US\$100 are considered very poor. The poor are automatically enrolled in the NRCMS and eligible for the MA scheme. MA benefits are in addition to those under NRCMS. The main messages for Tanzania are shown in box 4.3.

Box 4.3: Key Messages from China

- There is value in starting with a small benefit package and increasing both the benefits and funding according to consumer demand.
- Risk pools and administration at lower levels of government require capacity at that level, and smaller risk pools can be problematic.
- There is always a requirement for strong central regulation to ensure consistency in administration and delivery at the local level.

Ghana⁴

The National Health Insurance Scheme in Ghana is one of the legacies of the John Kufuor administration. A National Health Insurance Authority (NHIA) licenses, monitors, and regulates the operation of health insurance schemes in Ghana. There are three main categories of health insurance in Ghana. District mutual health insurance schemes are operational in every district. This is the public or noncommercial scheme, and anyone who is a resident in Ghana can register under this scheme.

The second category comprises private commercial health insurance schemes that do not receive National Health Insurance Scheme subsidies and must pay a security deposit before they start operations.

The third category is known as the private mutual health insurance scheme. Any group of people, such as members of a church or social group, can come together and start making contributions to cater for their health needs, thus providing for services approved by the governing council of the scheme. Private mutual health insurance schemes do not get a subsidy from the National Health Insurance Scheme. The details are highlighted in table 4.4.

Table 4.4: Summary of Health Financing Approaches in Ghana

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	District medical health insurance schemes				
Coverage (number)	12.5 million (2008)				
Coverage (% of population)	54				
Source of revenue	Premiums of US\$8 to US\$53 per year for the informal sector, plus 2.5% points from VAT and 2.5% points from Social Security contributions for the formal sector				
Revenue collection method	District fund for premiums, and central government for VAT and Social Security contributions; significant exemptions from premium payment (for example, under 18, elderly)				
Number of risk pools	One per district (145 districts)				
Payment methods	Diagnostic-related groups for inpatient, capitation, or fee-for-service for outpatient				
Benefit package	Full inpatient, outpatient, maternity, emergency care, and essential drugs				
Facility coverage	Member with a card in any scheme to have access to any provider				
Regulatory oversight	NHIA that licenses, monitors, and regulates the operation of health insurance schemes				
Other insurance schemes	Private schemes and private mutual health insurance schemes (any group of people, such as members of a church or social group) that are alternatives to MHI				

Source: Author.

Coverage is mandatory for both the formal and informal sector, although it is hard to enforce for the informal sector. People who register under any of the schemes are given a card that can be used to seek treatment in any hospital in the country. There are no copayments unless extra services, such as a private ward, are used. The card can also be used to buy prescribed drugs at accredited pharmacies or licensed chemical shops. There is an extensive benefits package.

There have been delays in processing claims and making payments, which have led to reports of hospitals and pharmacies turning patients away. A number of reforms are being implemented to deal with such challenges and the issue of cost escalation generally, including (a) the establishment of a consolidated premium account to collect all premiums, (b) the establishment of consolidated claims management centers to process claims, (c) the use of a standardized prescription form, (d) the introduction of capitation for outpatient services, (e) the implementation of a unitary system of contracting with service providers, and (f) several other initiatives. A one-time premium payment was also promised some time ago, but it has not yet been implemented. Box 4.4 highlights the main takeaway messages from Ghana.

Box 4.4: Key Messages from Ghana

- Although small, district-level risk pools are politically attractive, the realities of health insurance operations require specialized expertise in revenue collection, contracting, and claims management.
- Expanding the revenue base through earmarked taxes (for example, VAT) can be an effective strategy for ensuring financial stability and coverage of the poor.
- Fee-for-service should be avoided if at all possible.
- It is essential to match the revenue received to the benefit package.
- Reaching the poor requires special efforts and approaches.

Rwanda⁵

Rwanda has pioneered major programmatic, organizational, and health financing reforms aimed at improving the quality of care and, ultimately, the health status of the population with a particular focus on the most vulnerable segments. Prepaid financing was organized in the form of mutual health organizations (MHOs). From only one initiative in 1998, these schemes have expanded to cover virtually the entire country. Table 4.5 highlights the key features of the current arrangements.

Table 4.5: Summary of Health Financing Approaches in Rwanda

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	RAMA and MMI	MHO or RAMA	MHO (<i>Mutuelles</i>) schemes		
Coverage (number)	297,000 (2006)	7.6 million (2008)			
Coverage (% of population)	3.3	85			
Source of revenue	RAMA–15% (shared equally); MMI–22.5% (17.5% government)	Member contribution of US\$7.60 per year for up to seven in a family, plus contributions from government and donors for those who cannot afford this amount			
Revenue collection method	Payroll deduction	Collected by MHO			
Number of risk pools	One each for RAMA and MMI	One per district (approximately 392), but National Guarantee Fund and District Solidarity Fund have been created to provide equalization and reinsurance support			
Payment methods	Fee-for-service	Some capitation and fee-for-service; output-based payment methods that have also been implemented for some services			
Benefit package	Full range of services	Preventive and curative services, prenatal care, delivery care, laboratory exams, drugs on the MoH essential drug list, ambulance transport to hospital, limited district hospital services			
Facility coverage	Own facilities plus contracts with public/FBO	Contracts with district health center and surrounding hospitals; recent changes that have allowed subscribers to obtain service at any health facility			
Regulatory oversight	RAMA/MHI Boards	MHOs that are nonprofit, self-administered organizations; policy direction that comes from MoH			

Source: Author.

Notes: FBO = faith-based organization; MHI = medical health insurance; MHO = mutual health organization; MMI = military medical insurance; MoH = Ministry of Health; RAMA = Rwanda Health Insurance Company (Rwandaise d'Assurance Maladie).

After a pilot implementation, MHOs were adapted to fit within the decentralization model that was being developed in Rwanda, specifically involving the Ministry of Decentralization and Local Affairs (MoDLA) and its agencies in promoting MHOs. This adaptation anchored them in the community and facilitated the mobilization of local authorities in the various administrative districts and district subdivisions. This involvement also resulted in the involvement of nongovernmental organizations (NGOs) and religious leaders, which raised the population's awareness of the importance of enrolling in MHOs. Leadership at the central level was also mobilized to ensure the backing of the highest authorities in government.

In mid-2006, benefit packages were expanded, and coverage for the indigent, vulnerable groups and for people living with HIV was institutionalized by the government and foreign partners. The benefit packages now covered primary health care, secondary care, and tertiary care, which dramatically improved the price-quality ratio for MHO services.

Recognizing the potential problems involved in small risk pools, Rwanda established a National Guarantee Fund (FNG) and a District Solidarity Fund (FSD) to bolster financing mechanisms for MHO expansion in the country. The FNG/FSD system strengthens equity of access and financing by harmonizing MHO benefits with those received by the beneficiaries of other social health insurance systems and by providing care for the indigent. The FNG is financed through contributions from the government, Rwanda Health Insurance Company (RAMA, or *Rwandaise d'Assurance Maladie*), military medical insurance (MMI), private insurance systems, and foreign partners, including the Global Fund. The FSD is financed by the contributions of MHOs, administrative districts, transfers from the FNG, and contributions from the development partners that are involved at the district level. The main takeaway messages from Rwanda are shown in box 4.5.

Box 4.5: Key Messages from Rwanda

- Strong government leadership, vision, and a regulatory framework at all levels, foster the short- and long-term sustainability.
- Strategies must be adapted to a changing macro and health sector environment.
- Independent controls and quality checks are essential for monitoring and evaluating health facility performance.
- Cultural and social factors, particularly solidarity within communities, contribute to the success of several health service delivery innovations.
- Provisions are needed for financial protection and other support for indigent populations.
- Government coordination of donor funding is critical to ensure that aid is used effectively and aligned with national priorities.

Kenya⁶

The previous examples highlight reforms that are already in place; Kenya presents some of the evolving thinking on health financing in a system that is similar to Tanzania in many respects. The process for the Kenya strategy drew heavily on the previous failure at health financing reform in 2005 and is the result of a broad consultation process, which included a wide variety of stakeholders and drew on both extensive analytical work and reviews of health financing systems in other parts of the world. The key elements of the strategy are highlighted in table 4.6.

Table 4.6: Summary of (Proposed) Prepayment Schemes in Kenya

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	National Health Insurance Fund (NHIF) or private insurers offering benefit package		NHIF		
Coverage (number)	6.8 million including informal sector		Not known	(See left.)	
Coverage (% of population)	18 (including informal)		Target 100%	Currently small but increasing proportion of population	
Source of revenue	Payroll contribution based on income, ranging from US\$22.50 to US\$300 annually		Government or development partners	Negotiated contributions (for groups), premium subsidies for near-poor	
Revenue collection method	Deduction from payroll paid directly to NHIF		NHIF paid from budget	Through community health funds or associations	
Number of risk pools	One				
Payment methods	Proposed case based (capped) for inpatient care and capitation for outpatient care				
Benefit package	To be determined—but to start with modest package and expand as resources allow				
Facility coverage	All facilities (public, FBO, NGO, private) willing to accept tariff				
Regulatory oversight	Proposed Benefits and Tariffs Board for health-related issues (including quality) and financial oversight by Ministry of Finance				
Other insurance schemes	Private schemes that can provide the basic benefit package if they are willing to charge the same premiums and pay the same tariffs (subscriber choice) and that can also offer private supplementary insurance for services outside the basic benefit package				

Source: Author.

Improving efficiency is an important focus of the strategy, including maximizing the value from the current resources and the functioning of the health system generally. The role of the Ministry of Health (MoH) should be as the steward of the health system, thus providing overall direction and guidance and setting the overarching policies of the system but not being involved in day-to-day management of health service providers. Making the MoH both the regulator and a service provider will inevitably lead to conflicts of interest.

Strong quality assurance and accreditation mechanisms are extremely important, and strengthening the referral system will ensure that each level of care provides the most appropriate services efficiently and effectively. Separating the purchaser from the provider of services will also enhance efficiency, but this move will require increased autonomy for public health care providers, so that they have the ability to manage their facilities in the most cost-effective way.

The strategy proposes the creation of a Benefits and Tariffs Board to work with purchasers, providers, and other stakeholders to develop appropriate reimbursement levels, as well as the basic benefit package. Although this package will initially be a limited set of services, as the economy grows or as the total resources available for health increase or both, the package would be reviewed and expanded. An important feature of these processes will be transparency and availability of information. For services not included in the package, options would exist for people to take out supplementary private health insurance. Because this option would be an important element of the overall health care financing and delivery system, it will be necessary to develop effective financial and quality oversight structures to ensure that private insurance remains sustainable.

If one is to reach informal workers and farmers, smaller risk pools in the form of community health funds may be established. Moreover, the NHIF would essentially act as a reinsurer for those funds, covering the full range of services for members regardless of the claims activity. Capacity will need to be developed in actuarial analysis to determine the appropriate and minimum premium levels for such schemes, as well as for the general population of insured people covered through formal employment or informal group arrangements.

Protection of the poor is central to the overall health care financing strategy. A critical issue, therefore, will be the timely and accurate identification of the poor. An important element is to make sure that health service providers do not face disincentives to treating the poor. Thus, it will be important to compensate providers for lost user-fee revenue when they treat poor people. The registration card that members receive will both signal to the provider that no user fee should be collected and signal to the purchaser that the reimbursement should be augmented by the user fee that would otherwise have been paid.

To involve development partners, the strategy suggests the creation of an Access and Equity Fund, which would receive funding from both government and development partners and would use those funds to expand coverage through premium subsidies for the poor and near-poor. Box 4.6 highlights the key messages from the proposed Kenya strategy.

Box 4.6: Key Messages from Kenya

- It is essential to improve the functioning of the health system, including efficiency.
- Conflicts of interest from having the MoH as both regulator and provider must be addressed.
- The regulatory framework must include independent and transparent institutions.
- Protection of the poor requires careful planning, including identification, incentives for providers to treat the poor, and funds that will allow premiums to be covered.
- Development partners' support should follow the shift from input- to output-based financing.

Colombia⁷

Before 1993, inefficiency, badly targeted public subsidies, and fragmented markets resulted in only one Colombian in five having any protection against the financial risk of health shocks from serious illness. Moreover, only those with more financial resources could afford to join social security schemes or pay out of pocket for health care. Households contributed a significant portion of health care financing, and cost was the most significant barrier to health care, with only one individual in six who fell ill seeking medical care.

Law 100 of 1993 mandated the creation of a new national health care system with universal health insurance coverage and reorganized financing and delivery. A key feature of this law was that public subsidies would go directly to individuals rather than to institutions. The effects of the changes on the overall framework of social health protection are shown in table 4.7.

Table 4.7: Summary of Health Financing Approaches in Colombia

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	Contributory scheme (RC)		Subsidized scheme (RS)	RC if able to contribute (over US\$170/month), otherwise RS	
Coverage (number)	RC—21.5 million (2007)		RS—18.2 million (2007) Eligibility determined through proxy means test		
Coverage (% of population)	50		42		
Source of revenue	11% of payroll		For RS, national and local tax revenue and 1.5% payroll tax (solidarity contribution from RC)		
Revenue collection method	Submitted by employers to Social Security Fund (SSF) Insurers paid US\$244/person/year, on average		National and local governments and employers (for solidarity contribution—to SSF); insurers paid US\$137/person/year, on average		
Number of risk pools	Subscriber choice of 21 insurers		Subscriber choice of 43 insurers		
Payment methods	Contracted providers paid mostly capitation for primary care and preventive services, fee-for-services, or case-based for specialist care		Contracted providers paid in the same way as RC Public providers funded through historical budgets to provide services not covered by RS benefit package or to the uninsured		
Benefit package	RC—comprehensive benefit package including all levels of care		RS—low-complexity care, catastrophic illness, only limited coverage for most hospital care, no short-term disability coverage		
Facility coverage	Insurers that contract with a network of public, private, or own service providers (owned by the insurers) Insurers in RS that must contract with public providers for at least 40% of premiums				
Regulatory oversight	Premiums and benefits that are determined by the government; insurers that compete on quality				
Other insurance schemes	Partial subsidy scheme for those who do not fully qualify for RS; separate plans for police and military and some other groups (5% of population)				

Source: Author.

The reform introduced four main elements to reach the poor:

- Having a proxy-means testing to target public health subsidies to the neediest (SISBEN, or Selection System of Beneficiaries for Social Programs)
- Transforming traditional supply-side subsidies, which financed the public health care network, into demand-side subsidies, which subsidize individual insurance premiums for the poor
- Having an equity fund in which revenue from payroll contributions and treasury resources cross-subsidize insurance premiums for the poor
- Contracting for health service delivery from both the public and private sectors

The new system is a universal health insurance coverage plan with two schemes:

- A contributory scheme (RC) to cover formally employed and independent workers who contribute to the scheme, with contributions collected by the insurer of choice
- A subsidized scheme (RS) to cover the poor and indigent individuals who could not afford to make any insurance contribution

Payroll contributions go into a national health fund with four separate accounts. The fund finances insurance premiums for all enrollees in the RC. In the RC-RS cross-subsidization process, a share of the contributions is allocated to finance the RS, together with treasury transfers to the territories. Those who are eligible for enrollment in the RS but are still uninsured are to rely on public hospitals for care.

Every insured individual is free to choose an insurer and to consult any provider in the insurer's network. Both schemes have a basic benefits package, but the RC package includes every level of care while the RS package has to be complemented with services provided by public hospitals and financed through supply-side subsidies. The design provides that the supply-side subsidies would be turned into demand-side subsidies (financing services provided rather than inputs) over time to achieve universal insurance coverage with the same package in both schemes.

The reform increased financial protection for all, but especially for the poor and rural population. For Colombians as a whole, financial protection increased from 23 to 62 percent, but insurance coverage among the poorest group increased from 9 to 49 percent, compared with a much smaller increase from 60 to 82 percent for the wealthiest group. Formal insurance in Colombia reduced out-of-pocket expenditures on ambulatory care by between 50 percent and 60 percent. The poor in the RS spent about 4 percent of their income on ambulatory care, but the uninsured poor spent more than 8 percent.

Out-of-pocket expenditures on hospitalization among the uninsured poor absorbed more than 35 percent of their income in 2003. The poor in the RC spent a smaller proportion of their income on inpatient care than the poor enrolled in the RS. Further, a health shock requiring hospitalization pushed 14 percent of those hospitalized and uninsured below the poverty line compared with only 4 percent of inpatients covered by the RS. Access to preventive care was also improved.

Despite positive results, the Colombian social insurance scheme has been criticized for not having achieved universal coverage and for financing a less comprehensive benefits package for the poor (RS) than for the wealthy (RC). The slower-than-planned transformation in changing supply-side subsidies (which finance public hospitals) into demand-side subsidies so they finance health insurance for the poor has also come under fire for slowing down the expansion of the RS benefits package. The key messages from the Colombian experience are summarized in box 4.7.

Box 4.7: Key Messages from Colombia

- Explicit cross-subsidies can be an effective way of financing the poor, but financing from government will still be required.
- Different benefit packages for contributory and subsidized plans can help to contain costs but may be attacked on equity grounds.
- Health insurance improves access to both curative and preventive services and reduces both out-of-pocket and catastrophic health-related payments.
- Long transitions from supply-side subsidies to performance-based payments can be problematic—a more direct and immediate approach may be preferable.
- Existing or consistent mechanisms for identifying the poor should be used if possible.

Mexico⁸

Mexico established social security institutions for formal private and public employees some time ago, but the poorer half of the population faced problems with access to services, quality of care, and affordability. There was a great risk of impoverishment because of health spending: 2 million to 4 million households spent 30 percent of their annual disposable income on health. In 2000, a new health insurance program, Seguro Popular (SP), was introduced for those not covered by existing plans. As a voluntary program, it provided beneficiaries with subsidized insurance coverage comparable to formal sector plans. Table 4.8 shows the key features of the various plans.

Table 4.8: Summary of Health Financing Approaches in Mexico

Dimension	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment scheme	Social Security Institute for Government Workers (ISSSTE)	Mexican Social Security Institute (IMSS)	SP—state governments to identify and enroll	SP	
Coverage (number)	9.6 million	42.6 million	41 million		
Coverage (% of population)	9	40	42		
Source of revenue	8% of payroll (2% worker, 6% employer, plus US\$11.10/month from government)	8% of payroll (2% worker, 6% employer, plus US\$11.10/month from government)	Government revenue	Premiums (waived for first two income deciles, US\$56 for decile 3, rising to US\$887 for decile 10) plus national and state government revenue	
Revenue collection method	Employers and government pay to ISSSTE	Employers and government pay to IMSS	Premiums and government funding collected by state health insurance agencies		
Number of risk pools	One	One	32—one per state		
Payment methods	Capped budgets	Diagnostic-related groups for inpatient, capitation for outpatient	Capped budgets		
Benefit package	Extensive package	Extensive package	266 primary/secondary plus 17 tertiary interventions		
Facility coverage	Own network: 1,123 primary health care units and 95 hospitals	Own network: 1,077 primary health care units, 215 general, 41 specialty hospitals	Specified institutions, mostly state government facilities, plus tertiary care at a network of higher-level tertiary care institutions operated by the federal and state governments		
Regulatory oversight	Part of overall ISSSTE scheme Board includes government and worker members	Part of overall IMSS scheme tripartite board—labor, management, government	Separation of insurers (payers) and providers at state level, leading to active purchasing with nonpublic providers		

Source: Author.

The health ministries of Mexico's 32 state governments are responsible for identifying, enrolling, and serving eligible SP participants. SP was designed to focus on the poorest families first. Premium payments are subsidized on a sliding scale, and families from the poorest quintile do not pay. Participants are entitled to treatment at no additional cost through some 250 interventions at specified institutions (mostly state government facilities). SP participants are also eligible for 17 interventions at a network of higher-level tertiary care institutions operated by the federal and state governments. The gap between premium revenue and the program's total cost is covered by government subsidies. Most of the subsidies come from the federal to state governments, with federal funding covering 83 percent of the premiums. There is also equalization between states. The program has required significant increases in federal government resources allocated to health. Between 2004 and 2008, government health expenditure increased about 23 percent in real terms, while health spending as a percentage of GDP rose about 13 percent.

The program design includes three related measures to increase the focus on the poor. First, premium rates are graduated by economic status, with exemptions for the poor. Second, mechanisms are in place to identify poor families and to determine premium subsidies or exemptions. Third, there is a system for paying implementing agencies that gives them an incentive to focus on enrolling poor families. Families pay up to 5 percent of disposable income (defined as total spending after basic needs are covered). Further down the economic ladder, the premium falls and the government subsidy rises. Identification of the poor uses mostly existing proxy-means test programs at the discretion of the state. About 40 percent of those enrolled are in the poorest quintile, compared with less than 3 percent in the population's richest quintile. Thus, Yazbeck (2009, 252) notes that the SP program is very pro-poor. SP participants in need of health services were significantly more likely to obtain them than were those who did not participate.

Challenges for the SP program include the ongoing commitment and requirement for federal funds, and ways to encourage those above the poorest income quintile to pay the premiums required to participate in SP. Those people will constitute an ever-increasing proportion of the additional people who will have to be enrolled in the coming years if SP is to meet its objective of universal care. Box 4.8 highlights the main takeaway messages from the Mexico experience.

Box 4.8: Key Messages from Mexico

- Substantial and sustained government financing will be needed to cover the poor.
- It is a challenge to get those above the lowest income quintile to pay premiums.
- Different benefit packages for contributory and subsidized plans can help to contain costs but may be attacked on equity grounds.
- Capped budgets and case-based payment methods can help control costs.
- Existing or consistent mechanisms for identifying the poor should be used if possible.

Summary of Lessons from International Experience

This section summarizes the lessons learned from international experience by organizing the specific lessons from each country into the key health financing functions of the collection of funds, the pooling of risks, and the purchasing of services, as well as the various regulatory issues.

Regulation and the Political Environment

Thailand shows that rapid scale-up of health insurance is possible if political will and popular support exist. However, it must be planned and executed properly. This lesson can also be drawn from Rwanda, where we learn (a) that strong government leadership and vision are essential to the short- and long-term sustainability of such reforms and (b) that strategies must be adapted to a changing macro- and health sector environment. Cultural and social factors, particularly solidarity within communities, also play a role in the acceptability and success of health insurance initiatives, although the initiatives are quite difficult to influence, which suggests that the health insurance approach selected must be adapted to such factors rather than the other way around. However, the Rwanda example also shows that any health insurance initiative must be supported by a strong regulatory framework at all levels. The China case reinforces the need for strong central regulation to ensure consistency in administration and delivery at the local level, and the Kenya case shows that the regulatory framework must include independent and transparent institutions. The Vietnam example shows that there can be efficiencies from shared administration between health and other social insurance programs.

Various case studies, including Colombia, Ghana, Kenya, Mexico, and Rwanda, show that reaching the poor requires special efforts or approaches. The Colombia and Mexico examples suggest that, where available, existing mechanisms should be used for identifying the poor and that those mechanisms should be applied in a consistent manner. The Kenya case study shows that protection of the poor requires careful planning, including the identification of the poor, incentives for providers to treat the poor, and funds to enable premiums for the poor to be covered. The Rwanda example shows that provisions are needed for financial protection and other support for indigent populations.

Revenue Collection

The Colombia example shows that explicit cross-subsidies can be an effective way to finance the poor but that financing from government will still be required. This message also emerges from the Mexico example, where substantial and sustained government financing is needed, especially because it is a challenge to get those above the lowest income quintile to pay premiums. The Ghana example suggests that expanding the revenue base through earmarked taxes (for example, VAT) can be an effective strategy for ensuring financial stability and coverage of the poor, but that it is essential to match the revenue received to the benefit package.

From Thailand we learn that although a rapid scale-up is possible and additional financing will be needed to cover the poor, this approach should not necessarily increase total health expenditures. Rwanda is a good example of the mobilization of donor financing to support prepaid health insurance. However, it also shows that government coordination of donor funding is critical to ensure that aid is used effectively and aligned with national priorities.

In terms of improving revenue collection, the Vietnam example shows that the reach of the formal national health insurance organization can be extended by employing community-based contractors to collect premiums.

Pooling

The Colombia example shows that health insurance improves access to both curative and preventive services and reduces both out-of-pocket and catastrophic health-related payments. Those results are echoed by the other case studies.

From the Ghana example, we learn that although small, district-level risk pools are politically attractive, the realities of health insurance operations require specialized expertise in revenue collection, contracting, and claims management. The results are consistent with the experience in Tanzania with respect to CHF/TIKA. The China example teaches us (a) that risk pools and administration at lower levels of government require capacity at that level and (b) that smaller risk pools can be problematic in terms of sustainability. Issues related to the identification of the poor, the coverage of their premiums, and the inclusion of the poor in the risk pool are all important in the overall consideration of risk-pooling arrangements. Examples from Colombia, Ghana, Kenya, Mexico, and Rwanda all underscore this message.

Purchasing

The China example shows us that there is value in starting with a small benefit package and increasing both the benefits and funding on the basis of consumer demand. Different benefit packages for contributory and subsidized plans can help to contain costs but may be attacked on equity grounds. This approach is used in a number of countries, including China, Colombia, Mexico, and Thailand. However, regardless of the approach chosen, the Vietnam example and that of other countries show that it is essential to match the benefit package to available revenue.

In terms of purchasing methods, Ghana, Thailand, and Vietnam all show that the use of fee-for-service payment methods should be avoided if at all possible, particularly for informal sector schemes where premiums are lower. Further, as demonstrated in Mexico and Thailand, capped budgets and case-based payment methods can help control costs. However, the example of Colombia shows that long transitions from supply-side subsidies to performance-based payments can be problematic and that a more direct and immediate approach may be preferable. Regardless of the payment methods chosen, the Kenya and Rwanda examples suggest that development partner support should follow the shift from input- to output-based financing.

Service Provision

The experiences of Thailand and other countries suggest that it is essential to plan for the utilization growth resulting from the introduction of expanded health insurance coverage. Further, the Kenya example indicates that the functioning and efficiency of the health system must be addressed as an essential element of any scale-up strategy if one is to ensure that maximum value is obtained from the funds that already exist in the system. This example also suggests that conflicts of interest from having the MoH as both regulator and provider must be addressed. From Ghana, we learn that independent

controls and quality checks are essential for monitoring and evaluation of health facility performance. Finally, the Vietnam example indicates that there should be a place for both public and nonpublic providers within a national health insurance arrangement.

These various lessons should be borne in mind as health financing options for Tanzania are examined in more detail in the next chapter.

Notes

1. For further details, see appendix A.
2. For further details, see appendix A.
3. For further details, see appendix A.
4. For further details, see appendix A.
5. For further details, see appendix A.
6. For further details, see appendix A.
7. For further details, see appendix A.
8. For further details, see appendix A.

Key Policy Issues and Reform Options

We summarize the analysis as follows:

- Special efforts are required to reach the poor because they cannot afford services and often cannot afford prepaid health insurance.
- Such special efforts to serve the poor and other members of the informal sector require incremental subsidies.
- Such incremental subsidies can increase public spending by as much as 1.0 to 1.8 percent more than existing levels expressed as a share of GDP, although this percentage can be largely offset by reductions in out-of-pocket payments.
- Capped, capitation, or case-based approaches or a combination are essential for cost control; fee-for-service should be avoided if at all possible.
- If a country is to maintain a sustainable system, it is critical to match benefits to revenue, even if this approach means starting with a small benefit package or different packages for different groups.
- Given the fiscal transfers required and the redistributive effect of major health financing reforms, political leadership is essential, as shown in the Ghana and Thailand examples.
- Given the need for cost controls, a strong regulator is also essential for reform as shown in the Rwanda and Thailand examples.
- Although small risk pools can enhance community ownership, the Ghana and Rwanda examples show that they can also create sustainability problems and administrative capacity issues, unless explicit cross-subsidization or reinsurance mechanisms or support systems such as consolidated revenue collection or claims management are put in place.

It is clear that health reforms require tradeoffs that must be acceptable to the majority of the population. For example, meeting the goal of enrolling 45 percent of the population by 2015 requires confronting the costs of identifying, registering, and serving the informal sector and the poor. Increasing enrollment in those groups will require raising the awareness and understanding of the concept of risk pooling and insurance generally, as well as building trust in the institutions that offer insurance so that those who sign up are confident that the benefits offered will be received when needed. It is also likely that a broader range of benefits will need to be offered, especially low-use and high-cost services such as inpatient care, because the attractiveness of the CHF benefit package is limited by the relatively low cost of primary care.

Public and political support is required in other areas as well, whether it is (a) offering different benefit packages for the formal and informal sector, (b) accepting increased autonomy for health care providers and allowing “money to follow the patient,” or (c) simply committing to the fundamental requirements of expanding coverage (for example, increased funding and effort). Therefore, although a number of options or suggestions are put forward, they need to be carefully reviewed to determine what is acceptable within the Tanzanian context. This review will be an important next step in the development of the overall Health Financing Strategy.

Areas to be Considered in the Health Financing Strategy

With these words of caution in mind, a number of measures can be taken on the revenue and expenditure sides to improve health financing in Tanzania. This section considers the five health financing functions discussed above (service provision, purchasing, pooling of funds, revenue collections, and regulation and the political environment).

Service Provision

Three critical areas must be addressed on the service provision/expenditure side. First, existing inefficiencies and inequities in the health system must be reduced. Inefficiencies include (a) productivity losses caused by absenteeism and other factors, (b) supply chain problems, and (c) the uneven distribution of resources. The potential effect of cutting the inefficiencies is large. For example, Kurowski and others (2003, 34–36) estimated that the productivity of front-line health workers was 57 percent, with patient productivity at only 37 percent. The potential productivity gain was 26 percent, which could translate into another 20 million outpatient visits on the basis of Tanzania’s current outpatient utilization. As noted in chapter 3, the CAG report showed significant variation in staff productivity, with 80 percent of facilities seeing 10 or fewer patients per front-line health worker per day, thus suggesting excess capacity despite the overall lack of staff members in Tanzania (NAO 2008, 19).

The Joint External Evaluation reported that “all [health facilities] still experience major delays in supply. In all visited regions and councils, the situation in hospitals has not improved as much as in [health centers] and dispensaries” (Denmark, Ministry of Foreign Affairs 2007, 69). This situation persists. For example, a report of the meeting of the Technical Committee of the Sector-Wide Approach (TC-SWAp 2011, 2) on February 9, 2011, stated, “Health facilities have been experiencing stock-outs of essential medicines and medical supplies attributed by delayed delivery, nondelivery of right quantities, and delivery of expired products or almost expiring.” Added to those issues are the current inequities in the distribution of resources. For example, in fiscal 2010, the ratio of per capita budget allocations between the highest and the lowest funded regions was 2.6:1 (JAHSR 2010, slide 7-8 and author’s calculations).

The CAG performance audit indicates that facility allocations for drugs and medical supplies are unrelated to the number of patients seen, with the average allocation per patient ranging from T Sh 51 to T Sh 1,218 (US\$0.03 to US\$0.81) (NAO 2008, 20). The findings suggest significant potential for both stock-outs in some facilities and excess drugs in others, leading to wastage if drugs expire before they are used.

The examples suggest that efforts to improve efficiency could increase the value and quantity of health services by 25–30 percent. This finding is consistent with the findings of the World Health Report (WHO 2010, xvii). If the lower end of this range of efficiency

gains could be achieved, this accomplishment would create savings of T Sh 150 billion (US\$100 million) of the government's resources and T Sh 240 million (US\$160 million) in total. Because both the causes and the potential remedies are already well known, what is needed now is both detailed planning and renewed commitment by all stakeholders to addressing efficiency issues. The elements should be reflected in any comprehensive health financing strategy.

A second area of efficiency gains on the service provision or expenditure side is the need to review the management and governance structures of health facilities. Effective management and accountability structures are essential if any of the efficiency gains mentioned in the previous paragraphs are to be realized. In terms of other health financing options, the ability of individual managers and health facility boards to respond to the challenges and opportunities of "money following the patient" will be closely correlated with the success of these options. This approach means that oversight structures, including the MoHSW, Ministry of Finance, PMO-RALG, President's Office–Public Service Management, regions, and districts, will all need to be prepared to let go of some of their current role in day-to-day management of health care service delivery at the facility level and to shift from "rowing" to "steering" the health system.

Day-to-day decision making—including some control over staffing, allocation of funds to different types of expenditures, and even hours of operation—must be left to health facility managers and their board structures. Only by making this shift can facilities respond to the decisions made by patients enrolled in prepayment schemes regarding where they obtain their care. Facilities that offer better services and are consequently preferred by patients should be able to respond to patient demand by changing their staffing mix or opening hours or by providing performance bonuses to their staff members.

A third area of service delivery or expenditure is mechanisms for the allocation of drugs and medical supplies to facilities, so that the distortions mentioned in the CAG report do not continue. Those issues will become more important over time, as more people register with prepayment schemes in the expectation that drugs and medical supplies will be available.

Lack of supplies at lower level public facilities deters CHF membership. Therefore, mechanisms need to be developed to translate the registrations into the availability of drugs and medical supplies. As a minimum, the allocations to facilities for the supplies should be related to the workload: either the number of patients seen or the number of patients registered with the facility, or a combination of both. One approach may be to extend the concept of the matching grant to drugs and to medical supplies as well, so that each person or household registered with a CHF would generate an allocation to his or her home facility (either an actual funding transfer or notional allocation that can be drawn upon). This allocation would be similar to the "fund-holding" approach that has been used in Latvia and the United Kingdom.

The small size of risk pools (individual facilities) could increase costs, but this situation could be mitigated by establishing a mechanism that would enable facilities to continue to get drugs even if their allocation was exhausted. There would also need to be the opportunity to top up the allocation from the central budget with the facility's own resources, whether from user fees, CHF prepayment revenue, Health Basket Fund allocations, or other sources. This approach implies a much more interactive relationship between health facilities and the Medical Stores Department, in terms of both the flow of

funds and the ordering and delivery of supplies. Of course, in addition to incorporating such provisions into the mechanism for financing drugs and medical supplies, health facilities would also need to have the discretion to make such allocations, which links this issue directly to the one of management and governance discussed earlier. They would also need their own bank accounts so that they could readily access the available funds.

Purchasing

The case studies show that fee-for-service models should be avoided if possible. In the current health financing structures, neither the CHF nor the NSSF use this approach, whereas the NHIF does. Yet the NHIF represents the largest insurer in terms of both population coverage and funding. It is, therefore, important (a) to evaluate how alternatives to fee-for-service could be implemented within the NHIF, as well as other insurers, and (b) to develop action plans for shifting to an alternative approach over time. Although this approach would generate significant resistance from providers, international experience shows that moving away from fee-for-service is an important element in ensuring the long-term sustainability of the health financing system.

Similarly, the effect of the per diem system used by the NHIF for inpatient care should be evaluated, and the feasibility and potential benefits of moving to case-based reimbursement should be reviewed. Following this examination, a decision should be made about whether to use per diem or case-based reimbursement for inpatient hospital services, and an appropriate action plan should be developed. Considerations here would include not only the incentives for over-provision of care inherent in the per diem system and the extent to which the incentives affect care, but also the ability of facilities providing inpatient care to cope with case-based approaches. Appropriate regulations and administrative mechanisms would be needed to ensure cost containment and to set suitable tariffs for both public and private facilities. Although a diagnostic-related group system such as those used in Europe and North America is probably not feasible, there are examples of more simple systems such as the one currently used in Ghana or that in Bulgaria (Georgieva and others 2007, 101–3). The incentives inherent in case-based systems (re-admission, unnecessary admission) would also need to be considered.

Risk Pooling

The risk pools in the current health financing system are fragmented, with different schemes for the formal public sector, the formal private sector, and the informal sector. In addition, the current government contribution to prepaid health financing currently goes to those who are relatively better off than the general population. In this section, options are explored for reducing this fragmentation and for directing government funds to areas where they more clearly benefit the poor and vulnerable.

As the largest single risk pool, the NHIF can serve as the anchor of any new risk-pooling regime. However, for it to assume this role, its revenue and expenditures need to be rationalized. Currently, the sum of the benefits paid plus administrative costs is only 35 percent of the premium revenue collected. Although benefits could be increased, this approach would have a distortionary effect relative to other schemes, perhaps leading to a situation such as that in Thailand, where the benefit packages for the formal sector schemes are significantly more generous than the universal scheme, with resulting budget pressures and inequities. Even with the recent increases in the payout percentage, the matching contribution is not required to provide current benefits.

One approach would, therefore, be to change the NHIF to a subscriber-only financed scheme, with a contribution rate of 2.5 percent of salary. Subscribers would, therefore, save 0.5 percent of salary, while the government would save its entire contribution (about T Sh 47.4 billion in 2010/11), which could be applied to matching funds to help support the expansion of CHF membership. Although this application would still provide the NHIF with a bit of a cushion to absorb future utilization growth, the NHIF would need to strictly control its operating costs and to stop financing noninsurance-related activities (for example, purchasing equipment and financing renovations) out of operating income.

There are significant needs for improvement in health infrastructure and other HSS investments. The NHIF currently makes some of these types of investments, but the efforts are problematic in two respects. First, they are not strictly related to the core business of the NHIF, which is providing prepaid insurance to its subscribers. Second, the extent to which the investments are coordinated with the government's overall HSS efforts is not clear. Thus, while funding such investments out of operating funds is not advisable, the accumulated surplus represents a unique opportunity to support the overall HSS initiative, thereby improving health facilities for NHIF members and non-members alike. One way to do this would be to redirect T Sh 250 billion of the estimated T Sh 300 billion in accumulated surplus toward a special Health System Strengthening Account within the NHIF, which could help finance the improvements and expansion of the health system that will be needed to accommodate improved insurance coverage. Planning for the use of the funds could be done through a joint process that would include the NHIF, the MoHSW, the PMO-RALG, the development partners, and other stakeholders. The account could also receive contributions from other sources, including development partners. Such an account would represent a significant legacy by past and current NHIF members to the health system as a whole, as well as a tribute to the first 10 years of NHIF operations.

The remaining T Sh 50 billion would still be sufficient to cover 2.5 years of claims at current expenditure levels and should represent a suitable reserve, given that the NHIF is backed by the government and is a going concern. It is worth noting that established health insurance funds, such as that in Estonia, have reserves of just 8 percent of revenue, "legal reserves of 6 percent of its budget, and risk reserves of 2 percent" (Gottret, Schieber, and Waters 2008, 244).

The prepayment scheme for the formal private sector is currently being run by the NSSF as one of the seven benefits that it provides. A review of the pension system done by the World Bank determined that the current pension system was unsustainable in its present form and that significant reforms would be needed. One option is to separate the financing of the pension and non-pension-related benefits. For the NSSF, this option would include the health insurance benefits (SHIB). The latest actuarial review of the NSSF determined that the current SHIB could be financed through 2.5 percent of payroll, which is consistent with what has been proposed for the NHIF (see earlier; also see Tanzania NSSF 2010).

Rather than continuing to run the SHIB as a separate program within the NSSF, one approach would be to remove the SHIB from the NSSF and to provide coverage through the NHIF, with a total premium of 2.5 percent of salaries paid by employees. This approach would make the scheme for all formal sector workers the same and should result

in administrative efficiencies, especially if participation in the NHIF was made mandatory for such workers. As noted in the previous section, a review of the provider purchasing approaches should determine which purchasing method is the most cost-effective for different types of care.

The CHF/TIKA is the other main prepayment scheme at present, with a number of issues as described in chapter 3. Initiatives are under way as part of the CHF Action Plan and, through various development partners, to train district-level staff members in health insurance operations, but another option is proposed in this policy note. Overall, it may be more cost-effective and appropriate to have CHFs focusing on community mobilization and raising revenue and to have the NHIF act as the claims processor, card issuer, and funds manager. Such an option will allow both the NHIF and the CHF to focus on their areas of comparative advantage, and the option should increase the value of CHF membership to community members, especially if provisions for portability of benefits between facilities and eventually between districts and regions can be built into the overall structure.

One of the difficulties with the present CHF approach is that the premium payments and benefits vary by district. This variance could be addressed by establishing uniform CHF rates at T Sh 30,000 per household per year for urban members and T Sh 15,000 for rural members. The rates reflect both the differing ability to pay (as measured by average income levels) and the differences in potential benefits that would accrue to urban and rural residents. To justify the new rates, the benefit package for CHF/TIKA would be expanded to include first-level inpatient (for example, district hospital), as well as outpatient care in public facilities. To help offset some of the ability to pay differences, matching funds could be set at different levels, perhaps 100 percent for urban members and 150 percent for rural members. The matching grants could be used to (a) top up the contribution of paying subscribers (resulting in total revenue of T Sh 48,000 per household for urban and T Sh 22,500 per household for rural) and (b) pay the contributions of the lowest 20 percent (urban) or 40 percent (rural) of the population (percentages that are based on the poverty incidence in urban and rural areas).

Savings from the NHIF changes could be used to provide the matching funds. Initial calculations reveal that this provision would be sufficient to achieve 45 percent health insurance coverage for the entire population (see information that follows). As in the current arrangement, the matching grant would be driven by the number of people who voluntarily enroll, but the grant would benefit not just the household that enrolls but other poor households in the same community. This arrangement provides some type of "micro-solidarity" ("if I enroll, some of my poorer neighbors will also be able to be enrolled"), which could help to encourage the overall enrollment efforts, especially if explicit, uniform, and transparent ground rules are in place. The creation of larger, more stable risk pools should help to ensure the ongoing sustainability of the CHF/TIKA-based approach.

Revenue Generation

Special efforts are needed to raise the participation of the informal sector, including subsistence farmers, in prepayment schemes. This need is due to (a) the poverty in the informal and rural sectors, which prevents people from making payments; (b) the high vulnerability to adverse events such as drought and crop failure, which require frequent

use of financial reserves and prevent many from participating in prepaid programs; and (c) the lack of understanding of prepayment schemes and of the benefits of risk pooling.

From the revenue generation standpoint, an important element is the need for flexible payment approaches for CHF/TIKA membership, which reflect the irregular income patterns of informal sector workers and subsistence farmers. In addition, there is a need for a significant amount of awareness raising and communications regarding the changes and the benefits that can be obtained by enrolling in a prepayment scheme (as well as the concept of risk pooling) to ensure there is an appropriate understanding of how funds will be managed and used. This scheme should be an essential element of the overall implementation of the Health Financing Strategy.

Another potential revenue generation option would be to use budget funds to subsidize premiums for the informal sector and the working poor, thereby allowing them to enroll in prepayment schemes and leveraging existing budget resources to promote access to services. If one is to finance outputs rather than inputs and to have the money follow the patient, it should be possible to obtain better value from the funds that are already spent in the health sector and to encourage the efficiencies and quality improvement mentioned in the section on service provision. Health providers would get paid only when they provide services or encourage subscribers to sign up with their facility, so this approach to financing should encourage health facilities to provide high-quality services. Of course, the changes in the management and accountability structures mentioned earlier would need to be in place to allow providers to respond to those incentives. Complementary pay-for-performance schemes at the health worker level—such as those currently being piloted—could also be useful in promoting effective use of service and improved quality.

Despite improved efficiency and the rationalization of existing revenue sources, including the NHIF, the health system will likely require additional funding at some point. It would, therefore, be useful to look at other sources of sustainable financing for the health sector. Although the discussion on fiscal space concluded that there would be limited capacity for increasing government funding for health care, the realities of improving social health protection clearly indicate that additional funding will be needed. Other countries have looked (a) at targeted taxes such as “sin taxes” on cigarettes and alcohol or (b) at earmarking a specific proportion of particular taxes to support sustainable social health protection improvements.

As noted earlier, Ghana currently allocates 2.5 percentage points of the VAT to the NHIS, and the amount generated goes up automatically when spending on goods and services increases. The VAT revenue is the major source of funding for the NHIS. Similarly, Latvia allocates a fixed proportion of income tax to the health insurance scheme, which does not charge premiums to subscribers. In the Tanzanian context, 2.5 percentage points of the VAT is equivalent to approximately T Sh 200 billion, which would go a long way toward ensuring universal health coverage for the population. Further, as seen in figure 3.8, the VAT is progressive in Tanzania and would not place the entire burden on the formal sector. Any revenue raised through this source could help increase coverage, starting with the poor.

Finally on the revenue side, there is a need to review user-fee policies to better target the poor for exemptions, waivers, or premium subsidies. User fees are currently a significant source of discretionary revenue for health facilities, but they are also clearly a major barrier to accessing care, especially for the poor for higher-level services (see

figure 3.11). It is, therefore, essential that the effect of user fees on the poor be mitigated as much as possible, but such fees should also be set to promote enrollment in prepaid schemes by those who are not exempted. Other countries have put in place clear and transparent means to identify the poor (such as using existing targeting mechanisms for social benefits in China, Colombia, Mexico, and Vietnam). Similar approaches need to be considered in Tanzania. The new National Social Protection Framework, as well as the conditional cash transfer scheme currently being piloted under the Tanzania Social Action Fund, provide both an opportunity and some potential lessons for developing harmonized targeting mechanisms, which should then also be used to identify the poor and near-poor for premium waivers or subsidies.

It is also important that exemptions and waivers be “revenue neutral” to the facility, so that a facility’s financial position is not adversely affected by applying the user-fee policy appropriately. This approach means that—to the extent that user fees are retained as a means of raising revenue—facilities should be compensated for the exemptions and waivers that they provide. Of course, this plan would require both objective, verifiable criteria to be used and ex post verification to be performed. Because exemptions and waivers are part of the overall social protection system, this compensation should be provided by the government, possibly through the reallocation of existing resources (again shifting from financing inputs to outputs) or with the support of development partners. The role of user fees in an environment of increasing prepaid health insurance coverage also needs to be determined.

Regulation and the Political Environment

A comprehensive regulatory framework must be in place to govern the health financing system. Although the SSRA Act has been passed and a director has now been appointed, the extent to which this authority will interact with the health sector in general and health insurance in particular (either public, private, or both) has yet to be determined. The Technical Working Group on Health Financing is conducting further analysis of the regulatory framework, including the following areas:

- Premiums and subsidies
- Reserve requirements and investment regulation
- Contracting, including the selection of providers
- Benefit package determination, tariff setting, and provider payment methods
- Licensing, accreditation, and governance for health providers
- User-fee levels, waivers, and exemptions

The various provisions should be integrated into a comprehensive and mutually supportive framework of legislation to guide the overall operation of the health financing system.

A critical element of health financing reform is political commitment to change. Such political leadership was instrumental in the successes of some of the case studies in chapter 4, especially in Ghana and Thailand. As shown in figures 3.9 through 3.11, some elements of society are benefiting more than others from the status quo, which means that any changes to increase equity and coverage could be seen as coming at the expense of those who are currently benefiting. For example, even though the funding that is currently being raised is not used for providing health services, the potential changes identified for the NHIF may be seen by some members as making them worse off. Therefore,

it is clear that garnering the appropriate political commitment is a critical element of any health financing strategy.

Economic and Financial Impact of Reform Options

Some of the reforms described here were assessed using a “scaling up” model developed in the SHIELD project.¹ Three options were simulated using the model.

First, a status quo option was calculated based on the assumptions that (a) there would be no major changes in the parameters of health financing, and (b) there would be no significant initiatives to encourage enrollment in prepaid schemes. This option therefore shows the effect of population growth alone on the demand for health services. This information provides an important baseline because the population is expected to grow by 51 percent or 22 million people between 2010 and 2025, reaching 65.3 million by 2025. This option also assumes that the current efforts at HSS—including investments in the development of health human resources, M&E, and infrastructure—would be sufficient to accommodate the growth in population and services. Such efforts are expected to cost T Sh 843 billion over the projection period, with most of the investments front-loaded into the first five years of the simulation. Of the total amount, T Sh 321 billion is expected to be provided by income from foreign donors, including the Global Fund, the United States, Canada, the Netherlands, Norway, and Japan, while T Sh 250 billion is expected to be provided from the NHIF surplus, and the balance (T Sh 272 billion) would come from the government’s contribution to the MMAM and other infrastructure development.

A second simulation was done to determine the financial and utilization effect of reaching the stated objective of covering 45 percent of the population with prepaid health insurance by 2015. This “45 percent target option” (also referred to as Option 1) incorporates the changes mentioned earlier in terms of (a) premium levels and incidence for the NHIF, (b) use of the NHIF surplus, (c) replacement of SHIB, and (d) CHF/TIKA coverage and premium levels.

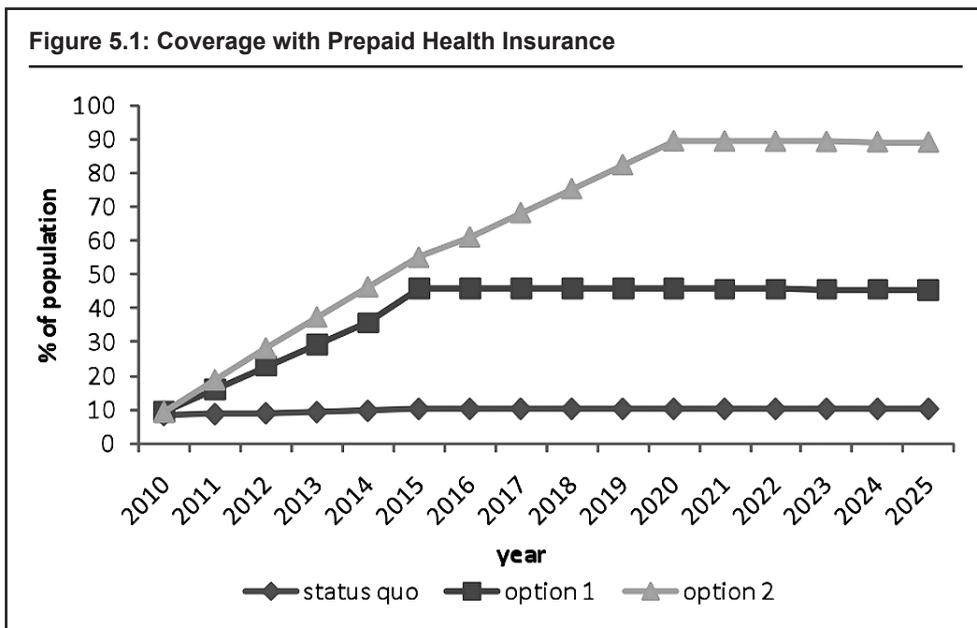
In addition to these changes in the financing parameters, it was assumed that inpatient utilization by CHF/TIKA members would grow as such services are added to the benefit package and that both inpatient and outpatient utilization for NHIF members would grow as the number of accredited facilities increased. Compared to the status quo, this option recognizes that this projected increase in services will require additional investment. Thus, a total of T Sh 1.8 trillion is provided over the 15 years of the simulation (average of T Sh 120 billion per year), essentially extending the level of HSS in the first five years of the status quo option throughout the life of the projection.

Finally, a universal coverage option (Option 2) was run, again using the same basic parameters. However, in this option, it is assumed that the entire informal sector is covered through either the CHF (rural) or the TIKA (urban) scheme, while 77 percent of the private formal sector is covered through either private insurance or the NHIF. The increases in coverage will be phased in over 10 years. Specific utilization assumptions mirror those of Option 1. As will be shown next, this option will generate significant increases in services. To accommodate them, one must assume that the total HSS investment in this option will be T Sh 2.6 trillion between 2011 and 2015, or an average of T Sh 170 million per year.

Each option is assessed using different assumptions regarding economic and government budget growth, with mid-range, low-growth, and high-growth scenarios. For the ease of presentation, the results shown next include only the mid-range and low-growth results, thereby providing an expected and a pessimistic scenario of the economic and financial effects.

Population Coverage

Figure 5.1 shows the expected total population coverage with the three scenarios, assuming a 5-year scale-up for Option 1 and a 10-year scale-up for Option 2. As shown, Option 1 tops out at 45 percent of the total population, while Option 2 reaches almost 90 percent. The status quo option keeps total coverage for about 10 percent of the population throughout the simulation period.



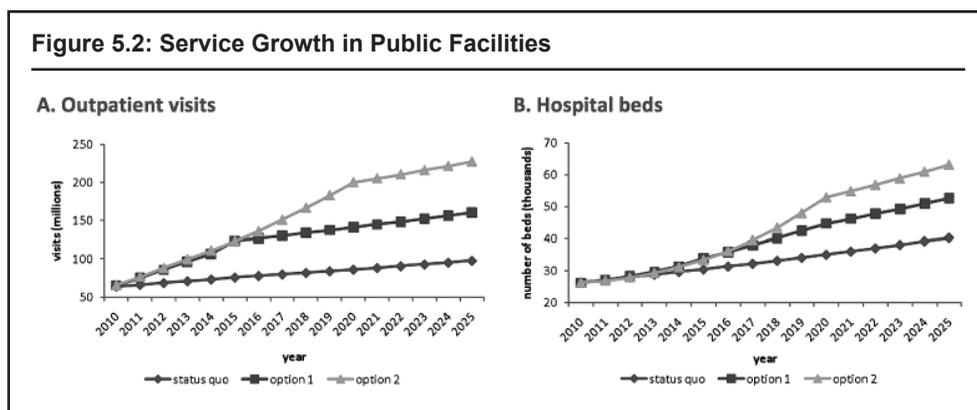
Source: Author's calculations using Ifakara "scaling up" model.

In terms of absolute numbers, enrollment in the NHIF and CHF/TIKA is expected to grow from 2.0 million and 1.5 million in 2010 to 3.2 and 3.3 million for the status quo option, 5.7 million and 23.8 million for Option 1, and 11.3 million and 46.7 million for Option 2.

Health Care Services

Figure 5.2 shows that the total number of outpatient visits in public facilities will increase from 65 million to almost 100 million in the status quo option, 160 million in Option 1, and 227 million in Option 2, while the number of required beds in public hospitals is expected to grow from 26,000 currently to 40,300 in the status quo option,

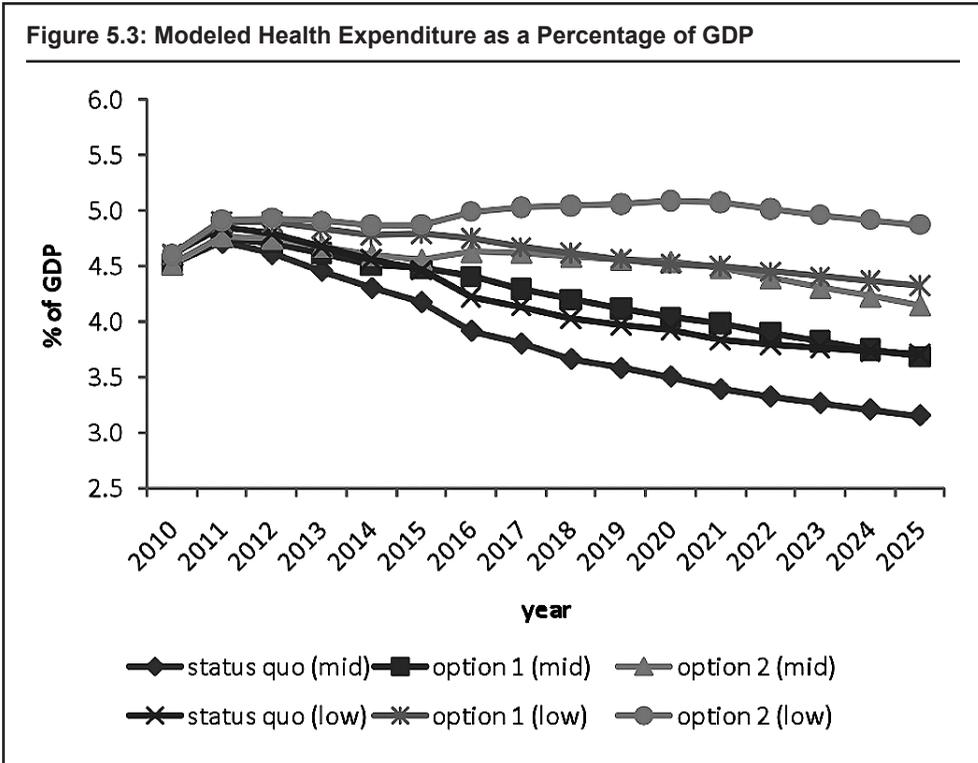
52,600 in Option 1, and 63,200 in Option 2. The number of required beds was estimated using an assumed average occupancy of 70 percent and current average lengths of stay. In each option, there would be an additional 17,200 FBO and private beds, increasing to 25,000 for the status quo option, 22,700 for Option 1, and 19,700 for Option 2. The lower requirements for nonpublic beds in Options 1 and 2 reflect the assumption that the CHF/TIKA benefit package will cover public facilities only. Although it would be possible to use FBO and private facilities for some of the increased utilization, issues such as the higher cost structure of such facilities and the scope for facility expansion would need to be addressed.



Source: Author’s calculations using Ifakara “scaling up” model.

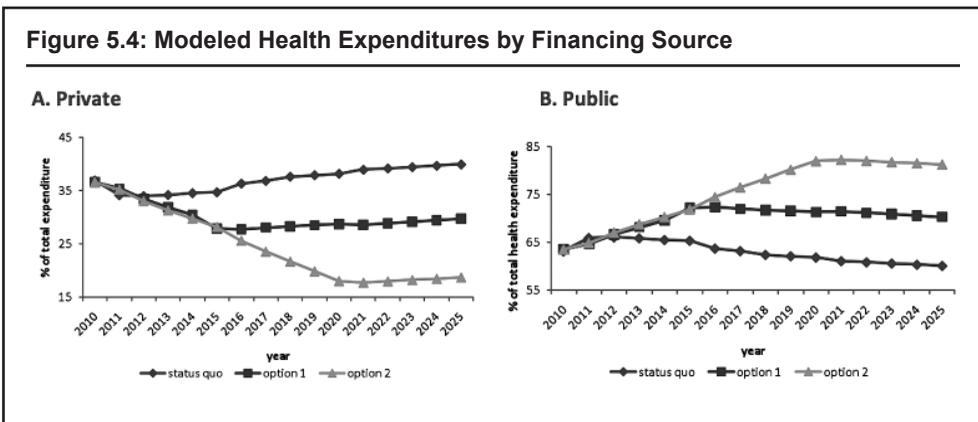
Overall Economic Impact

The total health expenditure covered by the model is estimated at 4.5 percent of GDP in 2010. Because there are expenditures in other areas not covered by the model, such as off-budget donor financing, a direct comparison between this percentage of GDP and the National Health Accounts data is not possible. However, the figures can be reliably compared year over year as shown in figure 5.3. Assuming that current economic growth projections continue, all options show an initial bump in expenditure as the HSS funding kicks in and then a gradual decline in the percentage of GDP spent on the services to a level below 4.5 percent. In fact, even with lower economic growth, all options except for Option 2 result in health expenditures as a percentage of GDP returning to current levels by 2020.



Source: Author’s calculations using Ifakara “scaling up” model.

However, the shift to prepayment schemes with significant support for the poor through the matching grant will greatly reduce direct out-of-pocket expenditure. As can be seen in figure 5.4, private payments are expected to decline as a percentage of total expenditures while public expenditures (including on-budget donor financing) are projected to increase.



Source: Author’s calculations using Ifakara “scaling up” model.

In the status quo option, private expenditure is expected to increase from 37 percent to 40 percent, while public expenditures are expected to decrease from 63 percent to 60 percent. In Option 1, by contrast, private expenditures are projected to decline to 30 percent, while Option 2 estimates that private expenditures will be just 18.7 percent of total health expenditures. The public share is estimated to be 70 percent for Option 1 and 81.3 percent for Option 2.

Government Budget Impact

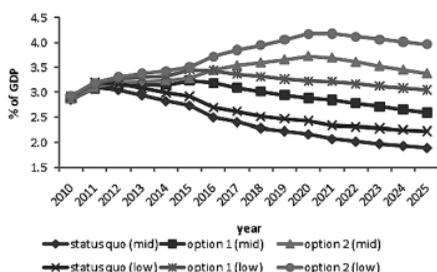
The increasing share of total health expenditures flowing through the public purse is examined next (figure 5.5). The status quo option indicates that despite a slight increase in public health care expenditure as a percentage of GDP and the total government budget as the HSS investments kick in, both the mid-range and low economic growth options see expenditures quickly return to 2010 levels and dip even more throughout the projection period. Public health care expenditures are expected to dip below 2 percent of GDP and 6 percent of government spending, assuming mid-range economic growth, and then to drop to 2.2 percent of GDP and 7 percent of government spending under a lower-growth scenario.

Looking at Option 1, public health care expenditure tops out at 3.5 percent of GDP under the lower-growth assumption and 3.2 percent under the mid-range assumption, while spending as a percentage of the government budget is expected to reach a maximum of 10.8 percent for the lower-growth scenario and 10.1 percent in the mid-range scenario. In both scenarios, spending as a percentage of both GDP and the government budget decreases to close to or below 2010 levels by 2025. As can be seen from figure 3.2, this level of variation is within the range of movement experienced over the past five years or so.

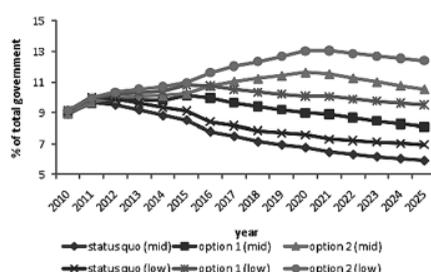
With a significant amount of both service growth and support for health insurance premiums, Option 2 results in higher sustained levels of financing, staying around 3.5 percent of GDP and 11 percent of government expenditure for the mid-range economic growth scenario (average real GDP growth of 6.6 percent) and 4.0 percent of GDP and 13 percent of government expenditure in the lower-growth scenario (average of 5.6 percent). It is worth noting that both of those levels of financing are still below the Abuja targets.

Figure 5.5: Public Health Expenditures as Percentage of GDP and Government Budget

A. Public as share of GDP



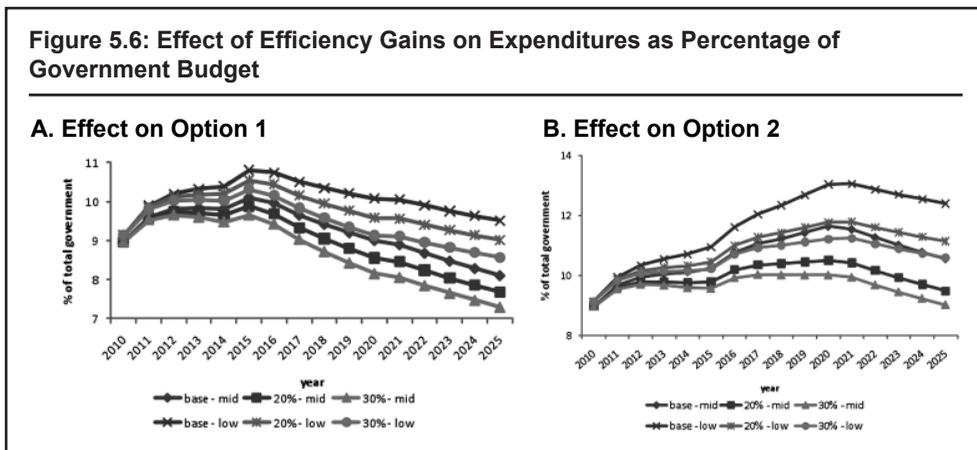
B. Public as share of government



Source: Author’s calculations using Ifakara “scaling up” model.

It has been mentioned frequently that there is significant scope for efficiency gains in the delivery of publicly financed services. Figure 5.6 shows the effect of various efficiency scenarios on health care expenditures as a percentage of the government budget. In Option 1, even a 10 percent efficiency gain will result in expenditures returning to the current level by the end of the projection period on the basis of lower economic growth; this level will be reached by 2018 if mid-range growth is achieved. An efficiency gain of 20 percent will result in current expenditure levels being achieved in 2022 in the mid-range growth scenario and 2017 in the lower growth scenario. Because the health system strengthening and matching grant funds are not affected by efficiency gains, the initial increase in expenditures is inevitable regardless of the efficiencies obtained.

Panel B shows the potential effect of efficiency gains on Option 2. Here both the prolonged HSS requirements and the substantial matching grant requirements limit what can be done, although the effect relative to the base case can still be significant. For example, using a lower economic growth scenario, health as a percentage of government spending would be reduced by up to 1.1 percentage points if 20 percent efficiency gains are achieved and up to 1.6 percentage points if 30 percent efficiency gains are possible. Translated into real numbers, this reduction would mean between T Sh 220 billion and T Sh 315 billion in savings annually once the full efficiency gains were realized in 2020 (a 10-year phase-in period is assumed). Even a 20 percent efficiency gain in a lower growth scenario will result in health expenditures being kept in the 11–12 percent range seen in figure 3.2 for a number of years.



Source: Author's calculations using Ifakara "scaling up" model.

Incremental Costs of Each Option

Table 5.1 highlights the additional costs to the government of Tanzania for each of the two scaling-up options. This finding assumes that the current level of donor support grows by an average of 3 percent annually in real terms and that the already pledged HSS funds materialize. In the absence of specific additional funding commitments, all of the remaining costs are attributable to the government.

Table 5.1: Incremental Costs by Type

	Total for Period (\$ million)			Annual Average for Period (\$ million)		
	2011-2015	2016-2020	2020-2025	2011-2015	2016-2020	2020-2025
Option 1						
Matching Grant	0.0	0.0	41.8	0.0	0.0	8.4
Systems Strengthening	90.7	270.7	390.7	18.1	54.1	78.1
Subtotal Transition costs	90.7	270.7	432.4	18.1	54.1	86.5
Service Delivery	214.6	998.5	1,344.0	42.9	199.7	268.8
Total	305.3	1,269.2	1,776.4	61.1	253.8	355.3
Option 2						
Matching Grant	0.0	132.5	432.1	0.0	26.5	86.4
Systems Strengthening	90.7	421.0	641.2	18.1	84.2	128.2
Subtotal Transition costs	90.7	553.5	1,073.3	18.1	110.7	214.7
Service Delivery	62.6	1,474.0	2,676.6	12.5	294.8	535.3
Total	153.3	2,027.5	3,750.0	30.7	405.5	750.0

Source: Author's calculations using Ifakara "scaling up" model.

This table provides U.S. dollar estimates of both the five-year interval and average annual costs, and it separates the costs for each option into transition costs and service delivery costs, with transition costs including the incremental matching grant and the portion of the HSS costs not covered by donors or other sources. The estimates take into account both the use of the saved NHIF premiums for the matching grants and the use of the excess NHIF reserves for HSS. In the absence of those funds, the funding requirements would be significantly higher.

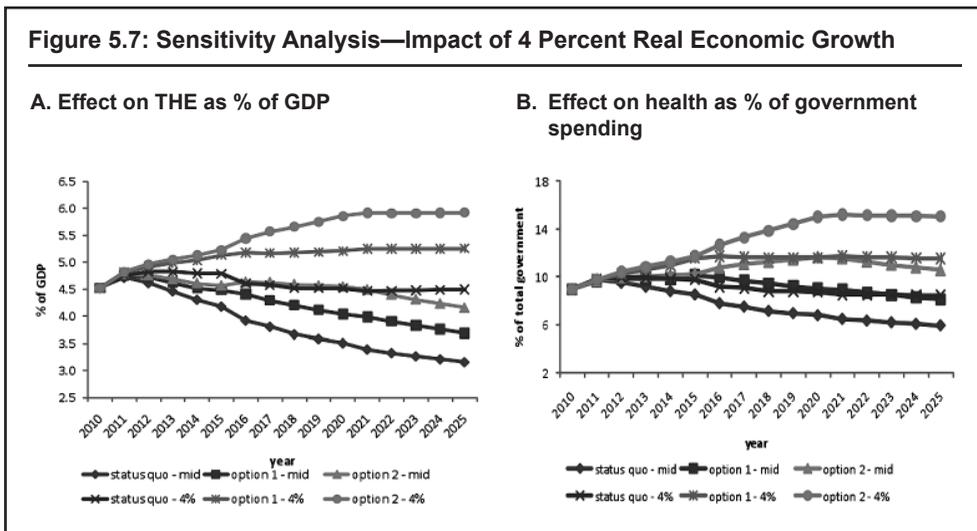
Table 5.1 shows that—even in Option 2—the transition costs for the next five years would be relatively modest, although the use of the NHIF funds is largely responsible for this result. Beyond 2015, annual transition costs increase to an average of US\$54 to US\$118 million per year for Options 1 and 2 until 2020, and then US\$87 million to 215 million per year for the last five years of the projection. Clearly, the "transition costs" do not necessarily have to be borne solely by the government, because both overall development partner interest in increasing financial health protection, as well as the time-limited nature of the investment costs, could make the costs attractive investments for increased donor financing. This approach would help to improve the overall affordability of this option to the public purse.

Sensitivity Analysis

This section presents a sensitivity analysis with respect to economic growth assumptions and real unit-cost growth assumptions.

In the model, economic growth is estimated at 6 percent in 2010, 7 percent in 2011, 8 percent for 2012 and 2013, 7 percent from 2014 to 2018, and 6 percent for the remainder of the projection period. This estimate is referred to as the "mid-range projection." The lower-growth scenario reduces the growth estimates by one percentage point below the mid-range level each year. For the purposes of this sensitivity analysis, real economic growth was set to 4 percent per year.

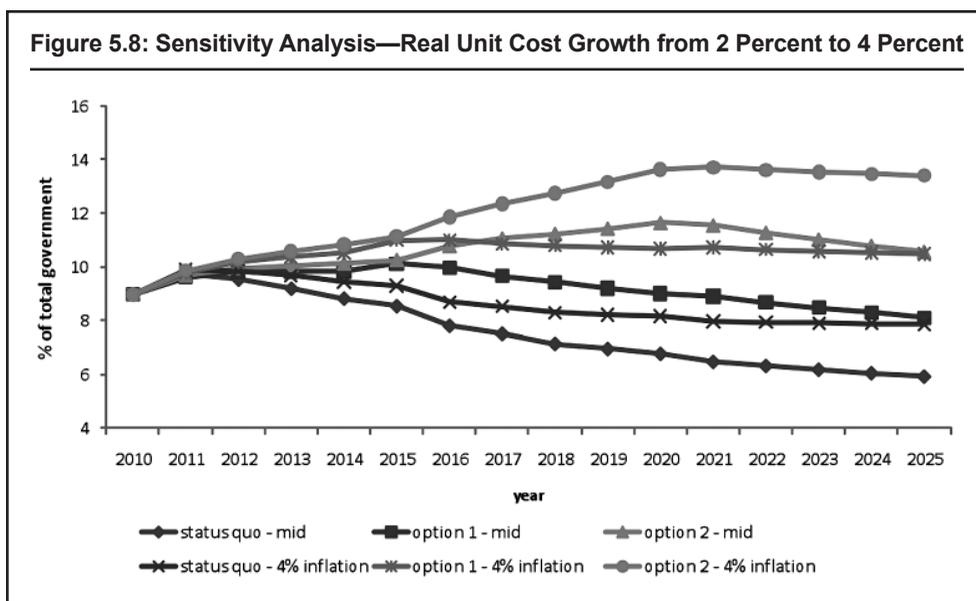
Figure 5.7 shows the effect of this change with total health expenditures as a percentage of GDP (panel A) for the status quo option being 1.34 percentage points higher than the mid-range projection, with Option 1 being 1.57 percentage points higher, and with Option 2 being 1.77 percentage points higher and heading to almost 6 percent of GDP by 2021. The effect on health as a percentage of government expenditures is similarly dramatic, with Option 2 reaching 15 percent (the Abuja target) in 2021 and staying there. For Option 1, health expenditure still hovers around the 11 percent mark for most of the projection period, and lower economic growth keeps the percentage of the government budget around the current level for the status quo option, once the HSS activities are completed.



Source: Author's calculations using Ifakara "scaling up" model.

Note: THE = total health expenditure.

The final area to be examined in terms of sensitivity analysis is the cost inflation for health care services. The base case model assumes that annual unit cost increases of 2 percent per year in real terms. The sensitivity analysis doubles this assumption to 4 percent annually. Figure 5.8 shows that unit cost changes also have an effect on publicly financed health expenditure as a percentage of the total government budget. By the end of the projection period, the status quo options would be expected to require 1.93 percentage points more of the government budget than the base case scenario, all other things being equal. The effect for Option 1 is an increase of 2.38 percentage points, while the effect for Option 2 is 2.83 percentage points. Each 1 percent increase in real unit cost growth will require an average of a 15.1 percent larger share of the government budget for the status quo option compared with the base case scenario, a 13.8 percent larger share for Option 1, and a 12.9 percent larger share for Option 2. The lower effects for Options 1 and 2 are a result of the significant investment in HSS, which is not affected by the service unit cost growth.



Source: Author’s calculations using Ifakara “scaling up” model.

Summary and Next Steps

The simulations show that the extension of prepaid health insurance coverage to a larger segment of the population should not cause significant increases in either the percentage of GDP spent on health services or the proportion of the total government budget devoted to such services, as long as robust economic growth continues. A lower growth assumption results in health expenditures as a percentage of GDP increasing from 4.5 percent to 5.0 percent in the universal coverage option and increasing as a percentage of the government budget from 9 percent to 13 percent, still well below the Abuja target. It would take a substantial slowing in economic growth (to 4 percent annually throughout the projection period) to push health expenditures to 6 percent of GDP and 15 percent of government expenditures.

Even in the absence of any reforms, there will be significantly increased demand for health services as a result of population growth, with about 53 percent more services projected by 2025 than are currently being provided. This projection underscores the need for continued attention to HSS, especially in terms of health human resources, but it also highlights that efficiently using the available human and financial resources will become increasingly important. The simulation results indicate that efficiency improvements can help to mitigate the cost implications of scaling up prepaid health insurance coverage.

Given the strong commitment of a number of development partners to improving social health protection, it should be possible to generate interest in helping to finance the transition and perhaps other costs associated with this expansion of coverage. Of course, a credible and sustainable action plan and detailed costing will be needed to garner such support, not just from development partners but also from the government, which will likely bear the greatest proportion of any cost increases. The health financing

strategy and the accompanying action plan should provide the basis for these types of discussions.

This policy note provides background information, cross-country examples, and policy options, which can all be incorporated into the development of a comprehensive health financing strategy. It also provides a framework for looking at the various elements of the health financing system and explores the financial, economic, and health system implications of a number of the options.

A key aspect in terms of moving forward is determining the acceptability of the various options from a political economy perspective, as well as more in-depth consideration of the feasibility and the expected costs. This examination should assist in finalizing the health financing strategy and lead to the identification of specific policy actions and reforms that will be needed to operationalize the strategy and its various components. Given the nature of the policy actions and the reforms they would support, it may be possible to consider them for inclusion in future development policy operations, either at the GBS level, or as a separate sectoral development policy operation. By drawing on the analysis just described, specific support could be targeted at the transition costs to universal coverage, notably the following:

- Setting in place an appropriate regulatory framework to monitor and provide oversight to prepaid health insurance operations (both public and private), bearing in mind the evolving role of the SSRA
- Addressing the role and future of the SHIB, consistent with the pension reforms that are also being pursued
- Making substantive changes to the financing framework for the NHIF, along the lines described in this policy note
- Focusing on the organizational and operational changes required for the CHF/TIKA to allow them to play the role envisioned in this policy note
- Addressing the need for increased efficiency and provider autonomy

Health financing reform of any significance will create major changes in the way in which the health sector operates. Because of this phenomenon, it is important that the overall vision for health financing, its subsequent effect on the health sector, and the specifics of any proposed changes are fully discussed with all of the relevant stakeholders before proceeding. The experience of other countries, most notably Kenya, shows that without fully explaining and discussing proposed changes, such reforms can be doomed to failure. It is recommended, therefore, that consultation and advisory mechanisms be put in place immediately to facilitate this essential dialogue. The explicit signaling of high-level support for health financing reform is also a critical next step in the process.

Notes

1. See Borghi, Mtei, and Ally (2010), for key assumptions, model structure, etc.

Health and Financing Systems in Other Countries

Thailand¹

In Thailand, health financing reform became a key issue in the 2001 general election campaign, and it has been reported to be an important factor in the election of the Thaksin government. In addition to strong political leadership, there was also strong civil society support for what was known as the “30 baht” scheme (representing the amount of the copayment, equivalent to US\$0.75).

Thailand had developed a good geographical coverage of health care infrastructure nationwide, primarily through facilities financed by the Ministry of Health, and a number of public financed schemes had been in operation as far back as 1974. The key milestones included (a) fee exemptions for the poor and a medical scheme implemented for private sector workers in 1974, (b) the development of a low-income scheme for the poor in 1975, (c) a medical scheme for civil servants (CSMBS) in 1985, (c) a social security scheme (SSS) with health insurance components in 1990, and (d) a health care scheme for the near-poor in 1991. By October, 2000, public financing covered 70 percent of the population with the four main schemes, and there was a great deal of accumulated experience in the management of the various health insurance schemes, including (a) local fund management, (b) public capitation contracts, and (c) development and testing of a diagnostic-related group system.

Implementation of the transition period toward universal coverage (UC) started in April 2001 with the enactment of the National Health Security Act using the Ministry of Public Health mechanisms and infrastructure. This implementation included reallocation of the existing health budgets with an additional B 10 billion from government for scheme implementation. Door-to-door approaches were used to sign up beneficiaries, and the new scheme was scaled up nationwide within one year, going from 1.39 million enrollees in April 2001 to 44.5 million in April 2002. There was some resistance from health care providers, but it did not hold up implementation of the scheme.

The major design principles include (a) getting to universal coverage as quickly as possible for those not already covered by existing schemes, (b) ensuring that cost control mechanisms are built into the UC scheme, and (c) including a minimal payment toward each patient’s care (B 30, or US\$0.75 per visit—Thailand is a middle-income country), although this copayment has since been dropped, with minimal effect on utilization.

Premiums for SSS are collected through payroll deduction and submission of both the employer and employee contributions to the Ministry of Labor Social Security Of-

fi ce. Funds from the Ministry of Finance for their contribution are also paid into the SSS account. There are no premiums for either the CSMBS or the UC schemes, and the necessary allocations are transferred directly to the plan administrators by the Ministry of Finance.

Different mechanisms exist for risk pooling in each of the schemes. The SSS uses a single risk pool consisting of 10 million people. Similarly, the CSMBS is a single risk pool of 5.7 million people, and the risk pool for the UC scheme is 47 million. Payment methods vary by scheme and type of provider. The SSS uses a capitation contract model for both inpatient and outpatient care, while the CSMBS uses fee-for-service reimbursement extensively.

The use of this payment method is felt to be a contributor to the high cost of this scheme (the cost of benefits for CSMBS are equivalent to about US\$400 per person while benefits for UC are about US\$60 per person). The UC scheme uses capitation for primary care and uses diagnostic-related groups that are global budget capped for hospital care.

Public health care providers are predominant, although the share of private providers is increasing. Private hospitals constituted about 24.4 percent of total hospitals and 20.2 percent of total hospital beds in 2005. Both public and private hospitals can participate in the UC scheme, providing that they are willing to accept the agreed tariff. Public providers also receive funding directly from the MoH for salaries and related costs, although the NHSO adjusts for this funding when calculating the payment amount. As already mentioned, there was originally a copayment of B 30 for each service under the UC scheme, although this co-payment has subsequently been eliminated. This change has resulted in no discernible long-term increase in utilization. There are no deductibles for any of the schemes.

The poor are automatically eligible for universal coverage. Research has shown that the scheme is particularly effective in targeting the poor, with 44 percent of the enrollees in this scheme belonging to the first two income quintiles. Even more important, the scheme has been successful in improving access to health services, with improvements in the concentration index, especially for inpatient services at district and regional hospitals. The incidence of impoverishment caused by illness has declined about 75 percent for families in the first income quintile and about 64 percent overall, and the benefit incidence of government subsidies for quintiles 1 and 2 have increased by five percentage points to 55 percent between 2001 and 2003. Moreover, the scheme has accomplished this improvement without showing any significant increase in overall total health expenditure, indicating that to a large extent UC benefits have replaced out-of-pocket payments, and the costs have been accommodated within GDP growth.

Although the system has shown significant progress in improving accessibility and financial protection, it faces a number of acknowledged challenges. Sustainability is an ongoing concern, especially because the benefit package for UC has recently been expanded to include both kidney dialysis and antiretroviral therapy. The payment methods selected as well as the monopsony position of the NHSO have helped to ensure that costs remain under control, and efforts at compulsory licensing have helped to contain drug costs. Quality and effectiveness have been addressed through disease management programs in areas such as diabetes and TB.

The increased financial access to health services has also strained the ability of the health system to cope with the additional utilization, which has amplified the effect of

human resources shortages and has led to discussions regarding the public-private mix of facilities and the speed at which the decentralized environment can cope with increasing the availability of services. Finally, the differences in the benefit packages between the two schemes, as well as the high cost of the CSMBS relative to the other schemes, will make for some interesting policy dialogue in the future.

Vietnam²

In Vietnam, the key driver for reform seems to have been the rising costs of health care and the decreasing accessibility by the population, especially those in rural areas and the poor. The consolidation of various schemes into a single administrative arrangement under the Vietnam Social Security Agency (VSS) and into a risk pool resulted in administrative efficiencies and increased solidarity between the Statutory and Voluntary Health Insurance (SHI) and Voluntary Health Insurance (VHI). Explicit targeting has resulted in a high level of enrollment by the poor in the VHI scheme.

The key milestones include (a) experimentation with health insurance and health sector reforms as a result of the economic crisis (1989–92); (b) introduction of health insurance at the national level, including SHI for employees (public and private), a Health Care for the Poor (HCFP) scheme, Free Care for Children Under 6 (FCFCU6), and VHI for farmers and the self-employed (1992–97); and (c) integration of HCFP and FCFCU6 into SHI (2005–09).

The main design principles appear to be (a) to sign up as much of the population as possible with health insurance, (b) to provide the same level of coverage for both SHI and VHI (with cross-subsidization if necessary), and (c) to focus on administrative efficiency by merging existing arrangements into just two programs and then having both programs administered by the same organization—that is, the VSS. Currently, about half of the population (48 million people) is covered by either SHI or VHI. SHI covers 14 percent of the population with a premium of 3 percent of payroll (2 percent employer, 1 percent employee). SHI also covers the poor (another 21.7 percent of the population) through a premium of 3 percent of the minimum salary, which is paid by the government. VHI covers informal workers and farmers (14.3 percent of the population) with a premium of US\$12–18 per year, which is based on urban or rural location. The premiums are partially subsidized by local governments.

All funds are collected by VSS, either through payroll deduction and submission to VSS offices or through collection of VHI contributions by either VSS offices or one of 10,000 agents at the village level. There are single risk pools for SHI and for VHI with allocations to regional and county branches of VSS. Branches are expected to live within their allocations, although the mechanisms for imposing budget discipline are unclear.

Fee-for-service is mostly used, although some districts are experimenting with capitation arrangements. The fee-for-service approach is leading to concerns about financial sustainability. Providers are mostly public, although private providers are able to participate if they are willing to accept the VSS tariff. Referral requirements are enforced so that if people go to a higher-level facility without a referral letter, they will have to pay the cost themselves. Since 2001, there have been moves to increase hospital autonomy, thereby giving more control over staffing, organization and management, and financial management.

Copayments of 20 percent are standard, although there are exemptions for the poor. There are no deductibles, but there are maximum payments for high-tech procedures (US\$1,250 equivalent). The Ministry of Labor and Social Welfare does an assessment to determine who is poor whereby it uses criteria of about US\$11 per month equivalent in rural areas and US\$14 month equivalent for urban residents.

A number of issues and challenges have been identified, including the following:

- How to ensure compliance with VSS requirements and control abuse of the system.
- How to deal with adverse selection (people who take coverage only when they are sick).
- Deal with the deficit, which reached 33 percent of SHI/VHI revenue in 2008 and which would require addressing both (a) the revenue side (premiums are already scheduled to increase to 4.5 percent [1.5 percent employee, 3 percent employer] next year and to 6.0 percent [2 percent employee, 4 percent employer] after that) and (b) the expenditure side by moving from fee for service to other payment methods.
- Make VHI more affordable, especially for the near-poor, by signing up the other 50 percent of the population.
- Improve the quality of the health services that are delivered.
- Apply effective information technology to VSS administration, and train staff members, especially inspectors to a higher level of competence to ensure effective control.

China³

A key driver for the New Cooperative Rural Medical Scheme (NRCMS) was the lack of health protection in the post-Cooperative Medical Scheme (CMS) era (1978–2003), which was a recessionary period of health protection system in China. There were problems with health resource allocation, which was plentiful in urban areas but sparse in rural areas, thus resulting in poor health services and infrastructure. For both NRCMS and Medical Assistance (MA), another driver was the fact that rising health care costs exceeded income growth, resulting in poor access to health care, lower health status, and illness becoming the main reason for impoverishment.

The major success factors included (a) having the highest-level political commitment to the programs at all levels (national, provincial, local); (b) piloting to prove the concepts but not waiting to achieve perfection in the pilots before scaling up; and (c) beginning with a small premium and benefit level that would quickly demonstrate the value of the scheme, thereby leading to both consumer demand and further political and financial commitment by governments to improve the level of benefits.

As far back as 1952, free medical services were provided for civil servants, with this coverage being extended to urban workers in 1956. A CMS for rural workers and farmers was set up in 1978. Starting in 2001, a Basic Medical Insurance (BMI) was set up for urban workers, and free services were stopped. In 2003, there were initial steps to implement the MA scheme in rural areas, followed by the piloting of the NRCMS from 2003 to 2006. The pace of scale-up was quite rapid. For example, NRCMS enrollment increased

from 333 counties and 80 million enrollees in 2003 to all 2,729 counties and 830 million enrollees in the first quarter of 2009.

The system was designed to be feasible and sustainable, ensuring the needs of basic medical services for different populations. The central government sets rules and provides overall leadership, while local governments implement. There is a conscious effort to perfect the system over time, rather than waiting to start with the perfect system and, especially in the NRCMS, to start with a smaller benefit package and to use patient demand to expand both the available financing and the level of government funding.

About 223 million are covered through BMI, representing urban workers and dependents, while 830 million rural workers and farmers are covered through NRCMS. Premiums for the BMI are 8 percent (6 percent employer, 2 percent employee), while NRCMS premiums are shared between the subscriber, the national government, and the lower levels of government (province, prefecture, and district) in about a 20-40-40 ratio. The MA scheme covers about 52 million poor people with premiums paid by the national government.

Funds for the BMI-workers scheme are collected through payroll contribution and submission to the tax authority. Premiums from individuals for BMI-residents are collected by the Social Security Department and for NRCMS are collected by the county-level NRCMS offices or local agents. The agents also provide reimbursement for services obtained outside the county, where subscribers need to pay the entire amount up front and claim reimbursement afterward. Funds from national, provincial, prefecture, and county levels come through regular financing mechanism.

For the BMI-workers, pooling of funds is at the county or prefecture level, but each employee is also his or her own risk pool. This approach is done through a combination of a pooling fund and private employee health accounts: about 70 percent of the 6 percent goes toward the social pooling funds (4.2 percent total), and the entire 2 percent employee contribution plus 30 percent of the 6 percent employer's share (3.8 percent total) goes toward the private account. The employees receive what is essentially a "debit card" which they can use at their discretion to pay some or all of the deductible or copayment portions they are responsible for when they receive care.

Management of all funds is at the county level (Social Security Department for BMI and Health Authority for NRCMS). Pooling for NRCMS is at the county level as well, with the rationale that this approach "increases risk-resilience and supervising capacity" (Wei 2009, 5). Farmers are involved in the management of the county-level risk pools. MA is also administered at the county level. There is some discussion about pooling at the prefecture level as a result of variations in county revenue-raising capability and the problems of smaller risk pools.

Under the NRCMS global budget financing of outpatient payment is being used in a number of counties, and hospitalization is reimbursed on a fee per bed-day. The fee is based on an investigation and analysis of inpatient expenses for different levels of hospitals in recent years, together with the effect of medical cost escalation and inflation.

All contracted service providers are eligible for payment. However, services are provided primarily by public providers. Efforts have been made at improving management at the Township Health Center level by posting director positions and entering a performance-based contract with those directors, as well as appointing accountants for

each center (a center has about 30 staff members and serves a population of about 20,000 people).

All of the schemes pay only a portion of the total medical expenses (30–70 percent based on the type of services), with deductibles, copayments, and ceilings on the maximum amount of reimbursement. These parameters are set at the local level in accordance with local conditions and financial availability, and they are revised on a regular basis. Reimbursement rates encourage the use of local medical facilities (for example, inpatient stays at township health centers are reimbursed at a higher rate than stays at county hospitals or higher-level facilities). For people belonging to MA, the reimbursement rate is higher, leaving about a 10–20 percent out-of-pocket payment.

Once a year, the local civil affairs agency conducts poverty-level assessments. Income levels of US\$100–150 equivalent per person per year are considered poor, and levels under US\$100 are considered very poor. Once people are assessed as being poor, they are automatically enrolled in the NRCMS and are eligible for the MA scheme. They obtain their MA benefits in addition to the ones they receive under NRCMS.

The issues and challenges include (a) inadequate funds, with great differences in revenue-raising capacity between regions; (b) great pressure to increase the levels of compensation for BMI, NRCMS, and MA; (c) lag in information management and lack of a unified platform for recording or sharing information; and (d) difficulty in supervising medical services behavior and controlling the increase health care costs.

Ghana⁴

The National Health Insurance Scheme (NHIS) in Ghana is one of the legacies of the John Kufuor administration. During the 2000 elections, he promised to abolish what was known as the “cash-and-carry system” of health delivery. Under that system, patients—even emergency cases—were required to pay money at every point of service delivery. People died either because they did not have the money or because friends and relatives were not around to make the required advance payment. For those who survived, the fees represented a significant burden, often driving people into poverty.

Under the new law, a National Health Insurance Authority (NHIA) licenses, monitors, and regulates the operation of health insurance schemes in Ghana. Ghana has three main categories of health insurance. The first and most popular category is the district mutual health insurance scheme, which is operational in every district in Ghana. Under this public and noncommercial scheme, any resident in Ghana can register. Anyone who registers in “District A” and moves to “District B” can transfer the insurance policy and still be covered in the new district. The district mutual health insurance scheme also covers people considered to be indigent—that is, those who are too poor, are without a job, and lack the basic necessities of life to be able to afford insurance premiums.

In addition to premiums paid by members, the district mutual health insurance schemes receive funding from central government. This central government funding is drawn from the NHIF. Every Ghanaian worker pays 2.5 percent of the social security contributions into this fund; 2.5 percentage points from the value-added tax in Ghana also goes into the fund. People sign up for the district mutual health insurance scheme at the district assembly in their district or at the offices of the scheme.

The second category of health insurance comprises private commercial health insurance schemes that are operated by approved companies, which do not receive subsidy from the NHIF and which must pay a security deposit before they start operations.

The third category of health insurance is known as the private mutual health insurance scheme. Under this scheme, any group of people (such as members of a church or social group) can come together and start making contributions to cater for their health needs, thus providing for services that are approved by the governing council of the scheme. Private mutual health insurance schemes do not get a subsidy from the NHIF.

People who register under any of the schemes are given a card that can be used to seek treatment in any hospital in the country. There are no copayments unless extra services, such as a private ward, are used. Bills are then sent to the scheme provider (district, private scheme, or mutual scheme), which then pays the hospital. The card can also be used to buy prescribed drugs at accredited pharmacies or licensed chemical shops without paying at the point of delivery. The pharmacy then contacts the scheme provider to claim reimbursement. Regardless of the form of health insurance, the benefit package consists of at least the following:

- Outpatient services—general and specialist consultations and reviews, general and specialist diagnostic testing including laboratory investigation, X-rays, ultrasound scanning, medicines on the NHIS medicines list, surgical operations such as hernia repair, an physiotherapy
- Inpatient services—general and specialist services in patient care, diagnostic tests, medication-prescribed medicines on the NHIS medicines list, blood and blood products, surgical operations, inpatient physiotherapy, accommodation in the general ward, and feeding (where available)
- Oral health—pain relief (tooth extraction, temporary incision, and drainage) and dental restoration (simple amalgam filling, temporary dressing)
- Maternity care—antenatal care, deliveries (normal and assisted), Caesarean section, and postnatal care
- Emergencies—crises in health situations that demand urgent attention such as medical, surgical, pediatric, and obstetric and gynecological emergencies, as well as road traffic accidents

The health insurance schemes have the following exclusions:

- Appliance and prostheses including optical aids, heart aids, orthopedic aids, and dentures
- Cosmetic surgeries and aesthetic treatment
- Anti-retroviral drugs for HIV
- Assisted reproduction (for example, artificial insemination) and gynecological hormone replacement therapy
- Echocardiography
- Photography
- Angiography
- Dialysis for chronic renal (kidney) failure
- Organ transplants

- All drugs that are not listed on the NHIS list
- Heart and brain surgery other than those resulting from accidents
- Cancer treatment other than breast and cervical
- Mortuary services
- Diagnosis and treatment abroad
- Medical examinations for purposes other than treatment in accredited health facilities (for example, visa application, education, institutional, driving license)
- VIP ward (accommodation)

Recently, there have been reports of hospitals and pharmacies turning patients away, complaining that the public schemes owe them significant amounts of money. Some hospitals have issued warnings that their operations could grind to a halt if the NHIS does not speed up payment of their claims. The NHIS has repeatedly assured the public and providers that it is working on the problems and, in due course, they will be resolved.

In response to the increasing concerns over fiscal pressures, the NHIS outlined its immediate strategic objectives to meet the challenges posed by systemic abuses and fraud and by the consequent exponential cost escalation in the NHIS. Announcing the measures, the chief executive officer identified cost containment as one of the key objectives in the drive for sustainability of the NHIS. Subsequent to this objective, he detailed various strategies designed to combat abuse and fraud responsible for the financial hemorrhage in the scheme, which, together with other challenges, had necessitated comprehensive arrangements to plug the leakages in the system, to strengthen internal controls, to inject accountability into the NHIS, and to ensure that the scheme gets value for money from service providers.

Consequent key reform initiatives being implemented include the following:

- The setting up of a Consolidated Premium Account that would be operational from July 2010—Scheme managers will be required to deposit all premiums collected into a centralized account in either of two designated banks (Ghana Commercial Bank and Agricultural Development Bank) with a nationwide reach and with an identification code for each scheme account. The schemes have been directed to close all other accounts. This move would redress the current situation where more than 70 percent of premiums collected are not properly accounted for.
- The establishment of a Consolidated Claims Management Centre in Accra—This pilot project will manage claims from the teaching hospitals and 10 regional hospitals. It was operational from July 2010 and was staffed by experienced and competent claims personnel. This change would provide a greater capacity for vetting of claims and efficient payment of service providers. If successful, the format would be rolled out in zonal claims processing centers across the country.
- Requirement for a payment plan before the disbursement of funds—To combat irregularities in payments arrangements, scheme managers will henceforth be required to produce and forward a payment plan in advance to the authority for endorsement and before funds are released for disbursement to service providers.

- Introduction of a standardized NHIS prescription form—The form will require the personal identification number (PIN) of the prescriber and of the dispenser and will identify the scheme involved. The form is also designed to check systemic abuse and fraudulent practices in the dispensing of medicines.
- Ways to streamline procedures for registration under the free maternal care program—Following the streamlining, pregnant women would be required to register—for free—before accessing care. The program went into effect from July 2010 and is intended to eliminate abuse of the program.
- Withdrawal of accreditation from all private health care facilities run by full-time staff members of public health facilities—This change will eliminate conflicts of interest and double billing of the NHIA for services to patients.
- Introduction of capitation for outpatient department services in primary health care facilities following a pilot program that is to be carried out in a selected region and is scheduled to start by the end of 2010—Capitation would be based on research into utilization rates and costs, would be projected over a whole quarter, and would involve advance payments to service providers subject to periodic reviews and adjustments. It is expected that capitation would introduce efficiency and drive down costs in primary health care delivery.
- Implementation of a unitary system of contracting with service providers—Under the review, contractual arrangements will involve apex bodies such as the Ghana Health Service, the NHIS, the Christian Health Association of Ghana, and other service providers.

A new financial and operational reporting tool has been developed by the authority to streamline and standardize the electronic recording and timely transmission of accurate data by the schemes to the authority. This tool is expected to improve financial and operational discipline at the schemes and to ensure prompt processing and payment of claims to service providers. Trends in the data would also be useful for evaluation and monitoring purposes.

Rwanda⁵

Since the introduction of user fees in public health facilities in 1996, Rwanda has pioneered major programmatic, organizational, and health financing reforms aimed at improving the quality of care and, ultimately, the health status of the population in Rwanda. The reforms have a particular focus on the most vulnerable segments of the population.

Prepaid financing in Rwanda was organized in the form of mutual health organizations (MHOs). In 1998, there was only one initiative that could be identified with a community MHO and with scattered experiences among provider-based health insurance schemes to facilitate access to care in a context of poverty. The Ministry of Health (MoH) launched pilot prepayment systems in three health districts in 1999 as an initial experimentation phase, which is part of developing a policy to promote MHOs in the country, and the MoH provided leadership to the overall process. MHOs were developed under the supervision of the MoH and its partners (USAID, WHO, the European Union, the Catholic relief and development organization Caritas, and other NGOs). Together, they closely involved community actors in the design and ensured that those actors would be in charge of managing MHO systems.

The scale-up was quite rapid, from 1 in 1999 to 53 in 2002, covering about 100,000 beneficiaries. Initially, MHOs began by providing coverage for the indigent, vulnerable groups and for people living with HIV while using funds from several NGOs and a few administrative districts. The pilot experiences were evaluated between 2001 and 2003, after which Rwanda moved to implement the recommendations of the evaluations. The main recommendation was to adapt MHO organization to fit within the decentralization model that was being developed in Rwanda. As in the pilot phase, the adaptation phase received technical supervision from the MoH and subsequently from the Ministry of Decentralization and Local Affairs (MoDLA), which supervised the decentralized authorities and has social protection as part of its mandate. The involvement of the MoDLA and its agencies in promoting MHOs anchored them in the community and facilitated the mobilization of local authorities in the various administrative districts and district subdivisions. This involvement also resulted in the involvement of NGOs and religious leaders, which raised the population's awareness of the importance of enrolling in MHOs. The institutional arrangements for MHOs and local MHO networks were aligned with the environment of the decentralized authorities during this adaptation phase.

Also, beginning in 2003, leadership at the central level was strengthened with the backing of the highest authorities in government. The MoH established a policy and strategic plan, and an MHO technical support unit to support MHO development and expansion. As part of mobilizing the local leadership in efforts to expand MHO-based health insurance, the degree of MHO promotion was made one criterion for evaluating the performance of the administrative districts.

The number of MHO beneficiaries increased from 556,000 by the end of 2003 (7 percent of the country's population) to 3,686,000 by the end of 2005 (44 percent of the country's population). This growth was a result of the expansion of MHOs to the entire country and of increasing the penetration of target populations. There was also an expansion of the package of benefits covered by MHOs. Until mid-2006, most MHOs covered only minor risks treated in health centers and only a limited package of major risks treated at district hospitals. In mid-2006, benefit packages were expanded, and coverage for the indigent, vulnerable groups and persons living with HIV was institutionalized by the government and foreign partners. The benefit packages now covered primary health care, secondary care, and tertiary care, which dramatically improved the price-quality ratio for MHO services.

The quantitative expansion of MHOs grew quickly in the second half of 2006, reaching a coverage level of 6,283,000 beneficiaries by the end of December 2006 (73 percent of the country's population). By the end of August 2007, some 6,497,000 Rwandans were covered by MHOs (74 percent of the country's population), and in 2008 it reached 85 percent.

The actual number of MHOs climbed from 88 in 2003 to 226 in 2004, 354 in 2005, and 392 in 2006. In 2006, all the health centers in the country had a partner MHO under the community health center partnership. Each administrative district had a district MHO that served as a mechanism to pool the major risks for the primary MHOs.

In June 2006, Rwanda established a National Guarantee Fund (FNG) and a District Solidarity Fund (FSD) to bolster financing mechanisms for MHO expansion in the country. The FNG/FSD system strengthens equity of access to and financing of health insurance coverage in the country through two mechanisms.

First, the system supports the functional expansion of MHOs to harmonize the coverage benefits received by MHO beneficiaries and the benefits received by the beneficiaries of the social insurance systems (Rwanda Health Insurance Company [Rwandaise d'Assurance Maladie, or RAMA] and Military Medical Insurance, or MMI).

Second, the system supports the expansion of MHOs by providing care for the indigent identified by communities and for people with HIV/AIDS who have HIV-related opportunistic infections. The FNG is financed through contributions from the government, RAMA, MMI, private insurance systems, and foreign partners, including the Global Fund. The FSD is financed by the contributions of MHO chapters, administrative districts, transfers from the FNG, and contributions from the development partners that are involved at the district level.

In addition to the MHO experience, Rwanda also led in the development of performance-based financing (PBF). In 2006, PBF became a major pillar of the MoH's strategy. It was implemented to provide additional resources and incentives to health workers so as to improve efficiency and the quality of care. PBF is currently implemented at three levels: health center, hospitals, and community levels. In the national model for health centers, payments for performance are based on the quantity of outputs achieved conditional on the quality of services delivered. At the hospital level, performance is assessed through a peer-evaluation mechanism. Finally, the community PBF consists of decentralized control and decision making and of payment for a community health worker cooperative after performance has been assessed.

An evaluation of the PBF approach by the World Bank concluded that it had a large and significantly positive effect on institutional deliveries and preventive care visits by young children, and it improved quality of prenatal care. The authors found no effect on the number of prenatal care visits or on immunization rates. The overall effect was greatest for those services that had the highest payment rates and needed the lowest provider effort. The financial performance incentives that were evaluated were found to be able to improve both the use of and the quality of health services.

Key lessons from the Rwandan experience and from factors contributing to the successful implementation of reforms can be formulated to provide a stronger base for future action:

- Strong government leadership, vision, and regulatory framework at all levels will foster the short- and long-term sustainability of health sector reforms.
- In light of the changing macro and health sector environment, the ability of government to adapt strategies is needed to strengthen health services.
- Independent controls and quality checks are essential for monitoring and evaluation of health facility performance.
- Cultural and social factors, particularly solidarity within communities, contribute to the success of several health service delivery innovations.
- Key reforms need to include provisions for financial protection and other support for indigent populations.
- Government coordination of donor funding is critical to ensure that aid is used effectively and is aligned with national priorities.

Kenya⁶

Although the previous examples highlight reforms that have already taken place, the example of Kenya presents some of the evolving thinking on health financing in a system that is similar to the one in Tanzania in many respects. The health financing strategy in Kenya was developed over several years, using a process that drew heavily on the previous failure to reform the health financing system. In 2005, the then health minister prepared a plan for mandatory health insurance and was able to obtain approval by parliament for the enabling legislation. The finance minister objected to the scheme by saying the government did not have money to fund it, and various employer and trade union groups also opposed the bill on the grounds of inadequate consultation and potential reductions in competitiveness and personal incomes. President Kibaki later refused to assent to the bill that sought to establish the scheme, arguing that the government could not afford it, and the bill expired when parliament rose for the election.

In contrast, the new health financing strategy is the result of a broad consultation process, which included a wide variety of stakeholders and drew on both extensive analytical work and reviews of health financing systems in other parts of the world. While the strategy has been discussed at the National Economic and Social Council and a number of key principles endorsed at that level, there are ongoing discussions on the organization and structure of the new health financing system. Based on the process undertaken to date, the current version of the health financing strategy includes the following elements, which are designed to be mutually supportive and reinforcing:

- Improving efficiency, accountability, and transparency
- Strengthening revenue collection
- Having more effective risk pooling
- Harnessing the informal sector financing potential
- Broadening the benefits package
- Strengthening provider incentives
- Protecting the poor and vulnerable groups
- Improving aid effectiveness
- Ensuring sustainability

The strategy identifies a number of areas where efficiency can be improved. First, it indicates that demonstrating the most effective use of the current resources is the best approach for securing support from the government, development partners, and the general public for increased health care financing in the future. A central element of the drive for improved efficiency is to ensure that each component of the health system focuses on what it is best at and that it leaves other activities to other parts of the health system. For example, the strategy proposes that the MoH should act primarily as steward of the health system, thereby providing overall direction and guidance and setting the overarching policies of the system, but it should not be involved in the day-to-day management of health service providers. Having the MoH play the role of both regulator and service provider inevitably leads to conflicts of interest, especially in a system where various types of providers are needed to deliver necessary health services.

Strong quality assurance and accreditation mechanisms are extremely important for ensuring that the services provided meet essential quality standards. Strengthening the referral system will also lead to efficiency improvements, which will include ensuring

(a) that each level of care provides the services that it is best equipped to provide and (b) that expensive secondary care resources are not used to provide services that can be delivered more efficiently and effectively at lower levels of care. Efficiency will also be enhanced by separating the purchaser from the provider of services, so the providers can focus on effective management of their facilities. This change will require increased autonomy for public health care providers, so that they have the ability to manage their facilities in the most cost-effective way and under the overall policy direction of the MoH.

The proposed move from providing inputs to purchasing services is expected to have several important effects. First, providers will have to deliver services to patients in order to receive funding, thereby increasing the incentive to ensure that necessary high-quality services are made available. Second, the method and conditions of payment will be developed in a clear and transparent way, so that the managers of health facilities will know what level of funding to expect for a given level of activity. This approach will facilitate better planning and management of resources. It also places the patient squarely at the center of health services delivery, because the funding will follow the patient and because providers who do not treat their patients competently will lose both patients and funds.

A substantial amount of investment will be needed (a) to develop a cadre of managers with the necessary skills and abilities and (b) to develop the governance and accountability structures that will be required in a more autonomous environment. The result will be that public health facilities will be run by professional managers and overseen by management boards. Boards will be responsible for hiring the manager, setting facility policy, and monitoring execution of that policy.

There are not enough public facilities to deliver necessary health services to the people of Kenya. Thus, another key element of the health care financing strategy will be to make all health facilities (including FBO, NGO, and the private health providers) eligible for contracts to supply health services, provided they are accredited and willing to accept the standard contract terms. Of course, in some areas, there may be more providers than necessary; in those cases, selective contracting will be undertaken. Private health providers will be encouraged to cover underserved areas through various incentive mechanisms (for example, premiums on the specified tariff). The fact that many private providers are currently not fully using their capacity suggests that there is a potential for progress in those areas, if mutually agreeable terms can be established.

Given the resources that are currently available, the package of health services eligible for coverage would initially be limited, although it would be expanded as resources permit. For those services not included in the package, options would exist for people to take out supplementary private health insurance. Because this provision would be an important element of the overall health care financing and delivery system, it will be necessary to develop effective financial and quality oversight structures if the package is to ensure that private insurance remains sustainable.

Although the amount of funding is limited, it is still very important to ensure that providers are adequately compensated for the services they deliver. In addition to providers being an issue of longer-term sustainability, it is also expected that certain types of providers will not participate if they feel that the reimbursement rate is not adequate. Because all types of providers are needed to ensure coverage, this situation should be

avoided. The strategy, therefore, proposes that a Benefits and Tariffs Board be established to work with purchasers, providers, and other stakeholders in developing appropriate reimbursement levels. An important aspect of this board will be ensuring transparency in its deliberations, so that the resulting tariffs and the rationale for determining them are clearly articulated and are available to anyone who may be interested.

The other important aspect of the board's operations will be the development of the basic benefit package or of those services that will be covered. Although this coverage will initially be a more limited set of services, as the economy grows or the total resources available for health increase, the package would be reviewed and expanded. Again, an important feature will be transparency and availability of information. In addition to stakeholder involvement, there will also be a critical role for expert advice, whether it is the effect of tariff changes or the consequences of insuring additional services. The board will need to regularly update the benefit package to reflect both changes in medical technology and updates in the available financing.

If health care is to reach informal workers and farmers, smaller risk pools in the form of community health funds may be established, but the NHIF would essentially act as a reinsurer for those funds, covering the full range of services for the members, regardless of the claims activity. Capacity will need to be developed in actuarial analysis to determine the appropriate or minimum premium levels for such schemes, as well as for the general population of insured persons covered through formal employment or other informal group arrangements.

The strategy suggests that premium levels clearly need to rise, but in the short run, this increase would have to be balanced against the public's perceived value with respect to the services provided or covered by NHIF and the public's ability to pay. This approach means that general revenue will continue to be an important factor in the overall success of this risk-pooling structure. Initially, this change will take the form of redirecting the funds currently spent to finance inputs at the (public) facility level into the NHIF, so that it can purchase services from those facilities. The transfer of funds would be used to "top up" the premiums that are paid, to pay health insurance premiums for the poor, or to purchase certain "public goods" services as specified in national programs. Over time, as both the perceived value and the ability to pay grow, the premium subsidies would be reduced.

The strategy proposes that the NHIF progressively penetrates the informal sector and grows membership from the current 440,000 to 7.5 million members. This growth will have the effect of increasing coverage from the current 24 percent to about 70 percent (leaving out the 30 percent of the population considered to be indigents). According to the National Health Accounts and the 2005/06 rate, this change has the potential of channeling into the NHIF an equivalent of K Sh 38 billion annually (through conversion of out-of-pocket expenditures into health care savings). Harnessing this informal sector potential will entail incorporating entrepreneurs, self-earning professionals, freelance workers, and members from the *matatu*, agriculture, and *juakali* sectors into the NHIF. Using a suitable model, the NHIF will seek to assess the income of members from this sector to align the actual contributions to those in the formal sector.

The NHIF will pursue a pro-market strategy for increasing the participation of the informal sector that is two-pronged: communicating effectively and providing suitable incentives, particularly through attractive products. The latter will include defining the

minimum package of care that is comprehensive and cost-effective and that includes preventive, health promotion, and outpatient care.

Through the introduction of a purchaser/provider split, the opportunity exists to give clear incentives to providers for delivering services of sufficiently high quality to meet the needs of the population. However, this quality depends very much on the incentives that are inherent in the underlying provider payment mechanisms. Accordingly, the strategy will pursue payment approaches that have been proven to provide the necessary incentives and have been proven to be feasible (in terms of data availability, collection, and processing) in countries at similar levels of development, including capitation for primary health care and case-based reimbursement for hospitals.

Protection of the poor is central to the overall strategy for financing health care, which means that the poor must be able to access necessary health services without either organizational or financial constraints. The evidence is clear that user fees at the point of service serve as a deterrent to accessing health services by the poor, so a central element of the strategy is the elimination of user fees for this group, with a view to possibly eliminating user fees for the rest of the population—as and when alternative resources permit. However, as noted earlier, user fee revenues from the nonpoor (defined as either the top three or four quintiles) are substantial, so it will be important to develop coherent approaches for replacing this revenue from other sources and, indeed, finding additional resources as financial barriers decline.

A critical issue will be the timely and accurate identification of the poor. By identification of the poor, it will be possible to ensure that, if necessary, those people can be registered with the social insurance system and that the contributions are made on their behalf through the joint efforts of the government and development partners. This approach will give the poor free access to necessary medical care, while ensuring that they do not face the barrier of user fees.

An important element is to make sure that health service providers do not face disincentives to treating the poor. Thus, it will be important to compensate providers for lost user-fee revenue when they treat poor people. The registration card that members receive would both signal to the provider that no user fee should be collected and signal to the purchaser that the reimbursement should be augmented by the user fee that would otherwise have been paid.

Aside from user fees, other barriers to access need to be addressed. For example, selective contracting could be used to encourage health service providers to relocate to underserved areas, thereby improving physical access. Furthermore, the introduction of a functioning referral system should ensure that care is provided at the appropriate level and that necessary care at higher levels is not impeded by the inability to pay. User fees could be increased (or kept) for patients who have not obtained a referral, further strengthening the continuum of care and guarding against the overuse of higher levels of care.

The strategy indicates that full acceptance and support of the development partner community are an important determinant in how quickly the strategy can be implemented. Considering the involvement of development partners to date (on both the development of the health financing strategy and the increased use of country systems) and anticipating ongoing support in both of those areas, the role of development partners is fully integrated into the approach—from the investments needed to build capacity and

improve the physical infrastructure of facilities to the support required to ensure equity and access so that the poor and nonpoor are able to receive essential health services. This integrated approach could include a potential new access and equity fund, which would receive funding from both government and development partners, thus ensuring that everyone in Kenya is able to obtain essential health services when they are needed. This full partnership in the implementation of the health care financing strategy is a unique opportunity for maximizing aid effectiveness across the health sector.

Colombia⁷

Before 1993, Colombia's Ministry of Health (MoH) was constitutionally responsible for providing all Colombians with health care. However, inefficiency, badly targeted public subsidies, and fragmented markets resulted in only one Colombian in five having any protection against the financial risk of health shocks from serious illness. Only those with more financial resources could afford to join social security schemes or pay out of pocket for health care. Although policy makers believed that (a) Colombia's public health was well targeted to the poor; (b) public health services were free to all comers, but especially the poor; and (c) the poor did not have to go to private providers for health care because public funds supported a large network of public hospitals and clinics; in fact, households contributed a significant portion of health care financing.

Cost was the most significant barrier to health care before 1993. In the poorest quintile, only one individual in six who fell ill in 1992 sought medical care. The poor had less access to health care than the rich, paid out of pocket for public as well as private health care services, and paid proportionately more of their income for any services they received. The governmental health care delivery network did not adequately serve the poor, leaving already impoverished sick people with huge medical bills and the likelihood of abject poverty from which they could not recover.

Before 1993, public subsidies were paid directly to hospitals rather than to users. However, the poor who could get into public hospitals incurred out-of-pocket expenses more often than did middle- and upper-income patients, who were often covered by private insurance. Rarely did the poor receive free care in public facilities. In fact, 91 percent of the poorest inpatients incurred out-of-pocket expenses, compared with 69 percent in the richest quintile.

The private sector was important in both financing and delivering health services before the reform. According to the government's National Household Survey in 1992, 40 percent of all health interventions and 45 percent of all hospitalizations were done in the private sector. Only 20 percent of the Colombian population had health insurance.

Law 100 of 1993 first mandated the creation of a new national health care system with universal health insurance coverage and then reorganized financing and delivery. A key feature of this law was that public subsidies would go directly to individuals rather than to institutions.

The reform introduced four main elements to reach the poor:

- A proxy means testing index to target public health subsidies to the neediest (SISBEN, or Selection System of Beneficiaries for Social Programs)

- Transformation of traditional supply-side subsidies (which financed the public health care network) into demand-side subsidies (which subsidize individual insurance premiums for the poor)
- An equity fund in which revenue from payroll contributions and treasury resources cross-subsidize insurance premiums for the poor
- A way of contracting for health service delivery from both the public and private sectors

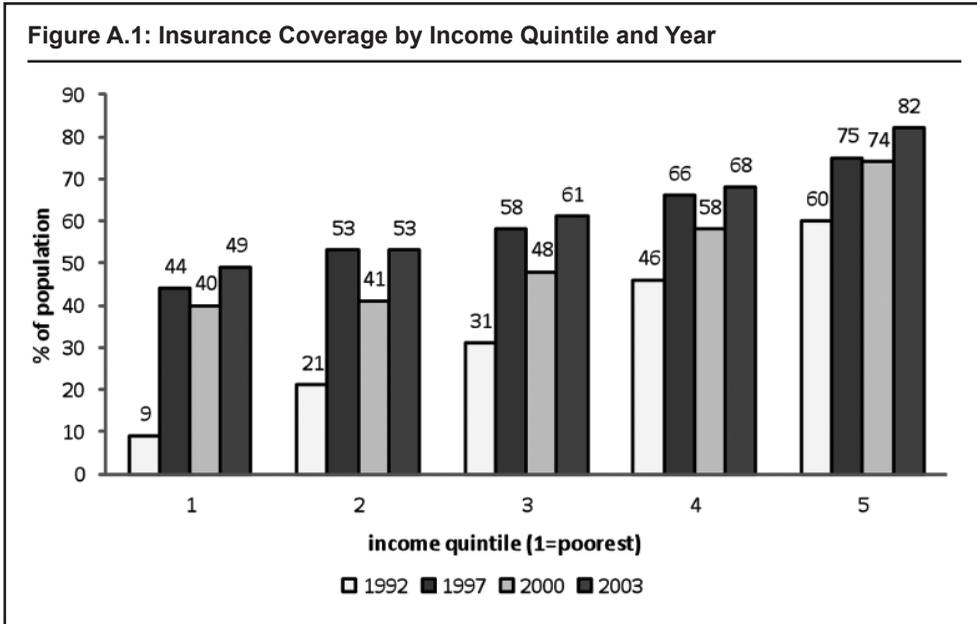
The new system is a universal health insurance coverage plan with two schemes: (a) a contributory scheme (RC) to cover formally employed and independent workers who contribute to the scheme so their contributions are collected by the insurer of choice, and (b) a subsidized scheme (RS) to covers the poor and indigent individuals who could not afford to make any insurance contribution.

SISBEN is a general-purpose system for selecting beneficiaries for social programs in Colombia. It has a statistically derived proxy means test index that serves as an indicator of household economic well-being. The variables that determine welfare include (a) availability and quality of housing and basic public services, (b) possession of durable goods, and (c) human capital endowments. The system includes norms and procedures defined at the central level and operated at the municipal level to gather information necessary to calculate the welfare index and to select beneficiaries for the numerous social programs. The RS scheme is one of the programs in which benefit incidence has been the highest for those targeted with SISBEN and was benefiting more than 11.4 million poor and vulnerable people by the end of 2002.

Payroll contributions go into a national health fund with four separate accounts. The fund finances insurance premiums for all enrolled in the RC. In the RC-RS cross-subsidization process, a share of the contributions is allocated to finance the RS, together with treasury transfers to the territories. Those who are eligible for enrollment in the RS but are still uninsured are to rely on public hospitals for care.

Every insured individual is free to choose an insurer and to consult any provider in the insurer's network. Both schemes have a basic benefits package, but the RC package includes every level of care while the RS package has to be complemented with services provided by public hospitals and financed through supply-side subsidies. The design provides that those subsidies were to be turned into demand-side subsidies over time to achieve universal insurance coverage with the same package in both schemes.

The reform of 1993 increased financial protection for all, but especially for the poor and rural population. As shown in figure A.1, before 1993, 23 percent of Colombians were financially protected against the risk of health shocks, while a decade later, 62 percent of the population had access to health insurance. Insurance coverage among the wealthiest group increased from 60 percent in 1992 to 82 percent in 2003, while insurance coverage among the poorest group increased from 9 percent in 1992 to 49 percent in 2003.



Source: Gottret, Schieber, and Waters 2008, 166.

Formal insurance in Colombia reduced out-of-pocket expenditures on ambulatory care between 50 percent and 60 percent. The poor in the RS spent about 4 percent of their income on ambulatory care, but the uninsured poor spent more than 8 percent. Out-of-pocket expenditures on hospitalization among the uninsured poor absorbed more than 35 percent of their income in 2003. The poor in the RC spent a smaller proportion of their income on inpatient care than did the poor enrolled in the RS. Further, a health shock requiring hospitalization pushed 14 percent of those hospitalized and uninsured below the poverty line compared with only 4 percent of inpatients covered by the subsidized scheme.

Access to preventive care was also improved by the introduction of health insurance. Although 65 percent of the insured saw a physician or a dentist at least once for preventive reasons and without being sick in 2003, only 35 percent of the uninsured did so. Regulations gave preference to children, single mothers, the elderly, the handicapped, and the chronically ill for priority access to insurance enrollment in the RS.

Colombia's Demographic and Health Survey (DHS) indicated a significant improvement in access to medical care during pregnancy, use of prenatal care, and medically assisted deliveries, particularly in the rural areas. DHSs between 1986 and 2000 showed a 66 percent increase in physician-assisted delivery, an 18 percent increase in institutional delivery, and a 49 percent increase in prenatal care use among rural women.

Despite positive results, the Colombian social insurance scheme has been criticized for not having achieved universal coverage and for financing a less comprehensive benefits package for the poor (RS) than for the wealthy (RC). The slower-than-planned

transformation of supply-side subsidies (which finance public hospitals) into demand-side subsidies (which finance health insurance for the poor) has also come under fire for slowing down the expansion of the RS benefits package.

Colombia still has many challenges to surmount to complete the consolidation of the social insurance scheme, not only to cover the entire population but also to improve the efficiency and quality of health care. The changeover to the new, insurance-based system has been difficult politically, administratively, and technically.

Mexico⁸

In the 1940s, Mexico established social security institutions for formal private and public employees that collect premiums from employees and their employers, that obtain additional funding through government subsidies, and that use those resources to provide services to the covered employees. The system has worked relatively well for the half of the Mexican people who have access to it.

The poorer half of the population—which tends to work in smaller and poorly regulated establishments, to be self-employed menial laborers, or to be unemployed—is far less fortunate. Because they are outside the formal labor market, they usually cannot access health insurance through the workplace or cannot afford it. This segment of the population was left to seek lower-quality services provided, at a fee, through health ministry facilities or through the expensive and often unregulated private sector.

The Mexican health system was also seriously unbalanced and underfunded, and government health programs were not able to address the challenges. Funding was not distributed efficiently or equitably—close to half of the population was uninsured, yet only a third of the federal funds for health went to them. There was great risk of impoverishment caused by health spending: 2 million to 4 million households spent 30 percent of their annual disposable income on health.

The government that took office in 2000 assigned a high priority to correcting this imbalance. It introduced a set of reforms that featured a new health insurance program, Seguro Popular (SP), for all those not covered by existing social security plans. This voluntary program would provide the people with subsidized insurance coverage comparable to that available to social security beneficiaries.

The health ministries of Mexico's 32 state governments are responsible for identifying, enrolling, and serving eligible SP participants. SP was designed to focus on the poorest families first. Premium payments are subsidized on a sliding scale by the state, and the families from the poorest 20 percent of the population do not pay. Participants are entitled to treatment at no additional cost through some 266 interventions at specified institutions (mostly state government facilities). SP participants are also eligible for 17 interventions at a network of higher-level tertiary care institutions operated by the federal and state governments.

The gap between premium revenue and the program's total cost is covered by government subsidies. Most of the subsidies come from the federal to the state governments, with federal funding covering 83 percent of the premiums. The funding formula factors in the level of development of the state (poor states get more funds than better-off ones), as well as the number of families enrolled. This approach gives states an incentive to improve the quality of services and to increase the number of participating families. State governments bear the remaining costs from their own resources.

The SP program is mostly responsible for the recent increase in federal government resources allocated to health. For example, the budget of the federal health ministry increased by about 53 percent between 2000 and 2005—largely attributable to the program's implementation.

The SP program originally aspired to universal coverage by 2010, reaching better-off and poor uninsured people alike, but ensuring that the disadvantaged are served first. The program design includes three related measures to increase the focus on the poor. First, premium rates are graduated by economic status, with exemptions for the poor. Second, mechanisms are in place to identify poor families and to determine premium subsidies or exemptions. Third, there is a system for paying implementing agencies that gives them an incentive to focus on enrolling poor families. By the end of 2009, approximately 31 million of 48 million eligible individuals were covered by SP (65 percent). The government recently took out a US\$1.25 billion World Bank loan to increase this coverage to 85 percent and to achieve universal coverage by 2012.

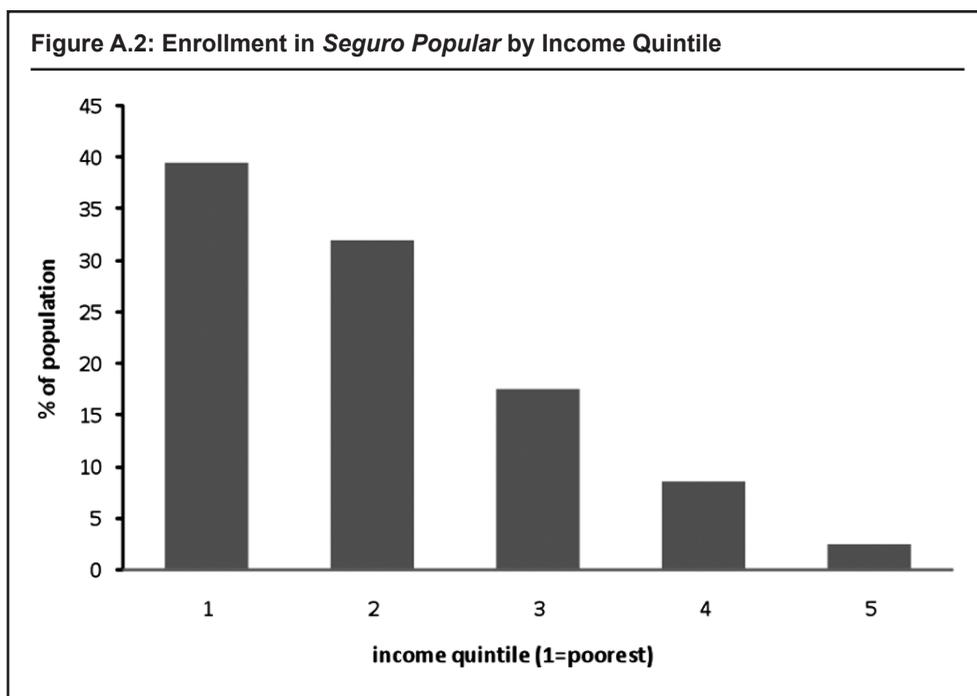
The system is based on prepayment for a package of services that will expand as demand and funding permit. This growth has already happened, and benefits covered by the SP have expanded significantly, from 76 health interventions at inception to 266 interventions today. Families pay up to 5 percent of disposable income (defined as total spending after basic needs are covered). Farther down the economic ladder, the premium falls and the government subsidy rises, with people in the poorest 20 percent of the population paying nothing at all.

States have several options available for identifying the people who qualify for different levels of subsidy. They can use the approach of the existing PROGRESA/Oportunidades program, whose enrolled participants are automatically eligible for SP coverage at no cost. They can also use the approach developed by the SP program or developed by several other federal subsidy programs, or they can enroll all members of specified groups without evaluating the individual members of those groups.

The PROGRESA/Oportunidades and SP approaches both use a proxy means test, which identifies the poor on the basis of information about the assets of households and the people living in them, rather than income or expenditures. Field workers score each item on the basis of guidelines developed through statistical studies of household economic status, sum the results, and compare the overall outcome with that of other members of the population. A family's SP premium is based on where the family fits on the economic spectrum thus identified: the lower the family is, the less it pays.

Federal SP support to state governments is replacing federal assistance based on inputs and is shifting to the number of people the states serve rather than the number of people they employ and the facilities they operate. This change gives states an incentive to enroll as many people as possible in SP. Because the poor do not pay premiums, they are easier to register and thus are prime candidates for early enrollment.

By the end of 2005, SP had enrolled about 11.5 million people, just under 20 percent of the 65 million to 75 million Mexicans not covered by the social security system. About 40 percent of the enrollees were in the poorest quintile, compared with less than 3 percent in the richest quintile. SP participants in need of health services were significantly more likely to obtain them than were those who did not participate. Thus, the SP program is very pro-poor, as shown in figure A.2.



Source: Yazbeck 2009, 251.

Two principal challenges have been identified for the SP program:

- The ongoing commitment of the federal government to provide funds for this program will continue to be a challenge, especially in light of the global economic crisis, which saw the Mexican economy contract by 6.5 percent. The recent renewed commitment to achieving universal coverage by 2012, together with explicit borrowing from the World Bank for this purpose, signals that—for now at least—this commitment is being maintained.
- The second challenge is how to encourage those above the poorest income quintile to pay the premiums required of them to participate in SP. Those people will constitute an ever-increasing proportion of the additional people who will have to be enrolled in the coming years if SP is to meet its objective of universal care.

Notes

1. This section is based on findings from a 2009 Africa health insurance study tour by the Ethiopia delegation, Tanzania delegation, Uganda delegation, World Bank Mission Team, and Abt Associates Mission Team (personal communication to author).

2. This section is based on findings from a 2009 Africa health insurance study tour by the Ethiopia delegation, Tanzania delegation, Uganda delegation, World Bank Mission Team, and Abt Associates Mission Team (personal communication to author).

3. This section is based on findings from a 2009 Africa health insurance study tour by the Ethiopia delegation, Tanzania delegation, Uganda delegation, World Bank Mission Team, and Abt Associates Mission Team (personal communication to author).

4. This section is based on Diop and Ba (2010).

5. This section draws heavily from Basinga and others (2010), Diop and Ba (2010), and the Rwanda Ministry of Health and World Bank Africa Region Human Development (2009).
6. This section is based on Kenya Ministry of Public Health and Sanitation and Ministry of Medical Services (2010).
7. This section draws heavily on Yazbeck (2009, 205–14); Giedion and Uribe (2009); and Gottret, Schieber, and Waters (2008).
8. This section draws heavily on Yazbeck (2009, 241–46) and World Bank (2010).

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