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SNAPSHOT: TANZANIA'S HEALTH SYSTEM

Brief

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Introduction

Over the past decade, the performance of Tanzania's health system has been mixed (USAID, 2013). The country will achieve many of its 2015 targets for malaria, HIV and AIDS, tuberculosis, and child health, but progress in reproductive health is lagging (see Figures 1 and 2). Neonatal mortality has declined but not enough to meet the set targets, and little or no progress has been made in other reproductive health indicators. And while numerous health systems strategies (see Box 1) have resulted in notable progress in systems development, improvements in service delivery have been slow, and further investments are needed in the areas of human resources for health (HRH), commodities and supply chain, health infrastructure, monitoring and evaluation (M&E), and health management information systems (HMIS) (Ministry of Health and Social Welfare [MOHSW], 2013a).

Human Resources for Health

- Tanzania suffers from a health worker shortage, with an imbalance in certain cadres and an inequitable distribution of HRH across regions (MOHSW, 2013a). The number of clinicians and nurses is below the national average in 13 regions, and 554 dispensaries are without skilled health workers (BRN Healthcare Lab, 2014).
- HRH planning is difficult because of inconsistent data from multiple sources (MOHSW, 2013b). Inconsistency in training quality, insufficient recruitment (due to a lack of incentives, particularly for rural posts), poor human resource management, and weak enforcement of policies and regulations have fueled the shortage and led to low productivity (MOHSW, 2013a; MOHSW, forthcoming).

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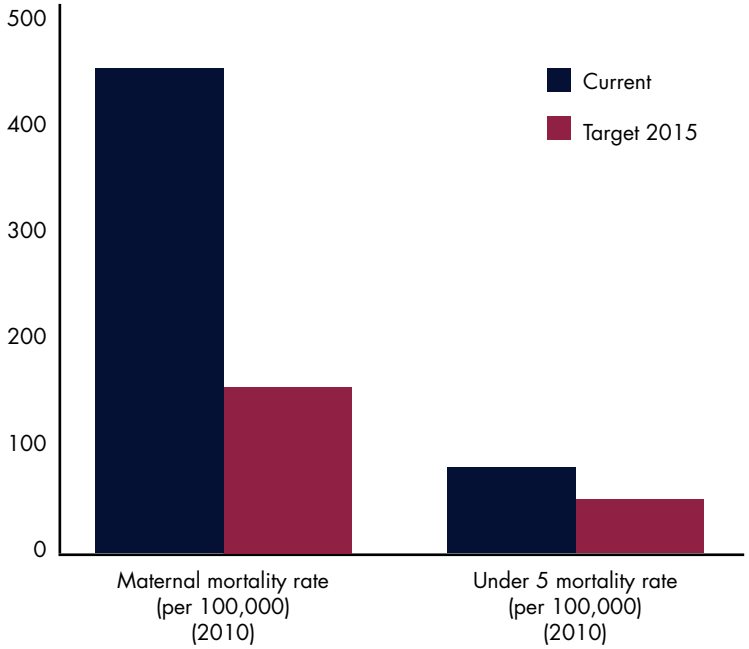
BOX 1. SELECT HEALTH SYSTEM STRATEGIES

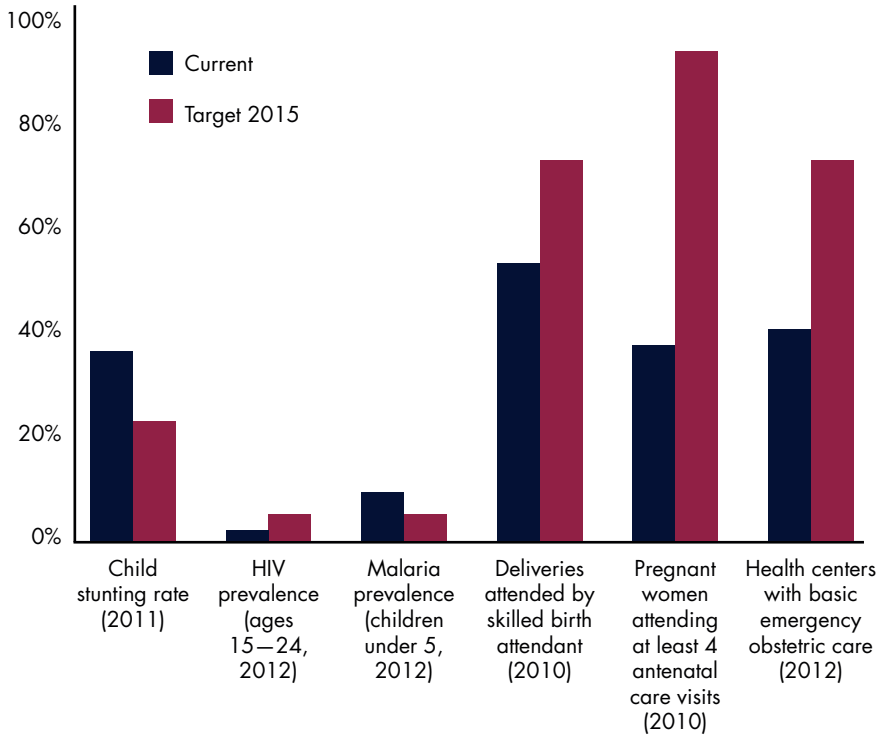
- Tanzania's Third Health Sector Strategic Plan 2009–2015 (HSSP III)
- Primary Health Services Development Programme 2007–2017
- Human Resource for Health and Social Welfare Strategic Plan 2014–2019
- National Health Sector Quality Improvement Strategic Plan 2013–2018
- Tanzania National eHealth Strategy July 2013–June 2018
- Tanzania Food and Drug Authority Strategic Plan 2012/13–2016/17

Figure 1. Health status indicators



Source: MOHSW, 2013a

Figure 2. Health status indicators



Sources: Tanzania Commission for AIDS (TACAIDS) et al., 2013; MOHSW, 2008; MOHSW, 2013a; MOHSW, 2013b

Table 1. Health system performance indicators

INDICATOR	ACHIEVEMENT (2012)	TARGET
HUMAN RESOURCES FOR HEALTH*		
Health worker density: Doctors and assistant medical officers	0.9/10,000	-
Health worker density: Nurse-midwives	4.9/10,000	-
Health worker density: Pharmacists	0.12/10,000	-
Training institutes with full accreditation	56	30
COMMODITIES AND SUPPLIES**		
Availability of medicines (day of visit, all health facilities; 14 items, mean)	41%	
HEALTH INFRASTRUCTURE***		
Health facility density: Dispensaries	5,776	7,767
Health facility density: Health centers	694	2,074
Health facility density: Hospitals	264	238
Health facility density: All facility types	6,734	10,174

Source: Adapted from MOHSW, 2013a. *MOHSW, 2008; **Ifakara Health Institute, and MOHSW, 2013, no target given; ***MOHSW, 2007

- As part of the Big Results Now (BRN) initiative, Tanzania is aiming to achieve a 100 percent balanced distribution of skilled health workers at the primary level by 2017–2018. The MOHSW will increase the density of clinicians and nurses in nine crucial regions and reduce the number of facilities without skilled health workers by 70 percent, requiring an estimated US$8 million ($1 equals TZS 1,800) (BRN Healthcare Lab, 2014).

Health Financing

- Though the Health Sector Strategic Plan (HSSP) III had an objective of the health budget reaching 15 percent of the total GOT budget by 2015, actual performance is closer to 8.1 percent in FY 2014–15 (MOHSW, 2014a), where the total budget includes non discretionary items.
- The HSSP III also included a target of increasing coverage of insurance schemes such as the Community Health Fund (CHF) and the National Health Insurance Fund (NHIF). The trend over FY 2011–12 to 2012–13 suggests stagnation in CHF membership and a slight increase at best in NHIF. Recent data over FY 2014–15 imply that CHF membership is increasing again. Other financial protection measures exist, such as exemptions and subsidies, but are not fully implemented, which means that the HSSP III vision of increased equity in financing is not yet met.
- The health sector as a whole remains heavily dependent on external resources; the National Health Accounts (NHA) for 2009/10 shows that development partners continue to contribute a significant amount to total health expenditure (40 percent). Public health spending continues to be low at 26 percent (MOHSW, 2014b). In addition to bilateral donors, Tanzania receives significant funds under a health basket fund arrangement. The basket funds accounted for 10.4 percent of total GOT health expenditure (total inclusive of non-basket external support).[1]
- Tanzanian stakeholders have approved the major design of a new health financing strategy, which will involve a single national health insurer. This will require some new legislative, regulatory, and administrative measures and hence will need time. In addition, the Tanzania Commission for AIDS (TACAIDS) is working with stakeholders and

Parliament to have an AIDS Trust Fund approved, which might increase sustainability in the HIV and AIDS response.

Commodities and Supplies

- On average, only 41 percent of facilities have essential tracer medicines in stock. Private (55%) and urban (54%) facilities are more likely to have essential medicines in stock than public (37%) and rural (37%) facilities, respectively (Ifakara Health Institute and MOSHW, 2013).
- Guidelines for improving the use of medicines are in place but have yet to be applied in practice (MOHSW, 2013a). Similarly, enhanced procurement procedures are being developed to increase efficiency, reduce waste, and improve the availability of medicines, but the impact of these procedures is unknown (MOHSW, 2013a).
- Under the BRN initiative, the MOHSW has committed to 100 percent on-time delivery of ordered health commodities, zero percent waste, and improved inventory management by 2017–2018, requiring an estimated US$17 million ($1 equals TZS 1,800) (BRN Healthcare Lab, 2014).

Health Infrastructure

- Overall, 66.4 percent of the population lives within 5 kilometers of a health facility. However, percentages range from 25 to 100 depending on the region, further pointing to an unequal geographic distribution of health facilities and services (MOHSW, 2013a).
- Maintaining the country's health infrastructure is challenging, with most facilities in need of additional refurbishment and resources, particularly at lower levels of care (MOHSW, forthcoming). Only 27 percent of facilities offer basic amenities such as consultation rooms and adequate sanitation, and the availability of six types of basic equipment ranges from just 17 percent in dispensaries to 67 percent in hospitals (IHI and MOSHW, 2013).
- To improve service readiness, the MOHSW drafted new standards for health and social welfare services in late 2014. These volumes specify requirements for staffing, equipment, management, and other inputs across five levels of care—each of which will require a significant investment.

Monitoring and Evaluation and Health Management Information Systems

- While disease surveillance has improved some, there has been little progress in integrating surveillance systems (MOHSW, 2013b).
- Access to health information is currently limited at all levels (from the community to the policymaker). The vital registration system is not functioning properly, resulting in a lack of complete national data on births and mortality (MOHSW, 2013b).
- The MOHSW established a data warehouse as a first step toward an envisioned data network, and there have been recent improvements in the information technology network. However, there is currently no overarching information and communications technology strategy for the health sector (MOHSW, 2013b).
- Tanzania's Monitoring and Evaluation Strategic Initiative (MESI) aims to improve the country's M&E and health management information systems. Strengthening the integration and interoperability of existing information systems and enhancing data quality through improved data quality assessments and data verification will be vital to the success of that initiative (Hickmann et al., 2014).

Conclusion

Improving health outcomes and meeting development targets—including those outlined in the BRN, post-Millennium Development Goals, and Tanzania Development Vision 2025—will require coordinated efforts to strengthen Tanzania's health system. To make them, the country will need to invest more heavily in HRH, the commodities and supply chain, health infrastructure, M&E, and HMIS. While Table 2 provides some cost estimates, the full investment required will not be known until the completion of Tanzania's OneHealth cost analysis of HSSP IV—the next health sector strategic plan.

Table 2. Priority health systems strengthening gaps, actions, and estimated costs

HEALTH SYSTEM BUILDING BLOCK	HEALTH SYSTEM GAP	SUGGESTED PRIORITY ACTION	ESTIMATED COST (US$M)
HUMAN RESOURCES FOR HEALTH	HRH information	Update HRH and training institution information systems	0.237-0.41
		Harmonize parallel HRH information systems	<0.535
		Build capacity in information system management/data analysis	0.190
	Retention	Implement a focused retention approach in high-need districts	4
		Institutionalize professional development standards/ opportunities	≤3.5
		Develop national health worker retention guidelines	0.178-0.207
	Performance and incentives	Strengthen implementation of the Open Performance Review and Appraisal System (OPRAS) and Public Service Pay and Incentive Policy (2010)	unknown
	Training and production	Strengthen the capacity of target health training institutions	unknown
	Community health workers (CHWs)	Harmonize CHW curricula and support implementation of training	unknown
PHARMACEUTICALS AND SUPPLY CHAIN MANAGEMENT	Stockouts	Strengthen commodity distribution/storage systems and fleet	23.7
		Support capacity building in forecasting/financial management	unknown
		Institutionalize Logistics Management Unit supported by e-LMIS	1.25
	Rational use of medicines	Develop/institutionalize approaches for rational medicine use	0.285
		Establish nine model medicines and therapeutics information centers	0.594-1.2
		Disseminate key rational medicine use policies/conduct trainings	0.57
	Medical Stores Department (MSD)	Shift MSD to commercial principles; Develop distribution systems and medium-term financing plan for medicines/health technology	3.5
		Re-capitalize MSD	unknown
	Quality assurance	Strengthen pre- and post-market surveillance of commodities	0.475
M&E AND HMIS	Linking and harmonization	Establish and operationalize a national e-health data warehouse	≤0.594
		Strengthen integration/interoperability of information systems; Establish an integrated e-system for disease surveillance/ response	1.25
	Data quality	Conduct supportive supervision and Data Quality Assessments	0.437
		Integrate the routine data verification system into the District Health Information System 2 (DHIS2)	0.5
	Surveillance	Support surveillance activities (e.g., sample vital registration with verbal autopsy or SAVVY)	0.238 (SAVVY)
	HMIS capacity	Support continual HMIS/DHIS2 development training	unknown

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