World Health Organization

Health Financing Case Study No 25

UNITED REPUBLIC OF TANZANIA

United Republic of Tanzania: Cross-Programmatic Efficiency Analysis

POLICY BRIEF

Objectives

A cross-programmatic efficiency analysis was conducted in the United Republic of Tanzania to identify and analyse critical areas of functional overlap, misalignment, or duplication across the country's **tuberculosis (TB), HIV/AIDS, malaria, Mother, Newborn and Child Health (MNCH), and Immunization Vaccine and Development (IVD)** programmes, and with the overall health system to inform plans as the country transitions from donor financing for priority disease programmes.

The cross-programmatic efficiency analysis took place between June 2018 to December 2018. This policy brief is written based on that analysis, with recognition that changes in the health system will have taken place since the study was conducted.

The United Republic of Tanzania Context

The United Republic of Tanzania is facing many health-related transitions that will have an effect on the health gains previously made. Like other countries, the United Republic of Tanzania has entered the demographic and epidemiologic transitions where they are seeing an increase in youth and elderly populations, as well as an increase in non-communicable diseases co-existing with the already high communicable disease burden. Furthermore, disease resurgence has been occurring in areas where they were previously eliminated due to climate change. All of these transitions pose significant barriers to the health security of the population.

The Tanzanian Government has placed strengthening the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC) as a high priority in both the "Sharpened One Plan", and "Big Results Now" implemented in 2014 and 2015 respectively. These efforts have made great strides in improving maternal and child outcomes in the country. Donor assistance has been playing an important role in this area by supporting the country's Maternal, Newborn, and Child Health (MNCH) goals as well as in other programmes, especially in HIV/AIDS, TB, and malaria. Spending on these four programmes is heavily reliant on donors and raises important questions regarding transition and sustainability challenges moving forward.

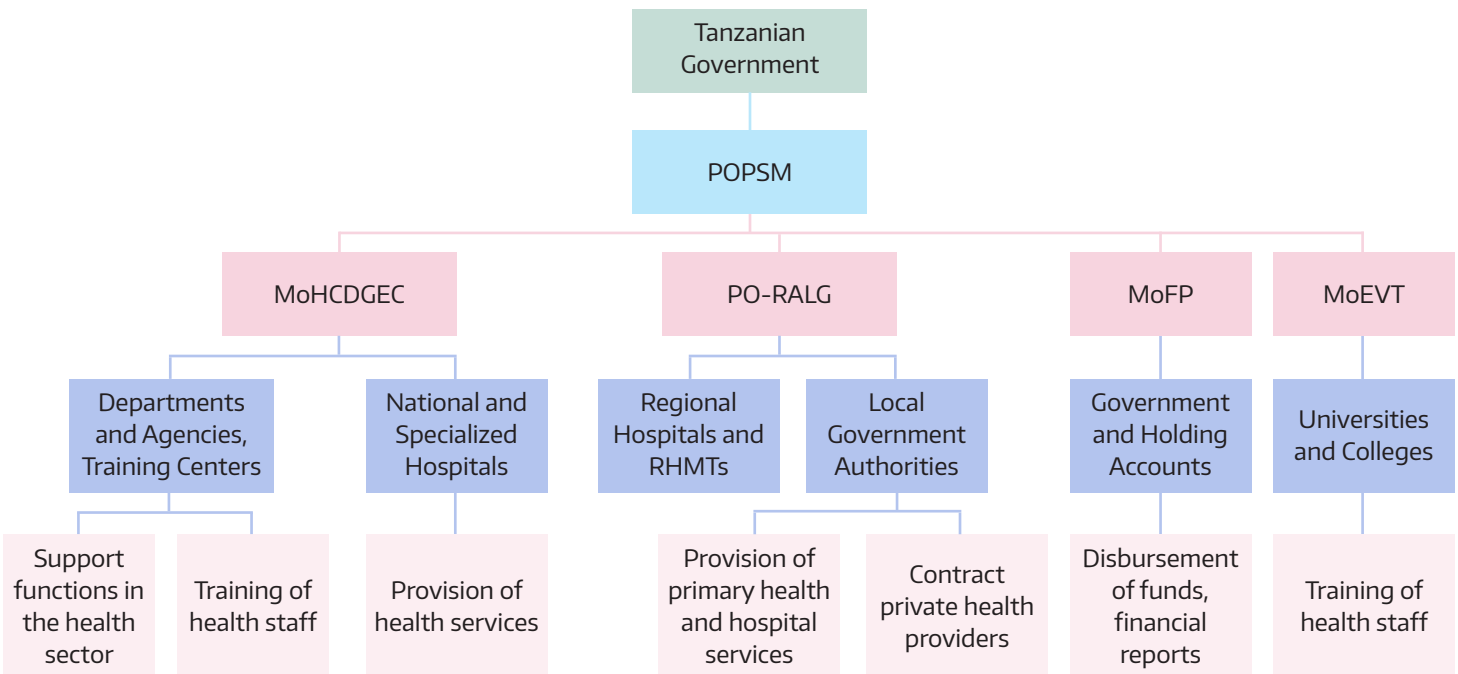
Key Findings

The five-key cross-programmatic inefficiencies, their implications, and potential intervention to mitigate each are discussed below.

1. Overlapping roles and responsibilities, as well as lack of coordination and harmonization

There are areas of overlapping roles and responsibilities between MoHCDGEC and President's Office Regional Administration and Local Government offices (PO-RALG) as depicted in Figure 1, particularly around the implementation of health programmes. For example, PO-RALG and MoHCDGEC are both responsible for hiring human resources for health, as well as supervising health facilities. The demarcation of these roles is often overlooked, resulting in the overlap of functions. Although the country has adopted sector-wide approaches, there are still coordination challenges related to health system strengthening approaches between donor technical assistance plans. In terms of programme governance, there are separate operational plans, which contribute to programmes working in silos.

FIGURE 1. MINISTERIAL LINKAGES OF THE OVERALL MANAGEMENT OF THE HEALTH SYSTEM IN THE UNITED REPUBLIC OF TANZANIA



LEGEND:

POPSM: President Office-Public Service Management
PO-RALG: President's Office – Regional Administration and Local Government
MoHCDGEC: Ministry of Health, Community Development, Gender, Elderly and Children and Social Welfare
MoFP: Ministry of Finance and Planning
MoEVT: Ministry of Education and Vocational Training
RHMT: Regional Health Management Teams

Adapted from Health Sector Strategic Plan, HSSP III. Quoted at: Human Resources for Health and Social Welfare Strategic Plan 2014-2019. Ministry of Health and Social Welfare. September 2014.

IMPLICATIONS	POLICY OPTIONS
• Overlapping roles in governance constrains decision making • Weak programme-level stewardship affects service delivery, resource generation, and financing • Wastage of limited resources and process duplication (e.g. training)	• Clearly delineate roles and responsibilities between the two agencies • Clear coordination mechanisms need to be put into place, such as establishing an information sharing platform between MoHDCGEC and PO-RALG, so that communication channels are open and complimentary action can take place

2. Multiple funding pools and modes of financing

The majority of health expenditures are derived from non-governmental sources (32.2% external and 23.9% out-of-pocket (OOP) sources)[1]. Donors mainly cover pharmaceuticals, tests, commodities, information systems, and often buildings and related infrastructures. Money is directly deposited to facilities to better match payment to priority services and empower facilities to manage funds. However, facilities do not have full ownership of their plans, which can be altered by the Council Health Management Team (CHMT). Additionally, facilities can purchase commodities directly if the Medical Stores Department (MSD) does not have the desired commodity.

IMPLICATIONS	POLICY OPTIONS
• There is a large dependence on off budget sources (donors and OOP), which raises sustainability concerns with donor assistance transition • Fragmentation within the flow of funds introduce distortions in financial allocations where certain health programmes receive more than others • Barriers exist to efficient and strategic purchasing of commodities • Scare flexibility in the reallocation of funds to the needs of service providers and the populations they serve prevent the effective allocation of resources	• Coordinate plans between donors and implementing partners with the government in order to avoid duplication • Link public financial management and health financing reform processes to better enable coordination across health programmes and the health system • Option for funds to flow to service providers to give them the ability to prioritize service delivery based on need

3. Multiple, uncoordinated information systems

Most vertical programmes generate and manage data separately using their own information systems that operate outside of the DHIS2. HIV and Immunization and Vaccine Development (IVD) specifically run their own patient, human resources, and training institution information systems. This fragmentation is largely due to donors setting up their own systems for each programme. The Health Data Collaborative initiatives and digital investment programme are among the plans to address this issue.

1 Tanzania National Health Accounts Report 2018

IMPLICATIONS	POLICY OPTIONS
• Evidence-based decisions are not guided by adequate information and can hinder quality of care and negatively influence health outcomes • Lack of information systems to aid in tracking patients with co-morbidities can contribute to loss to follow-up • Without comprehensive information systems, coordination for planning and budgeting purposes is challenging • Overstretched workforce due to the large administrative burden managing many different reporting systems	• Pool financing to develop and implement a stronger central system • Plans should be realistic given staff and electrical availability • Continue to build up the Health Data Collaborative initiatives for more coordination and routine information sharing across programmes

4. Fragmented procurement systems

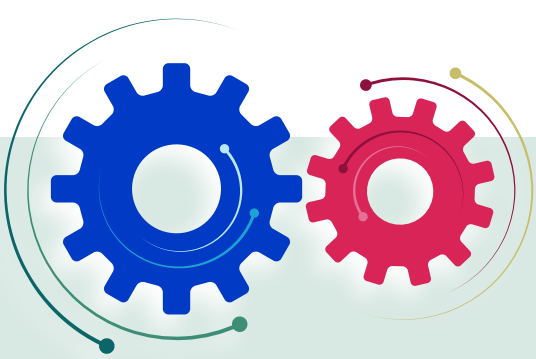
Development partners procure and have their own processes, while MSD is responsible for storage and distribution. Most commodities are procured through pooled procurement, while one fourth are procured through "local procurement" by each programme. This is done manually, ignoring economies of scale, and does not repeat the approaches applied abroad by MSD. Operational difficulties mean that the demand for health commodities does not match with budget allocations. In addition to these challenges, there are long lead times for imported goods, and a poorly built distribution infrastructure (e.g. poor roads in rainy season).

IMPLICATIONS	POLICY OPTIONS
• Additional financial cost is incurred without proper forecasting of needs • Lack of information system to monitor commodity availability across facilities leads to stock-outs of medicines with short shelf-life • Treatment delays from lack of available medicines • In-kind supplies are sent directly to facilities when they are not always needed • Mismatch between demand and supply	• Phase out the fragmented approach to procurement, while building capacity within MSD to be able to fulfil its central function as the primary procurement system • As part of this capacity building, use these discussions to strategize better coordination arrangements across the programmes, MoHCDGEC, PORALG, and even the private sector in terms of stock and distribution channels

5. Competing priorities and fragmented service delivery with weak health workforce training

At most points of service delivery, programmes services (especially HIV) are rarely integrated within facilities, and programme staff largely function independently and do not provide services outside their programme mandate. Additionally, skilled health programme staff are limited, and the skills available rarely match those required. Levers to address this mismatch are constrained as districts cannot hire or fire human resources. Furthermore, it is unclear what services are provided at each level of care. The distinguishing factor between the level of care it seems is dictated by the number of beds available, rather than the type of service provided.

IMPLICATIONS	POLICY OPTIONS
• Lack of referral system leads to underutilized lower-level facilities and an overload of higher-level hospital beds • Co-morbidities are treated in different clinics within the same facility • The government will be forced to absorb programme staff for priority diseases who were previously not budgeted for as the country transitions from donor financing for these programmes	• Ensure costing strategies take an integrated approach at health centres and dispensary levels to aid in shared service delivery of health programmes • MoHCDGEC and PO-RALG should present a detailed plan to the Ministry of Education to improve pre-service training and ensure it is responsive to the burden of disease • Map service delivery capacities that is matched to health workforce distribution plan



The main contributors of this policy brief were Antonio Durán, Alexandra Earle, Anuoluwa Ishola, and Maximillian Mapunda.

Financial support is gratefully acknowledged from the UK's Department for International Development's "Making Health Systems Stronger" programme & the Global Fund.

United Republic of Tanzania: Cross-Programmatic Efficiency Analysis. Policy brief (Health financing case study, no. 25)

ISBN 978-92-4-003444-0 (electronic version)
ISBN 978-92-4-003445-7 (print version)