Tanzania

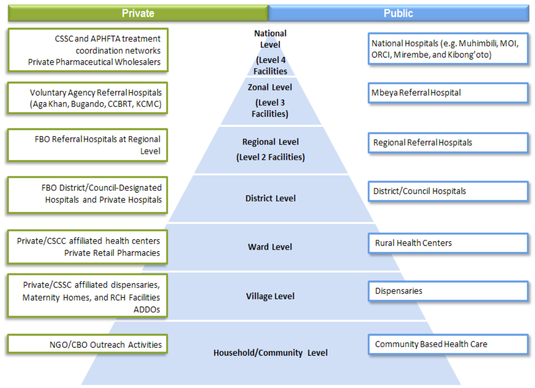
Making Provider Payment Mechanisms More Strategic: Removing the Roadblocks to Implementation

Dr. Ntuli Kapologwe
Dr. Catherine Joachim
Suzan Makawia
Dr. Gemini Mtei

Context:

Population	54M (projection for 2018)
GDP/ Capita	$955 USD (2015)
THE/ Capita	$45 USD (2015)

Health System Organization



Financing sources include:

- Domestic taxation
- Donor funding
- Out-of-pocket payment
- Insurance: private insurance, National Health Insurance (NHIF) and Community Health Fund (CHF)

Monitoring

PlanRep

- System can be used to assess whether facilities are planning and budgeting based on community needs
- Provides quarterly and annual implementation and financial reports

Facility Financial Accounting and Reporting System

- Accounting and financial reporting system at service provider level
- Integrated with PlanRep system, to assess value for money by comparing use of funds against service delivery by fund source
- Provides quarterly and annual financial reports

Government Hospital Management Information System

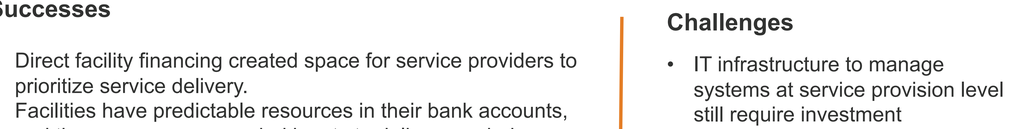
- Core system to manage patient information at dispensaries, health centres, district hospitals and regional hospitals
- Integrated with NHIF claim management system, helping to manage accuracy of claims

District Health Management Information System

- Provider information for adjustors used in the provider payment formula under HBF and CHF
- Provides information on utilization and catchment population to inform quarterly provider payment adjustments HBF and CHF

Provider Payment Mechanisms

- **Capitated rate for Health Basket Fund (HBF) and Community Health Fund**
- **Line item budget under central budget**
- **Fee-For-Service under National Health Insurance Fund**
- **Result Based Financing (RBF)**



Innovations

Direct Facility Financing

Health Sector Basket Funding

- Donors with specific interest in the health sector contribute to HBF to support different initiatives across the country.
- Under original funding flow, HBF from Ministry of Finance and planning (MOFP) was disbursed to Local Government Authorities (LGA) based on budgets and plans, subject to approval by MOF. This approach had numerous challenges: it was not possible to see how much had been allocated and spent for service providers and most plans submitted to the MOFP were not implemented.
- In 2017, the MOFP, MOHCDGEC and PORALG agreed to disburse HBF directly to facility bank accounts. The formula for disbursing HBF is calculated as a flat rate facility allocation adjusted for performance, need and equity. Total facility outpatient visits, catchment/service population and distance from facility to LGA headquarter are used as adjustors for performance, need and equity, respectively.
- With this HSBF direct facility financing (DFF) reform facilities are now visible and have autonomy to priorities service delivery based on patient needs.

Improved Community Health Fund

- CHF was introduced in 2001 as another mechanism to finance health care at LGA level and LGAs were responsible to prepare budgets and buy inputs using CHF funds and distribute to service providers through budget, similar to other government fund sources. From May 2018 year, provider payment mechanism under CHF was reformed by introducing improved community fund (iCHF).
- Under iCHF there is now purchaser provider split and clear provider payment mechanism. Service providers will now be paid using a formula similar to HBF by paying a flat per facility rate adjusted for performance and need. Total facility utilization of CHF members and CHF enrolment are used as adjustors for performance and catchment/service population is used as adjustor for need. This innovation also includes an extension of planning and budgeting system and financial management system to service providers. Now facilities are able to plan and budget and also ensure accountability through accounting and financial reporting.

Successes

- Direct facility financing created space for service providers to prioritize service delivery.
- Facilities have predictable resources in their bank accounts, and they can procure needed inputs to deliver needed services.
- Positive changes are now seen in reducing drug stock-out, provision of referral care for pregnant women, and on the side of facility infrastructure.
- Initial field assessment show that facility staff are now more motivated to provide service as they now have needed inputs

Challenges

- IT infrastructure to manage systems at service provision level still require investment
- Few human resource at facility level to cope with increasing demand for health care
- Still need to improve on data quality to inform refinement of PPM

Policies/ Progress/ Challenges for UHC

A comprehensive health financing strategy provides a vision of how UHC will be achieved. The strategy proposes:

- Introduction of Mandatory National Health Insurance (NHI) to act as a sole purchaser of minimum health care benefit package for all citizens. Contribution for poor will be subsidized using different fund sources.
- PHC providers will be paid using capitation
- Hospitals will be paid on a case-based system

Process for approval is still ongoing. Enactment of mandatory insurance will help address provider payment challenges currently embedded under central budget funding because all funds will pool under one entity responsible for purchasing health care.

Lessons Learned

- ✓ **It is important to make service providers visible in the planning and budgeting system by making sure that resources are flowing to their bank account and have step by step autonomy to plan and budget**
- ✓ **Even in a fragmented system it is possible to move to strategic purchasing by harmonizing provider payment mechanisms to simply service providers' task**
- ✓ **It is possible to introduce strategic purchasing under central budgeting if disbursements to service providers will be de-linked from line item budget disbursement to formulate output-based disbursement. Accounting and financial reporting may be managed by line items**

Next Steps

Short Term:
The country is continuing with harmonization of provider payment mechanisms across different funding sources

Long Term:
Tanzania is currently in the process of developing mandatory comprehensive health insurance that will provide a minimum benefit package and will be paid through capitation for PHC and case-based payments for hospitals