Primary health facilities in Tanzania:
A closer look at cost sharing revenue availability and use in the public sector

Key Points

- Total funds from Community Health Fund (CHF), National Health Insurance Fund (NHIF) and user fee revenue are a minimal share of the total resource envelope available to local government authorities.
- In districts with high CHF membership, CHF revenue is the major source of cost sharing revenue.
- User fee revenues at facilities are much less than expected.
- Only a small proportion of cost sharing revenue is being spent by facilities, although the nature of expenditure is in line with the guidelines.
- Access to cost sharing revenue relies on facilities claiming for money, a process which is limited when districts have a single district level cost sharing account.
- Pooling of cost sharing funds at the district level leads to facility cross-subsidization and should be encouraged.

What is cost sharing?
Cost sharing is a strategy to generate revenues for health providers to supplement funds provided by government to facilitate provision of quality health care including an adequate supply of drugs (Newbrander and Stephen, 1996).

Cost sharing in Tanzania
Cost sharing in Tanzania includes receipts from user fee revenue from Community Health Fund (CHF) premiums and matching grant funds and reimbursements from the National Health Insurance Fund (NHIF) (PER, 2008). User fees in public lower level facilities were introduced in 1993, along with a system of exemptions¹ and waivers²,

1 Exemptions: for priority population groups, e.g. children under five, pregnant women, and for selected diseases/conditions, e.g. typhoid, chronic illness, AIDS, TB and leprosy, epidemics.
2 Waivers are for the poor and vulnerable, offering free care to those who are unable to pay.

Table 1: Selected characteristics of sampled case study districts

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Rural District</th>
<th>Urban District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population size</td>
<td>486,900</td>
<td>175,717</td>
</tr>
<tr>
<td>Number of health facilities</td>
<td>57</td>
<td>16</td>
</tr>
<tr>
<td>Number of government facilities</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>Population per health facility</td>
<td>8,542</td>
<td>10,982</td>
</tr>
<tr>
<td>Year of introducing CHF</td>
<td>1999</td>
<td>2008</td>
</tr>
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The Community Health Fund (CHF) is a voluntary pre-payment scheme targeting the informal sector, rolled out in 2001. Households can enroll for between TZS 5,000 to TZS 30,000 per year. Subject to the district submitting requests, the central government will match the contributions made by CHF members through a matching grant. The NHIF is mandatory for public servants, with other formal sector employees being able to opt into the scheme. In May 2009, the NHIF took over the management of the CHF from the Ministry of Heath and Social Welfare (MoHSW), initially for a three year period.

Study methods
A case study of two districts (1 urban and 1 rural) was carried out to assess how facilities access and use cost sharing funds in a sample of 4 facilities (Table 1). The case study was carried out as part of a larger study to explore the effects of the takeover of CHF management by the NHIF (Spotlight 1). Data was collected for the years 2008-2011, covering the period before and after the reform.
### Characteristics

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<th>Rural District</th>
<th>Urban District</th>
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<tr>
<td>CHF premium</td>
<td>TZS 5,000 per household per year</td>
<td>TZS 5,000 per household per year</td>
</tr>
<tr>
<td>Total CHF members in 2011</td>
<td>11,802</td>
<td>792</td>
</tr>
<tr>
<td>CHF benefit package</td>
<td>Outpatient care in selected public primary facility (dispensary or health centre) plus referral care up to TZS 15,000 in regional hospital, district designated hospital (faith-based).</td>
<td>Outpatient care in selected public primary facility (dispensary or health centre).</td>
</tr>
<tr>
<td>User fee level</td>
<td>TZS 1000 until 2009, TZS 3000 since 2009</td>
<td>TZS 100 for dispensaries and health centres</td>
</tr>
<tr>
<td>Financial flows</td>
<td>CHF, NHIF and user fee revenue pooled in district CHF-account</td>
<td>CHF and user fee revenue deposited in facility bank account. NHIF revenue pooled in District Medical Officer account.</td>
</tr>
</tbody>
</table>


### Accessing and using cost sharing funds

All district revenue, including cost sharing funds, can be budgeted according to the yearly plans set out by the district council (the Comprehensive Council Health Plan (CCHP)). Facilities can also request funds from the district in an ad hoc manner. The process for accessing cost sharing funds depends on whether or not facilities have their own bank accounts.

In districts where cost sharing funds are pooled at the district level in a ‘CHF account’ (the case of the rural district), facilities send a request to the district authority for drugs, supplies or minor renovations. The amount of drugs and supplies purchased for a facility is not tied to the amount of cost sharing revenue generated by the facility, leading to cross subsidisation.

In districts where facilities have their own bank accounts, cost sharing funds are deposited directly into this account and can be spent without district approval (the case of the urban district).

### Cost sharing revenue - how big a source of district income?

Total funds from CHF, NHIF and user fee revenue were a relatively constant and minimal share of the total resource envelope available to local government authorities accounting for around 4% of total expenditure (Figure 1). However, cost sharing funds represented 1% of all funds in the urban case study district compared to 8% in the rural district in 2010/2011.

**Figure 1: Sources of funds for Local Government Authorities, and their contributions to the total resource envelope**

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**Cost sharing revenue**

In the rural district, total cost sharing funds increased in absolute terms within the analyzed period, due to an increase in CHF revenue (Figure 2). CHF revenue (inclusive of matching grant funds) was the most significant source of cost sharing revenue in the rural district, increasing from 74% of all cost sharing revenue in 2008 to 93% in 2010 (Figure 2). In contrast, NHIF revenue and user fee revenue were the predominant source of revenue in the urban district, reflective of the lower number of CHF members (Figure 2).

**Figure 2: Overview of total district funds from NHIF, CHF and user fees in the two case study districts between 2008-2011 in Million TZS.**

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Note to Figure: Data from Public Expenditure Reviews (PERs) of 2008/2009; 2009/2010 and 2010/2011. Note that for 2010/2011 data were derived from 124 Local Government Authorities (LGAs), for 2009/2010, data were derived from 120 LGAs, and for 2008/2009 data were from 2007/2008 and based on only 3 rural LGAs.

### Composition of cost sharing revenue

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**Figure 2: Overview of total district funds from NHIF, CHF and user fees in the two case study districts between 2008-2011 in Million TZS.**

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Note to Figure: _R: RURAL; _U: URBAN
CHF revenue was a larger share of dispensary compared to health centre cost sharing revenue (84% compared to 63% in 2011) (data not shown) in the rural district. In contrast, NHIF revenue represented a higher share of facility revenue in health centres compared to dispensaries (34% compared to 13% in 2011) (data not shown) in this district.

Typically the total cost sharing funds per capita available to the rural district were two to three times higher than in the urban district (e.g. 161 versus TZS 62 per capita in 2011).

**Is cost sharing revenue being used by facilities?**

Expenditure of cost sharing funds by facilities is generally low, varying from 11% to 24% in the rural district between 2008 and 2010 (Figure 3). The reported reason for low expenditure was lack of knowledge or confidence among facility in-charges to claim for these funds. In 2011, expenditure increased dramatically to 71% of cost sharing revenue, a result of district efforts to sensitise facility in-charges on the importance of submitting claims to use their cost sharing revenue. In the urban district, facility expenditure data were not available.

In the rural district, drugs and medical supplies were the main items purchased with cost sharing funds (83%), with minimal funds being used to undertake minor renovations to facilities (5%).

**Figure 3: Comparison of cost sharing revenue and expenditure for 2008-2011 in the rural district in Million Tzs**

![Figure 3](image-url)


**User fees – less than expected?**

User fee revenue was low for all facilities visited. When compared to how much user fee revenue facilities would be expected to earn if all non-insured patients paid for outpatient care at official user fee rates, reported actual revenue was 20% or less of expected revenue in all facilities (Table 2). There are only three possible explanations for these findings:

- a very high proportion of patients are being exempt from user fee payments;
- the outpatient visit reports at facilities are inaccurate (actual visits are less than reported visits);
- user fee revenue is not being fully accounted for and some revenue is ‘disappearing’.

Each of these potential reasons has its own set of concerns. The first, whilst desirable from an equity perspective, is concerning as it would discourage people from joining the CHF. The second reason, whilst unlikely, would be concerning as such reports are important for planning purposes. The third reason is the most worrisome scenario. If true, this would not only have equity implications, but also serve to discourage providers from sensitizing patients to enrol in the CHF, as they would gain more from their continued payment of user fees. Further research is urgently needed to examine the relationship between user fee revenue and service use by the uninsured in other facilities and to ascertain which of the above reasons holds.

**Table 2: Reported user fee revenue as a proportion of expected revenue in 2009-2010**

<table>
<thead>
<tr>
<th></th>
<th>Annual OPD among uninsured</th>
<th>Expected user fee revenue from OPD in TZS 1000</th>
<th>Reported user fee revenue in TZS 1000</th>
<th>Reported as % of expected revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural disp 2009</td>
<td>3,259</td>
<td>3,259</td>
<td>420</td>
<td>13%</td>
</tr>
<tr>
<td>Rural disp 2010</td>
<td>205</td>
<td>615</td>
<td>75</td>
<td>12%</td>
</tr>
<tr>
<td>Rural hc 2009</td>
<td>4,027</td>
<td>4,027</td>
<td>560</td>
<td>14%</td>
</tr>
<tr>
<td>Rural hc 2010</td>
<td>6,976</td>
<td>20,928</td>
<td>272</td>
<td>1%</td>
</tr>
<tr>
<td>Urban disp 2009</td>
<td>8,694</td>
<td>8,694</td>
<td>292</td>
<td>3%</td>
</tr>
<tr>
<td>Urban disp 2010</td>
<td>4,806</td>
<td>4,806</td>
<td>635</td>
<td>13%</td>
</tr>
<tr>
<td>Urban hc 2009</td>
<td>21,735</td>
<td>21,735</td>
<td>4,846</td>
<td>20%</td>
</tr>
<tr>
<td>Urban hc 2010</td>
<td>21,540</td>
<td>21,540</td>
<td>2,300</td>
<td>11%</td>
</tr>
</tbody>
</table>

Note to Table: Data on CHF utilisation levels were derived by multiplying the number of CHF households by 7.4 which was the average number of visits during the SHIELD survey in Singida in 2008, as data from facility registers seemed very low. However, for the rural dispensary facility register data were used. The expected user fee revenue from inpatient admissions in health centres was not included. The actual user fee revenue from inpatient admissions is included.

**Conclusions**

- Cost sharing funds are a minimal share of the total resource envelope available to local government authorities.
- In districts with high CHF membership, CHF revenue is the major source of cost sharing revenue, and when matching grants are
claimed, this can sizeably boost district cost sharing resources.

- User fee revenue levels are much less than expected, raising concerns as to why.
- Only a small proportion of cost sharing revenue is being spent by facilities. This is concerning as it may demoralise staff from increasing CHF enrolment rates, increase community drop out, as quality of care does not improve. Access to cost sharing revenue relies on facilities claiming for money, a process which is limited when districts have a single district level cost sharing account.
- Pooling of cost sharing funds at the district level leads to facility cross-subsidization. Promotion of facility accounts could undermine pooling and cross subsidisation and impact on equity unless district accounts are maintained and some cost sharing revenue is pooled there.

Policy recommendations

- Efforts are needed to sensitise health facility in-charges on the need to claim for cost sharing funds from the district.
- The introduction of facility bank accounts may facilitate access to cost sharing funds, but care is needed to ensure that this does not undermine equity by limiting cross subsidisation. A portion of these funds should be retained at district level for cross-subsidisation.
- In districts with health facility bank accounts, facilities should be mandated to issue reports to the district on expenditure levels.
- Care is needed to ensure that collected user fee funds are fully accounted for. Facilities should report on the total number of visits among CHF members, NHIF members, user fee payers and the exempt information captured in facility registers but not summarised. This would facilitate identification of reporting errors (where reported user fee revenue does not match with service use).

References


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