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**DISCUSSION**

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# **A case study of the Essential Health Benefit in Tanzania Mainland**

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of Integrated Services: Learning from Practice  
in East and Southern Africa

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## Executive summary

An Essential Health Benefit (EHB) is a policy intervention designed to direct resources to priority areas of health service delivery to reduce disease burdens and ensure equity in health. Mainland Tanzania's most recent benefit package – the National Essential Health Care Interventions Package-Tanzania (NEHCIP-TZ) – describes the EHB as a minimum or “limited list of public health and clinical interventions.” The package identifies where priorities are set for improved public health. This report shows the challenges of turning a policy ‘wish list’ and package into a reality of services that can be accessed across different facility levels.

This report describes the evolution of mainland Tanzania's EHB; the motivations for developing the EHBs, the methods used to develop, define and cost them; how it is being disseminated, communicated, and used; and the facilitators (and barriers) to its development, uptake or use. Findings presented in this report are from three stages of analysis: literature review, key informant perspectives and a national consultative meeting. The case study on Tanzania was implemented in a research programme of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC). The programme is being implemented in association with the East Central and Southern African Health Community, supported by IDRC (Canada).

Five key time periods are identified in mainland Tanzania's EHB evolution:

- Pre-intervention, 1960-1996
- Tanzania Essential Health Interventions Package (TEHIP), 1996-2000
- National Package of Essential Health (NPEH), 2000-2009
- National Essential Health Care Intervention Package (NEHCIP-TZ), 2009-2015
- Health Sector Strategic Plan (HSSP) IV, 2015-ongoing.

First defined during in the mid-1990s, the programme led to the development of a national package in 2000. Programmers used TEHIP tools to prioritise and plan for the burden of disease response. The national package was refined in 2013 in the NEHCIP-TZ, with costing scenarios identifying the resources needed. In line with the upcoming health financing strategy, it identified strategies for how such resources will be located. A single-health insurance scheme was planned to enable risk pooling and cost sharing across a greater population base to finance NEHCIP-TZ. However, the NEHCIP-TZ conceptually shifts the benefit from ‘essential’ to ‘minimum’ health interventions. In terms of achieving universal healthcare, this means challenges remain.

The report outlines the implementation of the current EHB, the NEHCIP-TZ, together with its dissemination and challenges. We raise as key findings that the EHB has evolved. In theory, it focuses not only on diseases but on tackling the social determinants of health across all facilities. It emphasises quality services for clients, prevention of disease and effective integration within the health system. The five services clusters defined are: reproductive and child health; non-communicable diseases; communicable diseases; local common diseases; and linked intervention packages, provided across all levels of services. To achieve this, the NEHCIP-TZ has been integrated into planning mechanisms, funding streams, budgets and the operationalisation of health strategies. However, with its design comes concern over cost and, in line with this, the ability to implement the EHB in a manner that adheres to policy guidelines and HSSP IV 2015-2020.

To achieve the outputs set out in the Comprehensive Council Health Plans (CCHPs) and the aims of the health sector, the EHP requires various inputs and resources, including infrastructure, staff, management, office, assets, equipment and commodities. In the 2013 costing exercise, however, a large resource gap was identified, raising a question of the feasibility of the EHB.

The median cost of running dispensaries in 2011/12 was US\$27 830 per year; US\$124 600 per year for health centres; and US\$3.37 million per year for regional hospitals (at 2012 exchange rates). Recurrent costs accounted for the highest portion, at 80% on average of total costs in health facilities. Personnel costs contributed the majority of the cost. The 'best,' 'expected' and 'actual' service delivery scenarios were modelled and costed. The packages for non-communicable diseases, particularly cancer and diabetes, were the most expensive.

The HSSP IV is introducing innovative strategies for delivering EHBs, including partnerships and improvements in pre-financing, as a transition towards a Single National Health Insurance Plan. A revised costing exercise has been conducted for the minimum benefit package (MBP)/MBP Plus schemes, as part of the upcoming health financing strategy, yet to be approved. Three scenarios were modelled with their costs to implement the MBP nationwide. The resource gap was between US\$9 and US\$178 million, with highest costs at the dispensary level. How the MBP/MBP Plus aligns with the current HSSP IV and its vision for health equity could be debated. The health financing strategy and key changes, such as the single-health insurance scheme, MBP and direct facility financing, have two main objectives: accountability and assurance in service delivery through increased health revenue, pooling of funds and improved public finance management and a shift towards an output-based provider payment system. This shift enables better matching of payment to MBP services provided, increases provider autonomy and improves strategic purchasing and value for money.

The EHB as a set of services provided to citizens requires full integration into facility planning and resource allocation, all of which seem to have been achieved. Examples of this integration into the health system includes its reference in the National Health Policy (2007), its guidance in forming the CCHPs and in informing basic facility standards and thus service provision. The EHBs integration with key planning and accounting tools has enabled its dissemination and has assisted in monitoring its delivery. Implementation challenges remain, however, given the gap in financing and need to strengthen management of public finances. There is a power imbalance between services and providers. A large vulnerable group entitled to the EHB are, in practice, not able to access it. The EHB has thus been criticised as being a 'wish list' of services. To deliver the EHB, Tshs 251bn (US\$158 million) are required, but, the 2016/2017 budget only allocated Tshs 112bn (US\$70 million) for essential commodities, leading to a resource gap. Not all funding is reported or accounted for, however, or pooled into budgets and plans, including external funding and non-government organisation support. Estimates of the gap also need to include the related costs of delivering the EHB, including processes, staff and medicines so that service providers have all the necessary requirements to deliver it.

EHBs are legal entitlements for all citizens. Nevertheless, greater clarity is needed amongst service providers on who is eligible for free services, what they are eligible for, and how funds will be provided for this. The shift towards working with facilities, and strengthening decentralisation, may assist to address these concerns. Tanzania's EHB remains complex, however, with a range of responsible actors, multiple financing streams and a large number of services to be provided. For example, the Quality Assurance sector (MoHCDGEC) developed it, PO-RALG implemented it, and a health basket, involving development partners and ministries, National Health Insurance schemes and the Ministry of Finance, financed it. This complexity means that communication roles and responsibilities need to be clearly defined.

In Tanzania, the EHB is a tool for guiding, organising and planning service delivery down to the community level and for standardising services. It sets the path for providing universal healthcare. However, with inadequate accountability, limited funding and a large and diverse vulnerable group, the capacity to achieve this vision remains a challenge. This report shows how the EHB is defined in Tanzania and the key challenges and enablers in its use. We highlight a number of areas requiring further discussion, including mapping purchasers and public and private providers and the pre-requisite required to ensure that facilities are empowered to provide the necessary services. These requirements call for a health systems approach that recognises the management, financial, and infrastructure resources required and the communication needed between practitioners and policy makers.

# 1. Introduction

An Essential Health Benefit (EHB) is a policy intervention designed to direct resources to priority areas of health service delivery to reduce disease burdens and ensure equity in health. The EHB represents a key policy intervention for Universal Health Care (UHC). Many east and southern African countries have introduced, or updated EHBs in the 2000s (Todd et al., 2016). Recognising this, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), is implementing research to understand the facilitators and the barriers to nationwide application of EHB in resourcing, organising and ensuring accountability on integrated health services. The work is being implemented in association with the East Central and Southern African Health Community and national partners in the region and is supported by International Development Research Centre (Canada).

This case study report focuses on EHBs in Tanzania mainland. We present evidence on EHBs at national level under the auspices of Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) and President's Office of Regional Administration and Local Government (PO-RALG). In 2015 the Ministry of Health and Social Welfare and Prime Minister's Office-Regional Administration and Local Government were restructured and renamed to MoHCDGEC and PO-RALG (URT, 2015b). The report contributes to national and regional policy dialogues on the role of EHBs, providing information on the motivations for developing the EHBs; the methods used to define and cost them; how they are being disseminated; used in budgeting, resourcing and purchasing health services, and in monitoring health system performance for accountability; and the facilitators/barriers to their use. The key concern for the government and partners is on the challenges of turning a policy 'wish list' into a reality of services that all citizens can access.

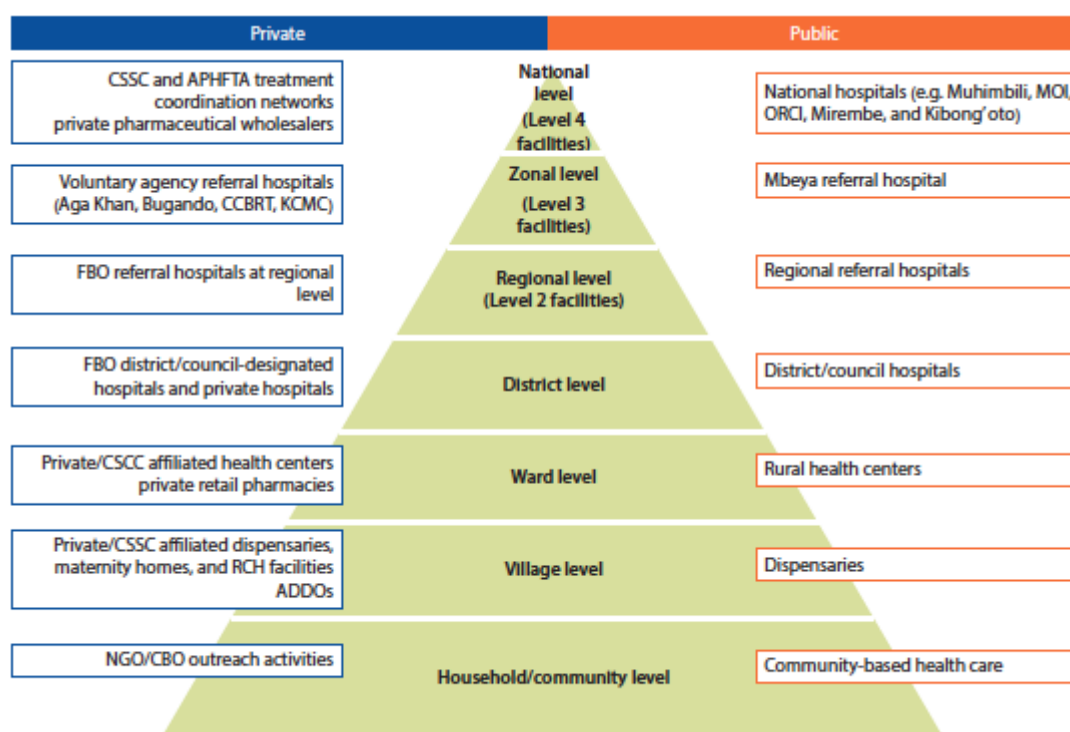
## 1.1 Socioeconomic and health context

In 2012, mainland Tanzania had a population of 44 million, with regional population distributions ranging from below 600,000 people in the region of Katavi to over 4 million in the region of Dar es Salaam (URT, 2012b). Although the 'right to health' has still not yet been enshrined in Tanzania's new constitution, the government recognises that all citizens have the right to a healthy and safe environment (Sikika, 2014). However, recent poverty mapping disaggregated to district level shows geographical variations in the percentage of poverty across Tanzania, based on access to basic needs, including safe water, basic latrines and electricity (Kilama, 2016). High poverty densities are found in urban areas. When analysing data on access to health services, Mtei and Makawia (2014) found only primary outpatient care to be pro-poor, with outpatient care at all other levels pro-rich. For inpatient care, district public hospitals and faith-based facilities were pro-poor, and private for-profit providers were not. Such results suggest that 'health' is not universal; access is not equal, and with variations in quality, life outcomes are inequitable across socioeconomic groups.

## 1.2 Organisation of the health system

Tanzania's 2025 Development Vision, adopted in 1999, sets the country's long-term development agenda. The Vision identifies five key priorities for Tanzania's growth: high quality livelihoods; peace, security and unity; good governance; education; and a competitive economy with well-being and universal access to good quality healthcare an underlying theme (URT, 1995). Overtime, national strategies have been set to achieve such goals – from the National Strategy for Growth and Poverty Reduction, 2005-2010 and 2010-2015 (URT, 2005; 2010a) to Primary Health Services Development Plan (PHSDP/MMAM 2007-2017 (URT, 2007b) and the 2007 revised National Health Policy (URT, 2007a). Sector-specific plans and policies were formulated. One such policy is the National Essential Health Care Intervention Package, termed from here the NEHCIP-TZ (URT, 2013a). The NEHCIP-TZ operates across Tanzania's decentralised health system, providing essential health intervention packages across the seven levels of care, including the public, private for-profit and not-for-profit sectors, shown in *Figure 1*.

**Figure 1: Organisation of and personnel in Tanzania's health sector, 2015**



Source: World Bank 2013 p68

This national report focuses on mainland Tanzania's NEHCIP, within the quest for universal health coverage (UHC). It reviews the reality of ensuring essential services.

## 2. Methods

This case study followed a standard protocol to facilitate regional comparisons. TARSC and IHI designed the protocol, with inputs from collaborating partners from Tanzania, Uganda, Zambia and Swaziland. To appreciate the impacts of the EHB and the enablers and barriers to its application, a standard conceptual framework brought together and evaluated information on three broad elements: national context, design factors and goals, and implementation and use. The framework utilises a 'health-systems' perspective to understand how its interconnected sub-systems determine the direction and achievements of the EHB (WHO, 2013).

Following ethical approval from the National Institute of Medical Research and IHIs Institutional Review Board, we reviewed relevant documents. Public domain documents post-1960 in English based on mainland Tanzania were reviewed. The documents were accessed through a systematic literature search and those recommended by technical advisers and key informants. Using the findings of the document review, we defined the areas for key informant (KI) interviews. KI stakeholders were selected for their experience in policy making or policy implementation, health sector, social protection sector, financing and insurance sector and public-private sector and service delivery. Fourteen face-to-face or over the phone KIs were conducted with experts involved in Tanzania's health sector, as shown in *Table 1*, overleaf.

Deductive coding was used to analyse the KI findings, with codes and themes developed prior to the interviews. Data were triangulated across respondent groups and backed by supporting documentary evidence. Finally, a one-day national consultative meeting was co-ordinated, inviting KIs and experts to discuss the findings and verify information.

**Table 1: List of key informants and consultative meeting participants**

Government of Tanzania (8)	Development Partners (6)	Others (national/international NGOs, research institution) (5)
MoHCDGEC (3) PO-RALG (4) Regional Medical Officer (1)	Danish Embassy (1) Swiss Agency for Development and Cooperation (1) German International Cooperation (1) Swiss Tropical and Public Health Institute (1) World Bank (2)	Cape Town University, SA (1) Comprehensive Community-based Rehabilitation in Tanzania (1) Public-Sector Systems Strengthening Tanzania (2) Tanzania Private Health Association (1)

N.B. Figures in parentheses denote the number of key informants, including consultative meeting participants.

### 3. Historical development of the EHB

Five key time periods were identified to be influential in the design, promotion and evolution of the EHB in Tanzania: pre-intervention (1960-1996); Tanzania Essential Health Interventions Package (1996-2000); National Package of Essential Health (2000-2009); National Essential Health Care Intervention Package (2009-2015); and HSSP IV-era (2015-ongoing). These five stages provide the context to how and why the EHBs were developed and evolved.

#### 3.1 Stage One: Pre-intervention, 1960-1996

Following independence, Tanzania adopted the Arusha Declaration (1967) founded on principles of socialism, self-reliance, equity, and development. Tanzania's key industries were nationalised, planning was centralised, and governmental bodies expanded. The government strategically built shared, communal environments to control citizen movements and ensure rural development and to ease efficiency in service distribution. One of the Arusha Declaration's health objectives was to ensure universal primary healthcare services. By congregating people in village clusters, the government assumed it would be better able to provide basic services, mainly education, health and access to water. During this period, social disparities in literacy and service access were reduced and life expectancy increased (Wenban-Smith, 2014).

From the 1970s, however, the global oil shock and subsequent energy crisis in 1974 led to unemployment and inflation, followed by the break-up of the East African Community in 1977. A series of reforms were adopted in the structural adjustment programmes in 1982-1990, signalling a shift from state control and government monopolies to trade liberalisation and free-market economic policies, with currency devaluation, social spending cuts and privatisation of health, education and water services. Tanzania experienced widening social inequalities and growing vulnerability (Mwakasege, 1998; Wuyts, 2006). Additionally, during this time, the government was decentralised. By 1982, Tanzania had defined a policy of 'decentralisation by devolution' (D-by-D) in the legal sector, public services, public finances and the local government. Power was devolved through community participation and a local government system for improved accountability and development. The health sector management and organisation was changed. Local government authorities (LGAs) were established through the Local Government Reform Act (URT, 1982) and given planning power and responsibility. This decentralisation also informed Tanzania's primary healthcare (PHC) strategy, adopted as a means of implementing the National Health Policy 1990 (URT, 1990). By decentralising power, financing, and decision making, PHC aimed to: strengthen districts to provide citizens with equitable and good quality essential services; encourage multiple non-government-, for-profit- and faith-based-organisation stakeholders to collaborate with government as providers; make key decisions with local communities and contexts in mind; support community participation and an intersectoral approach and preventative and promotive approaches to health. These elements were seen to be crucial, emerging before any international discussions.

The reforms continued into the 1990s. The 1994 Health Sector Reforms introduced financial reforms, public-private partnerships, continued decentralisation of health services, and the establishment of new structures, including council boards and health facility committees (URT,

1995). The financial reforms, in particular user fees, may be seen as contradictory to the objectives of D-by-D and PHC, which aimed for equitable health systems (Macha et al., 2012; Mtei et al., 2012). Chitama et al. (2011) and Tidemand and Msami (2010) argue that the full potential of decentralisation has not been realised, as local autonomy remains limited without the decentralisation of authority or financial autonomy.

### **3.2 Stage Two: Tanzania Essential Health Interventions Programme, 1996 – 1999**

Tanzania's Vision 2025 was introduced in 1995, with a three-year strategic health plan for (1995-1998), following the 1994 health sector reforms. Improved external funder co-ordination and a sector-wide approach were introduced in 1997. The 1999-2002 Health Sector Reform Programme of Work guided implementation of plans and budgets across the health sector, adopting a decentralisation approach, to improve health for all (URT, 1999). In 2003, the Health Sector Strategic Plan 2 replaced the programme of work (HSSP II 2003; URT, 2003b).

During this time, the Ministry of Health rolled out the pilot for the Tanzania Essential Health Interventions Package (TEHIP) in Rufiji and Morogoro (a four-year collaborative research policy project funded by the Canadian International Development Agency and IDRC). The TEHIP had three focus areas: health systems, health-seeking behaviours and health impacts. It aimed to influence (local and national) health policies by creating tools, and utilising evidence, to improve health sector planning (De Savigny et al., 2002). It provided a basis for developing an EHB package in Tanzania, one of the first countries to engage in the EHB discussion, identifying priorities and questions for evidence systems. By creating an evidence set, the project wanted to better understand the burden of disease (BoD); improve allocation (and management) of resources; and strengthen the functioning of decentralisation in the health sector. It used evidence for decentralised planning to apply investments and resources on cost-effective interventions for priority health burdens. It used available surveillance data in the districts in the Adult Morbidity and Mortality Project to establish demographic surveillance systems. Tanzania, the first country in the region to undertake discussion of an EHB using this approach, received guidance, from experts in the World Health Organisation (WHO) to ensure the package met international standards (KI academic, 2017).

Introduction of evidence-based planning using the BoD approach, training and innovative management tools (for building district planning capacity and improving the performance of health workers) were key to TEHIP successes in the two districts. The tools included the district health accounting tool, for allocating resources based on the BoD; the district health expenditure mapping, a tool summarising acquired resources and expenditure of the annual Comprehensive Council Health Plans (CCHP); and district health service mapping, a tool collating data to map trends of health facility utilisation and availability (Neilson and Smutylo, 2004). These tools have been incorporated by the council health management teams and in the CCHP guidelines. They continue to be used to assist in planning, reporting, and monitoring finances (URT, 2011a). They strengthened co-ordination between researchers and policy makers and guided budget allocations, providing evidence for decision making (URT, 2016g). The TEHIP was vital to the evolution of the EHB discussion in Tanzania.

### **3.3 Stage Three: National Package of Essential Health (NPEH), 2000 – 2009**

This period marked a further turn towards decentralisation and sector-wide approach (SWAp), with policy formulation becoming more inclusive of different stakeholders, including civil society and technical working groups, albeit with some debate on what this means for whose agenda is influencing policy (Shivji, 2004).

Formed in 1999, the NPEH was developed to ensure public health services were able to support high priority needs, with key services to be provided at all health facility levels. The services (clusters) were identified through the burden of disease approach – using mortality data evidence from the Health Management Information System (HMIS/MTUHA), the Adult



Morbidity and Mortality study and site-specific data sources (i.e., TEHIP, the Demographic and Health Survey and Essential Drugs Programme). The five same clusters, as TEHIP, were chosen to form the NPEH, with an emphasis on preventive interventions that could potentially reduce the demand for curative health services (see *Table 2*).

**Table 2: National Package of Essential Health, Tanzania, 1999**

Components of the NPEH	
Reproductive and Child Health	Material conditions; antenatal care; obstetric care; postnatal care; gynaecology; STD/HIV; family planning; IMCI; perinatal; immunisation; nutritional deficiencies
Communicable Disease Control	Malaria; TB/leprosy; HIV/AIDS/sexually transmitted diseases; epidemics (i.e., cholera, meningitis)
Non-communicable Disease Control	Cardiovascular disease; diabetes; neoplasms; injuries/trauma; mental health; anaemia and nutritional deficiencies
Treatment and care of other common diseases of local priorities within the district	Eye diseases; oral conditions
Community Health Promotion and Disease Prevention	IEC; water hygiene and sanitation; school health promotion

Source: URT, 2000:11

The NPEH was to be incorporated into each district health plan, the CCHP, so resources could be allocated accordingly (URT, 2011a). The NPEH is a guide for districts – through the CCHP and the council's priority setting of health problems – used alongside the BoD, council performance indicators and the HSSP (URT, 2011a).

Other changes at the same time included: setting Millennium Development Goals; and improving health system management, guided by the 1996-2001 five-year national health sector reforms in human resources for health. This focused on capacity building for the council health management teams and the regional health management teams, district health boards and heads of health facilities at the sub-district level (URT, 1996). A complex network of stakeholders and management are involved in putting the EHB into practice. The MoHCDCGEC is the technical adviser and policy maker, responsible for ensuring quality services to communities. PO-RALG is the implementation arm of the policies created, moving policy to practice and mandating D-by-D, through the regional health management team that guides the council health management team to oversee implementation of council health services within their districts (URT, 2015a; 2015b). Introduced in 1999, health facility governing committees were responsible for developing facility plans and budgets and generating facility revenue for delivery of high quality services (Macha and Borghi, 2011). These structural changes were in-line with the Primary Health Services Development Programme (MMAM, 2007-2017) – improving the provision of PHC and outlining the goal of the NPEH in improving health services at the district level and below (URT, 2007b).

There were also changes in how the health sector was financed, with the introduction of the SWAp and Health Basket Fund (central and district) in 1999, and a revised formula for allocating the recurrent health and education block grants in 2004/5 on the basis of weighted levels of population numbers, poverty, under 5-year disease burden and the length of medical vehicle route (URT and World Bank, 2010). The formula does not consider rural/urban variations; however, to reduce regional variations, it was observed that local authorities need to improve their financial management and budgeting and expenditure tracking (URT and World Bank, 2010).

During this period new stakeholders entered Tanzania's health sector domain, including the Global Fund and Global Challenges. The emergence of 'global health initiatives' began to shape priorities, with vertical funding financing specific diseases (KI academic, 2017). Such parallel financing initiatives undermined the national planning processes and made it difficult to cost the HSSP and identify the extent of a 'financing gap'.

Additionally, innovative pre-financing mechanisms for cost sharing were introduced by government. These included a Community Health Fund (CHF), piloted in 1999 as a voluntary pre-paid health insurance scheme for the rural population, and the National Health Insurance Fund (NHIF) that was mandatory for civil servants in the formal sector (Mtei and Mulligan, 2007; URT, 2001). Both schemes faced issues in enrolment and coverage, with consequent limitations in local funds, raising concerns about equity and financial protection of members (Mtei and Mulligan, 2007). Further, NHIF resources were collected centrally and only partially returned to local councils (Mtei and Mulligan, 2007).

In this period, measures for social accountability in the health sector were strengthened. The CHF policy stated that citizens would be able to demand better quality services if the services provided were deemed unacceptable (URT, 2001). Additionally, the Client Service Charter recognised service users as 'clients' with rights to access a particular service from providers (URT-MoFP, 2017). In theory, communities, and 'service users' were enabled to monitor and demand better services.

In summary, the NPEH was developed and initiated in 2000 following the 1996 TEHIP pilot outcomes. National ambitions coincided with a number of changes in health financing, management and accountability. The 1999 Programme of Work identifies that progress has been made in achieving Tanzania's health sector reforms, with key reforms such as CHF, cost-sharing and the development of the NPEH as a means of allocating public expenditure to improve services at district level and below (URT, 1999; URT, 2003a). However, challenges remained: healthcare access was not equitable, or of adequate quality, and did not meet population needs. Eight strategies were thus defined across the health system targeting the central ministry, districts, tertiary hospital services, health workforce and more. The district was a key focus for implementing NPEH. As Health Sector Strategic Plan II (2003) explains, improving sub-district services made the district health service boards the sole responsible actors, accountable to local government authorities (LGAs), with the NPEH incorporated into district health plans. The HSSP II committed to continued decentralisation by devolution, ensuring all district services provide the essential clinical and public health package, as defined by district needs. This was noted to require increased district-level responsibility to be met with capacity building and tools being available across districts to make informed plans and decisions.

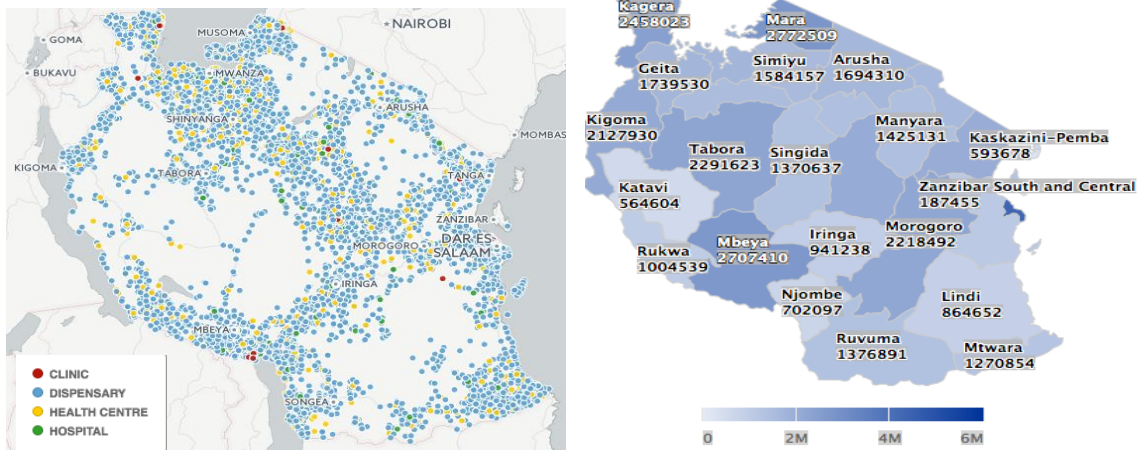
### **3.4 Stage Four: National Essential Health Care Interventions Programme-Tanzania, 2009 – 2015**

The health sector remains largely externally funded, and the government remains off target to reach the Abuja target. Government total health expenditure (THE) remained at 7% per capita in 2009/10 (URT, 2012a). Annual health statistics (2009) show that 'personnel emoluments' remained the predominant source of funding provided to regions by the government, followed by 'other charges' (URT-MoHWS, 2009). Both funds are part of 'recurrent expenditure' provided through recurrent bloc grants: personnel emoluments incorporate spending for staff wages within public sectors, and other charges include non-wage recurrent spending such as running costs for staff and facilities. However, external funders remained the major financing agents of the THE, mainly streamed to certain projects and interventions. Of the four priority areas (HIV/AIDS, malaria, reproductive and child health), HIV/AIDS had the highest THE spending (622 billion/Tsh (US\$3.9 bn) in 2009/10. External funders contributed 70% of this funding provided to regions through CHF, with minimal cost sharing, and increasing out-of-pocket contributions to THE high, from 26% in 2005/6 to 32% in 2009/10 (URT, 2012a).

Through the funding streams, government services remained the key source of healthcare. However, compared to primary care, the degree of government ownership in the provision of secondary services is much lower: 41% of hospitals are government owned and 42% are faith based, comparable to health centres (71%) and dispensaries (68%) being government owned (URT-MoHWS, 2009). *Figure 2* shows the distribution of services. Implementing the EHB requires inclusion of all such service delivery facilities. *Figure 3* maps population density. The

figures suggest the needs of certain population groups are not met, with areas not covered and clinics/hospitals showing lower availability.

**Figure 2 (left): Distribution of health services, by type across regions in Tanzania**  
**Figure 3 (right): Population density and growth in Tanzania (2012)**



Source: Open Data Portal, 2016; NBS, 2017

In 2009, Tanzania's HSSP III (2009-2015) strengthened the focus on health accessibility, performance and decentralisation on the national agenda (URT, 2009). HSSP III introduced eleven strategies to ensure the provision of quality, essential health services to communities and accountability within the health sector, shifting towards results-based systems. These services would all provide the NPEH. Quality assurance systems would be built within the Tanzania Quality Improvement Framework for specific disease control programmes and MNCH services. Such changes would be delivered by increasing the government's health budget to 15%, improved district fund mobilisation, and performance payment incentives to workers. Innovative district funding schemes include the development of an urban, pre-payment insurance equivalent – *Tiba kwa Kadi* – and the continued rollout of CHF. This focus on performance improvement has remained on the agenda with the rollout of the Big-Results-Now (BRN) national programme in Tanzania's public sectors. This programme focuses on human resources for health and mother and neonatal child health (URT, 2017d).

Improving partnerships for effective service delivery through existing joint planning and monitoring, platforms, such as the SWAp, were emphasised. Furthermore, public-private partnerships would be formalised through service agreements between LGAs and private sector providers. Finally, alongside the NPEH package to be rolled out in all district services, the HSSP III identified a need to improve priority health areas, particularly reproductive and MNCH interventions and specific disease control programmes.

HSSP III found that council health service levels required strengthening (community health, dispensaries, health centres and district hospitals), and the NPEH served as a reference for guiding equitable, and quality, service delivery in district facilities (URT, 2009). The intention was to build capacity for key personnel, ensuring essential services are provided within, and by, council health services. HSSP III identified how the EHB and a minimum of service care delivery, would be financed, as shown in *Table 3*. Emphasis was on the ability of LGAs and local stakeholders to contribute to financing. In 2013, a revised and updated NPEH was created – termed the National Health Care Intervention Package, Tanzania (NEHCIP-TZ) (URT, 2013a).

A progress review in 2013 found that the number of facilities rose and CCHPs were in place with improved district planning. However, weaknesses in service performance, implementation and funding in specific disease programmes limited the effectiveness of implementing the EHBs (URT, 2013a).

**Table 3: Strategies to finance the HSSP III and EHB package**

Goal	Mechanism	Impact
<i>Ensure domestic and foreign sources to fund HSSP III</i>	- <i>Domestic</i> : Central government funds, NHIF, user fees, <i>Tiba kwa Kadi</i> , CHF, drug revolving fund, council own-sources - <i>Foreign</i> : General budget support, HBF, foreign funded projects	Achieve goals of HSSP III
<i>15% of government budget on health</i>	- Maintain the Health Basket Fund (HBF) - Increase amount and partners of HBF	Increase number of facilities providing EHB
<i>Improved efficiency and effectiveness of financial resources</i>	- Costing exercise of EHB - Review national health accounts and PER - Improved transparency in health financing - Comprehensive health financing strategy	Increase in local complementary funds Increase number of facilities providing EHB
<i>Improve health insurance schemes</i>	- Increase health insurance coverage - Improve pre-payment enrolment - Improve management of cost-sharing i.e., community participate in budgeting health revenue - Regulatory body to guide schemes	Equity in access to services and facilities providing EHB Increase share of complementary financing in the total health budget

Source: URT, 2009

### 3.5 Stage Five: Political restructuring, HSSP IV-era, 2015 – onwards

The final stage cements the continued movement towards a preventative/promotive approach and improved performance, quality and results in Tanzania's health sector. HSSP IV, 2015-2020, sought to improve care from primary to tertiary levels, devolve responsibility, and rollout the BRN initiative. It aimed to achieve quality care, equity and improved performance in facilities (URT, 2015a). Delivery of essential healthcare interventions remains a priority in HSSP IV, achieved through the continued strengthening of CCHPs, management and logistics, human resources and district information systems. Monitoring progress in delivery of essential health services in the HSSP IV is based on 64 indicators, composed of three sets of performance indicators compiled annually: health sector performance and health status indicators; BRN key performance indicators; and specific indicators for HSSP IV.

However, the HSSP IV also identifies a key change. Alongside the NEHCIP, and improved quality services, a minimum benefit package for the Single National Health Insurance (MBP-SNHI) is being refined as part of the upcoming health financing strategy (yet to be approved) (URT, 2015a). Building from the defined NEHCIP 'effective' intervention services and using a BoD approach, the MBP is a set of standard, legally entitled services that citizens will be able to access, with new priorities to be identified and included, based on the availability of pooled financial resources from the SNHI. The latter aims to ensure a sustainable resource pool to enable the scale up of a MBP to a comprehensive set of services for the whole population (URT, 2015a:65) and defines how MBP services can be purchased from public-private providers (KI technical consultant, 2017). Fiscal estimations were made for this in the HSSP IV, by re-costing service costs and identifying 'innovative sources'.

A final key shift to note during this phase is the election of Tanzania's fifth president in 2015. The appointment has been followed by a series of political and structural changes for national development, in line with the HSSP IV trust on social accountability, improved governance and strengthened systems. These include scheduled and unscheduled hospital trips by political leaders that have highlighted service deficits (*The Citizen*, 2016; URT, 2017b), with follow up proposed for social protection, institutional strengthening and anti-corruption measures. Several reports have also been published: a Joint Annual Health Sector Review (URT, 2016g); Recommendations for Implementation of Health Work (URT, 2017c); and a Roadmap and Concept Note to Decentralised Direct Facility Financing (DFF) (URT, 2017a). They signal a shift towards output-based payments and direct financing of facilities to improve service

delivery, strengthen PHC, social accountability and community ownership of health services, ensure efficiency and effectiveness of basket funding and improve public financial management.

### **3.6 Summary**

Tanzania's EHB can be defined as a set of essential services, reforms and outcomes in the health sector to be delivered at all service levels. Five phases are identifiable. Although no EHB was defined prior to 1996, the first phase was influential in organising and structuring the healthcare system. Tanzania first defined an EHB at the TEHIP pilot stage, with what to include, prioritise and why it was important. Using evidence, the BoD was identified. NPEH was introduced in 2000 as a guide for implementation. TEHIP tools were reused to plan, prioritise and make decisions and to define five intervention clusters. The EHB was integrated into the health sector planning and budgeting processes. In 2013, refinements were made and NEHCIP-TZ introduced costing scenarios identifying what resources are needed and strategies for locating such resources. Key health sector changes have emerged during this period, such as single national health insurance, to provide innovative funding solutions.

Taking this evolution into account, several questions remain: how is it being implemented? where are the strengths/weaknesses? what are the outputs? and can resources keep up with the demand towards such intervention packages? Challenges remain in making UHC a reality in Tanzania: out-of-pocket expenditures are common, with limited enrolment in voluntary pre-paid insurance schemes. Additional difficulties include meeting exemptions for the most vulnerable and strengthening public-private partnerships for equitable service delivery (further discussed in *section 4*). The next sections discuss key features of the design and implementation of the current NEHCIP-TZ.

## **4. The current EHB in Tanzania**

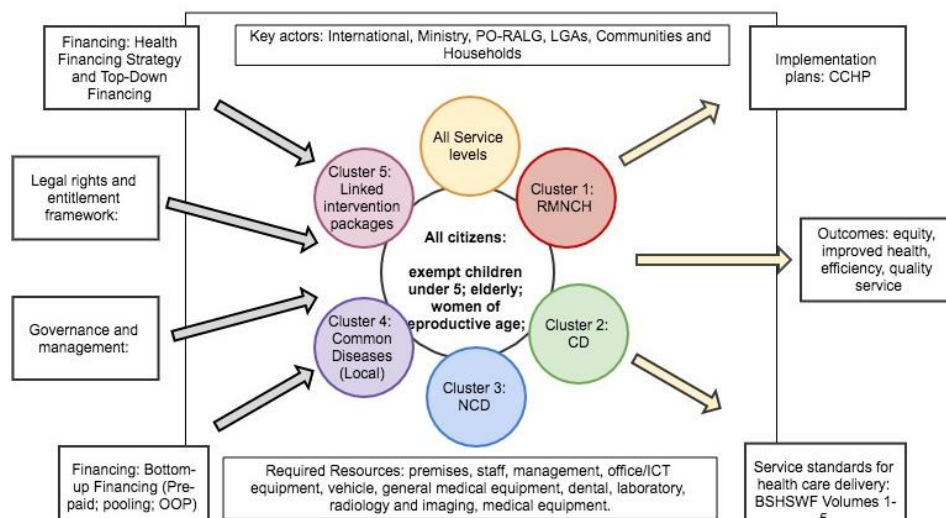
### **4.1 Content and purpose**

NEHCIP-TZ is the most recent EHB, described as a minimum or "limited list of public health and clinical interventions" (URT, 2013a). It is based on priorities for improving public health. As verified through key informant interviews, the NEHCIP-TZ aims for UHC in Tanzania: reducing the burden of disease, improving cost-effectiveness, equity and accountability.

Drawing on the NPEH (URT, 2000), the NEHCIP-TZ continues to focus on quality, results and clients, with a patient-centred service delivery mechanism provided at all levels: community/household (promotion, prevention, curative, palliative and rehabilitative), primary, secondary and tertiary. These interventions are identified as the best 'value for money', enabling Tanzania to achieve efficiency, equity, accountability and quality in universal healthcare. The services provided by health provider facilities are clustered around disease-specific interventions reflecting the key health burdens across Tanzania and broader community and household interventions. The interventions are based on available health expenditure per capita (URT, 2013a). *Figure 4* shows the different components of the NEHCIP in Tanzania. *Table 4* provides a summary of the content of the 2013 EHB across the different levels of care.

An important feature, highlighted in *Figure 4*, is that the 2013 package is not simply focusing on services to be provided. It also incorporates a series of reforms linked to strengthening Tanzania's health system, including management and governance changes that were proposed when conceptualising the package. The NEHCIP-TZ indicates that strengthening decentralised actors is vital. This is done through appropriate use of referral guidelines and local capacity development to ensure services, plans and budgets are implemented. The package is set in Tanzania's system of decentralisation, emphasising district implementation, district planning and district outcomes.

**Figure 4: Diagram of the current EHB in Tanzania**



Source: Authors own from URT, 2013a

**Table 4: Content by level of care for the 2013 NEHCIP-TZ**

Service level	EHB content for that level
Primary (community, dispensary, health centre)	RMNCH interventions, communicable diseases (CDs), non communicable diseases (NCDs), other common diseases and neglected tropical diseases, broader health systems interventions
Secondary (district hospital and services)	RMNCH interventions, CDs, NCDs, other common diseases and neglected tropical diseases
Tertiary (provincial/ regional/national referral hospital, services)	RMCH interventions, CDs, NCDs, other common diseases and neglected tropical diseases
Quaternary (national, central hospital)	Use of effective referral systems

Source: URT, 2013a

The package defines a set of outcomes in line with Tanzania's health vision, backed by improved resource allocation for efficiency, equity in accessing health and quality assurance. The goal includes making available, and access to, quality services and a reduction of financial burdens, so patients receive a continuity of care (URT, 2013a). The NEHCIP-TZ is thus aligned to the National Health Policy (2007) (URT, 2007a). All facilities are to be aware of the policy and related health systems strategies and guidelines, i.e., on Human Resources for Health. The NEHCIP-TZ was also intended to inform district plans and budgets from different levels – a basis for planning, reporting and service guidelines. The components are interconnected. For example, shortages in operational supplies, such as medicine, will delay service supply. This shows a theoretical shift in the NEHCIP-TZ, by recognising the need for prevention and moving away from curative thinking. There was no evidence found on how far this has yet been achieved.

## 4.2 EHB Costing

In 2013 the MoHSW and partners conducted a costing study for the NEHCIP-TZ, shown in Table 5. Its aim was to ensure efficiency in financial resource use and allocation and to have a role in the health financing strategy on the costs of the EHB and consequent funding strategies and reimbursements (URT, 2013a).

The cost analysis found that the median running costs for facilities varied based on the type of facility and ownership. The recurrent costs accounted for the highest portion (80% on average) of total costs in health facilities, with personnel costs a majority of this cost. Outpatient service

costs were a greater share of expenses at lower levels of care, whilst inpatient service costs contributed a greater share of costs in higher levels of care. The unit cost of services varied, with variations depending on the facility type and ownership.

When evaluating the specific EHB to be provided across health facilities, scenario analysis was conducted. The 'best', 'expected' and 'actual' service delivery scenarios were modelled and costed. The most expensive service packages were for NCDs, particularly cancer and diabetes (URT, 2013a:61-63).

Costs varied, based on the type of practice provided. In some cases, the provision of 'best' practice remained the most expensive – such as for estimates in providing reproductive and child health. But in some scenarios 'actual' practice costs exceeded the 'best' service costs scenarios; for example, even for the case of treating malaria (communicable disease) at a health centre, best practice was estimated to cost US\$27.46 per unit cost; expected cost US\$57.13; and the actual practice US\$116.76 (URT, 2013a: 66, calculated as per 2013 exchange rate: Tshs. 1,600 to USD 1). Such results question the methodology for calculating best practice costs, and why actual costs exceed best practice when quality services are not provided.

**Table 5: US\$ cost estimates for the EHB (2013)**

Service provider costs and facility unit costs (US\$)	Service level		
	Primary	Secondary	Tertiary
<b>Public Sector</b>			
Outpatient unit cost	13.28	13.58	20.82
Inpatient unit cost	70.03	99.66	109.36
Total cost	158,875	968,750	2,868,750
<b>Private not-for-profit sector (**)</b>			
Outpatient unit cost	6.87	9.80	12.30
Inpatient unit cost	75.21	120.48	N/A
Total cost	127,125	768,750	N/A
<b>Private for profit</b>			
Outpatient unit cost	12.61	13.58	N/A
Inpatient unit cost	N/A	263.58	N/A
Total cost	152,875	615,625	N/A

Source: URT, 2013a

\*All \$ figures in USA dollars based on conversion using exchange rate at year of costing 1600 TZS to 1 USD (2013); na=not available (\*\*) Faith based and non-state, Quaternary hospital not available

Total Costs based on mean total costs. Outpatient visits based on (median) outpatient visits; (median) Inpatient costs based on inclusion of inpatient bed days and (median) inpatient admissions at facility.

The limitations of the costing exercise need to be recognised. Although the main funding sources for NPEH and NEHCIP-TZ were identified, there are questions on costs presented, as the exercise did not incorporate all costs interrelated to service delivery from medicine supply to human resources. Limitations also emerge in that the costing has not been done for all sub-sector intervention packages. For example, the National Essential Health Sector HIV/AIDS Intervention Package has not been costed. Reportedly, the costs of delivering this package are not fixed, depending on: client demand, targets, activities, time frame and the capacity to deliver (URT, 2009) (cost estimates have been taken from the National HIV/AIDS strategy). Furthermore, as noted earlier, with vertical financing and off-budget funding, it is difficult to get an estimation of total revenue.

In the discussion raised in *Section 5* on the challenges of implementing the EHB, key informants indicated that one of the barriers to implementation was that the costing had not used a systems approach, incorporating management costs, staff costs, medicines and full implementation costs (KI development partners, academics and retired government, 2017). Further, the costing results had shown the package to be unrealistic:

*So I think that we have to be realistic, even if the package is minimum minimum minimum minimum, I think it's worse to start off... with assuming they have a lot of money, with assuming there is a certain minimum healthcare package and everything is based on unrealistic plans and dreams. Meaning that nothing will be done. And people will be very very very discouraged, including the healthcare providers... we need to look at how much money do we have and define (the package) in realistic way, according to the available resources... Get down to reality -- KI development partner, 2017*

Another key costing exercise was on the Minimum Benefits Package (MBP), a minimum guaranteed set of healthcare services covering all citizens (Ngowi et al., 2013). The MBP has been modelled through different scenarios or package types. The scenarios each match the EHB to different degrees: option one is the most basic, while option three includes more specialised services and treatments. The costs vary based on the MBP scenario, with calculated costs per capita (annual MBP cost range in brackets) between US\$34 (US\$388million to \$717 million per year) in option one; and US\$73 (US\$646million to \$1,194 million per year) in option three (Ngowi et al., 2013, *Table 6*). An updated analysis and costing was conducted in 2015, whereby two MBP options were presented: the standard MBP (combining options 1 and 2) and MBP plus (option 3 scenario) (Dutta and Mtei, 2015: *Table 7*). The costing included capitation rates, including cost recovery (i.e., labour and shared risk for providers). The highest costs were identified at the dispensary level, with costs estimated for different groups and upon identifying pooled revenue sources (SNHI, allocations for health, and innovation financing options). However, again off-budget sources were not included. A minimum resource gap was identified of between US\$9 million and \$178 million, which could be reduced by strategic purchasing and adhering to referral guidelines.

**Table 6: Costing options for MBP**

Interventions	Cost per capita		MBP total cost per year		MBP health (2013/14)	cost/total budget
	TZS	US\$	TZS (billion)	US\$ (million)		
<i>Option 1</i>	55,146	34	620-1,147	388-717	41-77%	
<i>Option 2</i>	65,622	41	744 – 1,376	465-860	50-92%	
<i>Option 3</i>	116,016	73	1,033– 1,911	646-1,194	69-128%	

Source: Ngowi et al., 2013

**Table 7: MBP (standard and plus)**

Standard MBP	MBP plus
Cover NEPHI services (PHC, IPD, DH, RH) Yet to define exclusions Intended for all, except MBP plus members Providers are public and faith based	Cover current formal sector scheme (NHIF) Providers are public, faith based and accredited private facilities The poor (subsidized) can access MBP plus

Source: Dutta and Mtei, 2015

### 4.3 Implementation of the EHB

By incorporating the NEHCIP-TZ into the national health policy (URT, 2007a), the EHB has been disseminated nationally as part of the planning process. CCHP, district and facility plans and budgets are drawn up with reference to the EHB, establishing a strong link between EHB resource allocation, service planning, standards and strategic purchasing and, ultimately, implementation.

Despite its integration into the national health policy and planning processes, confusion remains over exactly what the EHB involves. The level of detail in dissemination, interpretation, and ability to implement the EHB vary across Tanzania.

*Over the years they have been able to come up with a level where they know, that we have to follow this strategic plan or this programme... but definitely they may know the titles, not the detail.... -- KI government, 2017.*



Difficulties arise in what services to provide for free and to whom; how to finance the services and costs available for financing; and how to interpret the policy, or package. In terms of implementation challenges, two key themes are explored further below. Key informants mentioned the need for greater clarity on certain aspects of the EHB: the included/excluded populations, the service providers and purchasers, and the level of care by which citizens are covered (KIs development partners, technical consultants and academics, 2017). This raises questions on communication of policy implementation: where and what are the communication gaps in moving policy from design to implementation? EHB implementation also raised an ethical issue as the EHB is described as a 'wish-list' (KI development partners, 2017) that does not match reality: what is provided at a service facility is what can be provided considering the available resources. Service providers cannot refuse certain services and the idea of EHB is faced with a tough dilemma of 'life value' (KIs development partner, 2017). As a KI argued: *As an organising principle it's useful... (but) as an economist, for me what is more important than the norm, the normative analysis, is 'what is'... rather than aspiring to something; there are some core basic things that are not provided* -- KI development partner, 2017.

Although the EHB was seen as a useful starting point necessary for a resource-limited country, its implementation needs to focus on what is possible and on how to provide comprehensive integrated care (primary, secondary and tertiary) (KI development partner, 2017). Challenges in implementing the EHB often result in expectations not being met. These implementation challenges are discussed under the themes of management, governance, financing and service delivery. Tanzania's health sector was argued to be lacking a 'health systems approach' (KI development partner, 2017). A disease-based focus allows for vertical projects and allocations, with insufficient attention to addressing wider system inefficiencies and strengthening linkages. This is important to consider as the national health policy considers preventive healthcare and working across sectors to be a priority for improved population wellbeing (URT, 1990; 2007a).

#### **4.4 Leadership, management and governance: Management style and influencers**

EHBs worked well in some programme areas, particularly maternal and child health, vaccines and immunisation, but not in others. This is due to different factors: external politics/international priorities, funding streams and management style. A switch was required to better incorporate essential management improvements alongside the EHB. The focus cannot be on only providing a package of services. It also needs to identify management, human resources and infrastructure elements. KI's argued, however, that this had not been emphasised in practice (KI Development Partners, Service Provider and Government, 2017). A health systems approach connects basic service provision standards and essential services with management. This is necessary for improved outcomes. Greater investment is required in improving management and changing the management style to recognise the various health sub-sectors. Suggestions were made that management needs to focus on a bottom-up approach, working and interacting with the implementers and forming service agreements within the public sector between government and service providers. To ensure improvements in management at the service-provider level and effective application of Tanzania's Basic Standards guidelines for Health and Social Welfare facilities, emphasis needs to be on standards and outcomes (URT, 2016a-e: V1-5). These documents provide standards and guidelines for quality assurance, to be provided at community/household, dispensary and health centres, levels 1 and 2 hospitals, levels 3 and 4 hospitals and specialist clinics. The standards describe governance and management systems at each level and the services to be provided in line with NEHCIP-TZ and required resources, such as buildings, staff and finance.

However, the move towards improved standards and using a systems approach is not so simple. An analysis of why immunisation fares better than EHB areas points to the importance of funding streams. Vaccines are largely centrally funded, compared to other project-based initiatives (KI, government and retired government, 2017). Additionally, government

contributes more to personnel emoluments and other charges, which promote more of a 'health system strengthening' perspective. A key challenge can be raised over who is managing the health sector, and how standards can effectively be improved. The role of external funders and designs of specific, vertical projects influences EHB implementation. Members of the international community are key stakeholders driving health sector spending -- whether investment goes to projects or personnel emoluments and other charges. Each partner has their own priority, way of thinking and focus area (KI development partners, service provider and academics, 2017). External funders, such as Global Fund and USAID are key in setting priorities at the MoHGCDEC (KI academic, 2017).

This returns to the need to identify all stakeholders and communication channels. A multitude of stakeholders plays key roles in designing, financing, planning and implementing the EHB. As the EHB continues to evolve with the upcoming Health Financing Strategy, and subsequent MBP, further stakeholders will be engaged in this process. With this, capacity building and governance are key: from health workers, management, council teams and facilities.

#### **4.5 Use of the EHB in health financing**

As already described in *sections 3.2, 3.4, 3.5 and 4.3*, the EHB has been embedded over time within planning, reporting and budgeting protocols at district level. However, the EHB has yet to be effectively used for strategic purchasing, resourcing, resource allocation, service planning standards and monitoring.

Interlinked to leadership and governance, a key concern for implementation was around what is realistic considering available resources and where such resources get invested in a resource-constrained environment. The NEHCIP's integration into planning, and budgeting, at all levels means it is a reference source for funding allocation. However, the implications of resource constraints were realised, as well as the politics embedded within available funding. Financial limits and repercussions for implementation led to the package being perceived as unrealistic (KI development partners, 2017).

KI interviews raised two viewpoints on the resource gap: a) not having enough resources to meet needs; and b) money not trickling down to the districts and facilities (KI government, 2017). With the health sector heavily dependent on external funders and with the changing international funding trends, plans need to be made for how to sustain the health sector (KI development partner, 2017). The Health Basket Fund, a major source of funds, has recently been halved (KI development partner, 2017). Domestic resource mobilisation is seen to be key in a context of global health priorities and philanthropies, where powerful global funders are able to influence the type of research conducted and the programmes invested in, with less room for domestic-led innovation. The context of global funding has changed since the 1990s when TEHIP first received funding from bilateral and research funding, with its emphasis on supporting young scientists (KI academic, 2017). It was also noted by some KIs (notably academic/ development partners) that not all external funders support the idea of district power and decentralised decision making, a key element of strengthening the EHB and referral system procedures. Additionally, the push for BRN priority interventions, which is financing facilities, is argued to represent an external agenda (KI development partner, 2017), embedding vertical financing. These political influences are affecting how funding is provided to facilities, strategies for implementing projects and what districts or facilities should prioritise. Vertical funding streams were also argued to be based on an input-based approach, rather than being output driven, resulting in service delivery not being integrated into the approach (KI technical consultant, 2017).

The EHB is, on paper, supposed to be for all, with exemptions for key population groups. Services, however, are not exempted or service providers are not reimbursed due to financial constraints. It remains financially unsustainable to provide free services, given that demand exceeds supply of services within the region or district. This leads to a vicious cycle (KI government, 2017). A lack of accountable services and capacities leads to limited revenue creation in districts and regions, as patients relocate to where services are available.

Currently, facilities provide plans, budgets and expenditure reports, feeding into the CCHP; but funding is channelled via districts. As noted in *Section 3.5*, Tanzania is now preparing for direct financing of facilities (DFF) (URT, 2017a) The plan is to ensure all facilities have functioning bank accounts and are empowered on how to allocate resources and increase accountability in fund allocation and distribution, monitoring, and meeting citizens' needs (KIs, 2017). Whether it will overcome the challenges presented by vertically financed initiatives is yet to be seen. Will the amount to be received by each facility, estimated at around Tshs 5mn, (US\$2 233 at current exchange rates) including cost sharing and the government, be enough to provide EHBs and target poor quality services? (KI government, 2017). DFF also needs to go alongside capacity building for effective public financial management to ensure accounting systems and personnel can cope.

For the private and public sectors, there is limited pooling of resources to cross-subsidise income groups (KI development partner and service provider, 2017). Given this, a dual EHB system may be emerging, with equity implications. This raises the need for revised public-private partnerships and clarity over the package in public and private facilities. A different set of funding challenges affect the private sector. Free services are not financially feasible in private, not-for-profit facilities and it was raised that an appropriate reimbursement mechanism from insurers and the government back to this private sector is needed (KI service provider, 2017). Private practices make a slight profit that is then re-circulated to fund the poor and cover the cost of medical care, topped up by external funding. Subsidies are required to meet high running costs and to exempt the vulnerable people, including poor people, informal workers, older people, children and women of reproductive age. Targets and criteria were also suggested for the private sector, whereby the private sector facilities have different packages for different population groups, such as in a 'Very Important Persons', standard and exempted package (KI service provider, 2017). In this scenario, a private facility would then need to see a certain number of exempt patients, with the criteria for exemption clearly defined to include truly vulnerable people. This was seen as key, given that the private sector complements public service provision, with the for profit private sector contributing 7.6% of THE and the not-for-profit sector contributing 13.5%, in comparison to 46.6% from the public sector (SHOPS Project, 2013). The private sector does not benefit from funding received by LGA block grants and basket funding, despite this contribution, the promotion of public-private-partnerships and presence of service agreements between public-private sectors (SHOPS Project, 2013). Sustainable solutions are thus required for financing the private sector.

Implementing the EHBs requires attention to fiscal space, spending and resource allocation according to need. In moving from EHB policy to practice, one KI argued it is not simply a case of not having enough resources (KI academic, 2017). Governments across Africa were criticised for not doing enough to create a greater fiscal space, and need to be held accountable for creating fiscal space and for their management and use of resources (KI academic, 2017). KIs argued that there needs to be a political commitment to invest more in financing care and improved strategies for generating revenue at within the country, such as through facility membership fees or making CHF compulsory (KI academic, 2017). Political and external will has been key. KIs noted that the MOHCDGEC are pushing for UHC through the health financing strategy, but the Cabinet seems to be blocking this for unclear reasons, although cost sustainability may be one reason (KI development partner, 2017).

Tanzania's path to develop a SNHI is via sustained domestic resource mobilisation. However, the use of an insurance-based approach through the MBP in contrast to a tax system has its pros and cons in terms of sustainability, equity and governance (KI development partner, 2017). The choice to use insurance is historical and some KIs argued it to be donor driven. The SNHI builds on the earlier NHIF and CHF structures, pooled resources and insurance laws (KI development partner, 2017). The MBP is noted to be a means of upscaling the CHF and systematising the SNHI, with services provided based on the EHB. However, solutions to challenges in Tanzania's insurance context are vital. With persistently low enrolment, small contributions, and questions over the equity of who and how to include citizens, the rollout of the SNHI is a sensitive topic. A final concern is that of competition between private and public

insurers. To achieve the target of at least 70% of citizens being insured, defining the nature of the public-private partnership is key (KI service provider, 2017).

#### **4.6. Use of the EHB in planning and serviced performance**

The EHBs integration with planning and accounting tools, such as the Plan-Rep and CCHP, guides priority setting of primary health problems and use of available resources, as discussed in *sections 3.4, 3.5 and 4.3*.

All health facility, and dispensary, plans are linked to the CCHP. The CCHP is defined as “an annual health and social welfare plan for a council which collates the health and social welfare plans at all levels and involves all stakeholders” (URT, 2011a). This enables “LGAs (to) mobilise, manage and account for health and social welfare resources and implement health and social welfare activities in line with the national health and social welfare policies” (URT, 2011a). Guidelines ensure the relevant CCHP planning teams include the 13 EHPs, that HSSP objectives are adhered to, and that service providers (council health management teams, health centres, dispensaries, hospitals) are able to conduct their roles and responsibilities (URT, 2016g). Objectives and key activities are defined and then a cost analysis is conducted for activities and the cost-centre identified. Different levels of the government are involved in the preparation and approval of CCHPs. After approval the CCHP plan/budget is implemented, with quarterly reports. The NEHCIP therefore acts as a planning and service implementation guide. However, caveats emerge in the CCHPs produced. LGAs require more power to enable them to make, design and identify effective plans for their districts. Capacity development is required to strengthen the CCHPs produced.

Community needs also have to be captured within the plans. Participatory planning is necessary through the ‘opportunities and obstacles development’ when identifying community needs. However, planning often uses incomplete data that only captures part of the story, and responds to development partner and NGO priorities and funding opportunities. The HMIS as routine data collected from health facilities shows the picture of morbidity, mortality, service delivery, available commodities and financial management. This is used in capturing the disease burden. However, the data are not always complete, nor do they capture experiences of citizens who do not attend health facilities. Improved data collection is necessary for accurate resource allocation and understanding where patients are coming from, and what is causing ill health. When priorities are being set, equity, community participation, acceptability, availability, affordability and community needs should be considered.

Plan-Rep is linked to the CCHP and provides a basis for evaluating performance, budgeting and expenditure spending patterns of districts. Plan-Rep feeds into the national health accounts and reports for different levels to review. While it is thus crucial that all funding sources are effectively captured, Plan-Rep is missing some key CCHP inputs; for example, cost-sharing arrangements such as CHF, NHIF and revolving funds (De Savigney and Mwanyika, 2010). With plans to create a third generation of Plan-Rep, it was reviewed in 2012-13, with all tables in the CCHP guidelines produced automatically and linked. Improvements in capturing all revenues have been made, including funds outside the council account such as in-kind funds and including external/NGOs funds that do not pass through the exchequer account. This also includes in-kind funding from support from vertical programmes and medicines through the medical stores department and from cost-sharing arrangements.

Through this CCHP process, councils and council health management teams can be identified as key actors in ensuring planning for EHBs and ultimately their implementation. However, as stressed by a key informant, good-quality planning has been neglected as attention is increasingly focused on achieving indicator results, linked to funding disbursements in performance-based financing (KI development partner, 2017).

Planning, in Tanzania’s health sector, is argued to have become an exercise pre-determined by central activities and finances. Planning is no longer strategic, or based on achieving effective outputs, but has become mechanical, built from and limited to budget lines, rather

than focusing on the outputs and what the facility should be delivering. The planning process is also perceived to provide limited opportunity for flexibility and emergency planning, with a fixed timeline, funds and activities leaving little room to adapt to a changing health system and district needs. Improvements are being planned in planning tools (such as Epicor) to address some of these limitations: changing the Epicor tool to focus on outputs and service delivery outcomes, linking financial resources and outputs (KI technical consultant, 2017).

In terms of specific challenges at the service delivery level, Tanzania has a large vulnerable group and facilities are accessible but not functional, as they do not have the capacity to deliver the EHB. Recent 2017 service evaluations using a Star-rating show that about 86% of facilities were rated 0-1 star (URT, 2017c). The Star-rating assessments classified 34.5% of (public and private) facilities as 'zero stars', without adequate capacity to deliver EHB:

*We have access to services... but the infrastructures themselves are not enough and those which are available do not provide similar services... because a functioning health centre should be providing emergency obstetric care but if it does not it automatically serves as a dispensary. So it can't outweigh helping to facilitate that benefit package to be addressed....In terms of quality....Recently the Star-Rating Assessment was done and it also showed that about 34.5% were found not good, they were poor, which means those facilities are not even supposed to deliver services, to deliver a benefit package....*  
-- KI government, 2017

Having resources, and revenue, distributed to facilities or districts is one element, but this needs to go hand-in-hand with a wider system change to address service delivery. Facilities (service providers) need to have all core components available before implementation. These core components can be termed 'facility pre-requisites' that would need to be available so that the EHB can be delivered (KI retired government, 2017). These include: the facilities having all plans and policies available; having a clear guideline of planning and policy; and having core resources (health workers, commodities and infrastructure) available to be able to implement the services. Challenges are found in making these pre-requisites a reality, and moving inputs (resources) to processes (human resources to implement) and outputs (equitable and accessible service delivery). Plans are made but resources are not enough to implement, and differences remain across urban and rural areas in terms of human resources, ultimately influencing the quality of care provided.

For example, RMNCH is one of the EHB clusters. Despite significant investments in the One Plan for improving maternal health, the maternal mortality rate has increased from 454 to 556/100,000 (URT, 2016g). Quality and limited resources will be linked to this: such as a lack of commodities; poor performance and client-service provision by health workers; inadequate referral systems and transport; and lack of access to vital infrastructure (such as comprehensive emergency obstetric care or emergency obstetric care) (KI government, 2017).

In terms of investing in improving service delivery, concern was raised that the EHB and investment are focusing more on PHC and not service delivery in tertiary and quaternary levels (KI development partner, 2017). This comes back to where and how resources are used and the use of an integrated and health systems approach. Tertiary-level services need to be built to ensure referrals. The KI (above) explained that this is even more important today, given the need for specialised tertiary services for NCDs and that the cost of treating NCDs needs recognition.

#### **4.7 Use of the EHB in monitoring and oversight of services**

To date, no national evaluation of the EHB in Tanzania has been made. However, 'impact' assessments can be made based on health data systems' evidence. With increasing emphasis being placed on improved services and a client-oriented approach within the health sector, available performance data available have significantly improved and are able to provide a valid picture (KI government, 2017). In terms of routine data collection, Tanzania has led the way in establishing monitoring data systems, such as the District Health Management

Information System, Sample Vital Registration and Verbal Autopsy, TEHIP and Adult Morbidity and Mortality project. For example, planning services for the NEHCIP-TZ use data from Adult Morbidity and Mortality project, the HMIS and district health accounts. This is inputted into the Plan-Rep database whereby needs and the BoD are identified as priorities and a CCHP developed for districts. Indicators, from some of these platforms, show progress has been made in addressing health problems – particularly in immunisation packages and vaccines (KI government, 2017). The indicators also show a changing burden of disease, which needs to be taken into account. Further improvements in monitoring and evaluation systems are being planned with the proposed rollout of LGA Score Cards (URT, 2017b).

In 2012, service availability, and thus readiness, was assessed for 27 districts (URT, 2013b). Services for malaria, ANC, family planning, immunisation and more were commonly available in a high number of facilities, compared to specialist services such as diabetes treatment, blood transfusions or advanced delivery (URT, 2013b). In the case of family planning, an essential service, common available services included providing male condoms and oral contraception. However, upon evaluating how ready the facilities were in terms of amenities, equipment, standard procedures, diagnostic capabilities and medicines and commodities, readiness was found to be below average and private services more ready to cater to patients' needs, compared to public health facilities, despite the latter being more available. Facilities were more prepared to provide services for immunisation and family planning, compared to blood transfusion, basic surgery, ARV prescriptions and treatment for TB. A high proportion of public facilities were shown to not be prepared in providing specialist care and treatment and key essential services. Moreover as already noted, the recent star rating assessment of facilities shows that most facilities are not adequately equipped to provide acceptable quality of care. Data platforms enable effective monitoring and evaluation of performance/ quality.

Challenges have been identified in monitoring systems and platforms in terms of accuracy, reliability and quality. Reliable information is key for decision making and performance evaluation. However, there seems to be an identified lack of leadership over who will fund and maintain such systems (KI academic, 2017). As the KI explained, originally such data platforms were supported by research funds, but maintaining this is not a core service of research institutions and they do not have funding available. The KI observed that it should be nationally owned or led. The lack of funding for data systems, such as the sample vital registration and verbal autopsy, was linked to wider priorities of key funders, including the Global Fund and Centre for Disease Control. The priority focus of Global Fund is on drugs, diagnostic and patients, with monitoring and evaluation comprising a small percentage of spending (KI academic, 2017). Further, as indicators for monitoring become swayed by performance-based financing systems, greater emphasis will be placed on monitoring certain indicators based on disbursement mechanisms.

## **5. Discussion**

### **5.1 Conceptualisation and national policy**

As shown throughout, the most recent EHB, the national NEHCIP-TZ in Tanzania remains in line with national policies and strategies. From Tanzania's national Development Vision 2025 to the Health Sector Strategic Plans (I-IV), emphasis is placed on UHC, equity, accessibility and efficiency in health. Access to essential services for citizens remains a theme since independence. However, the recent evolution of the EHB shows a shift in thinking. Prevention and promotion of health needs have become a central focus in health system strengthening. Beyond curative care, communities, behaviour and the environment have been identified as prioritised areas. The emphasis on improving related health environments, both social and environmental, within the NEHCIP-TZ shows the national recognition of the social determinants of health and a shift to building safe, secure and healthy communities.

This shift in thinking away from the 'verticalisation' of diseases, is necessary, as the determinants of population health are complex. An unhealthy population cannot be resolved

through vertical, compartmentalised, disease funding and strategies. The NEHCIP-TZ as conceptualised is not just about service provision, but rather wider health system strengthening. The five cluster services to be provided at different levels, both public and private, were to go together with strategies for improvements in human resources, access to facilities of a standard quality, improved financial protection burden and strengthening of decentralisation. Although the package has health system strengthening at its heart, issues arise in estimating costs for providing such services in light of the current budget. Attention has been focused on identifying options for generating additional revenue. With social determinants of health as a key crosscutting priority to ensure overall well-being, there is also need to identify and overcome challenges in ensuring intersectoral collaboration.

An additional challenge of NEHCIP conceptualisation emerges in how services are provided at the facility or hospital and the transition from 'essential' to 'minimal' care'. The NEHCIP is to provide essential services at different health facility levels, including chronic, infectious, communicable and reproductive services. However, are the services available? Is there infrastructural space to separate screening of infectious TB patients and expectant mothers? Across sectors and partners, the current NEHCIP is under debate as to what is considered essential/minimum, particularly when fiscal space is considered.

## **5.2 Changes in health financing**

As described above, financing in Tanzania's health sector has evolved over time. However, the sector is largely externally funded, streamed from the central level down to LGAs, with insufficient funds to meet needs. To sustainably finance the sector, different mechanisms have been introduced: central restructuring has introduced SWAp and Health Basket Funding. Furthermore, private and public health insurance schemes operate for cost-sharing – including NHIF, *Tiba kwa Kadi* and CHF. However, use of insurance schemes remains low.

Tanzania is now designing a health financing strategy, in-line with HSSP IV. The strategy highlights the future direction of financing for the health sector in Tanzania, and thus NEHCIP implementation. The strategy is introducing a single national health insurance scheme to finance a Minimum Benefits Package (MBP) and MBP Plus. The strategy will act to further facilitate implementation of NEHCIP through pre-paid mechanisms, but the Constitution has not yet approved it. The NEHCIP was to represent a pro-poor policy intervention. Concerns have been raised over the equity outcomes and the limitations of adopting an insurance approach in comparison to a tax-based system. Improvements have been made in designing the MBP/ Plus to stop a dual health system emerging and ensure it remains pro-poor. Services cannot be provided for free, so such pre-paid mechanisms are building a base of payers and system of reimbursement to ensure basic services are available.

Alongside development of the national health financing strategy and the MBP, a key change within health financing is the further decentralisation of money. There is now a movement towards direct facility-based financing and output-based payments, with decentralisation of money from districts to facilities (URT, 2017a). This was identified as a positive change.

Such a full-circle call for decentralising funds shows striking similarities with a return to the TEHIP model: topping up funds for facilities and empowering agents within facilities to make decisions over how additional direct funding will best be spent. With this, questions emerge as to what were the barriers in its uptake. Stakeholders remain influential in the HBF, deciding the health financing methods, strategies and direction. So how synchronised will the objectives be? DFF support to facilities will include HBF funds. Will DFF be met with improved facility planning and evidence?

## **5.3 International influences**

The health sector remains heavily externally funded. For effective policy reform and formulation, however, political commitment and leadership need to come from the government, in collaboration with external actors (Stevens and Teggegan, 2004). International programmes and projects are often externally led and feed in vertically; but

platforms, such as technical working groups, provide an effective means of communication between national and international actors.

The reach of international funders goes beyond policy design, with their presence evident in design of key programmes for strengthening health systems, such as the BRN. The objective of these programmes is to strengthen the health system, albeit through different approaches and/or diseases. The funders aim to obtain best value for money for resources invested into the health sector and to introduce economic incentives to change the ways of working and employee behaviours. For example, BRN has introduced investment in four key result areas, while results based financing is providing additional funds based on results in strategic areas, with a focus on RMNCH. Do these strategic areas and international priorities match the national NEHCIP and community needs? If yes, are there any conflicts of interest and what does this result in – do health workers neglect essential services to focus on where financial incentives are found? Where financial resources are scarce is a conflict of interest developing and having negative impacts on health outcomes? Or rather, as the NEHCIP is embedded within broader health-system strengthening – emphasising improved referral systems and responsibilities through decentralisation and human resources – do such externally funded programmes improve the chances of achieving access to essential services?

Not all essential health services, or elements, are equally prioritised, as discussed in *section 4.2*. Additionally, results have shown improved progress in outcomes such as immunisation and vaccination in comparison to maternal healthcare, where determinants are more complex. A disease-based programme approach is common in Tanzania, and with additional funding being allocated to service delivery, priorities may be changed to focus on international priorities. However, to roll out NEHCIP, an integrated approach is vital: focusing on financing and strengthening the health system through stronger management principles, HR productivity and transparency. This has proven challenging and limited.

#### **5.4 Service quality and implementation**

With the NEHCIP in mind, and ensuring good quality and equity in health, the Tanzanian government has recently created a series of Basic Standards for Health and Social Welfare facilities (URT, 2016a-e: V1-5). These standards show Tanzania's continued shift to seeing essential health services as linked to the environment and social determinants of health. The standards highlight that village governments are responsible for ensuring that all settlements and buildings follow the Public Health Act (2009) and Urban Planning Act (2007), prioritising open and clean spaces (URT, 2015a).

NEHCIP in Tanzania provides guidelines on what to provide at which level, and the list of services is extensive. The concern is thus on how to ensure the care provided is of high quality. Human resources, infrastructure, and financial capabilities influence this outcome. The Quality Assurance Department of the MoHGCDEC created NEHCIP-TZ, and it was the same department that created the Basic Standards for Health and Social Welfare facilities. Discussions on the NEHCIP should thus reflect on who the service providers and service implementers are for quality improvement: Are they empowered? How are they managed and governed? How do they work together?

NEHCIP works in facilities at different levels, both public and private. A key aspect discussed was the need (and strategy) to empower facilities. Decentralisation has been criticised in Tanzania because of the imbalance of power and the decentralisation of service provision, and government structures have not been matched by the decentralisation of power. More needs to be done to ensure power and decision making are being devolved. NEHCIP relies heavily on councils and service providers (the facilities, dispensaries, and hospitals), but we need to recognise the barriers faced at these levels in translating the package. With preliminary BRN results showing a majority of facilities across Tanzania rated below one star, the health system needs strengthening. Although health personnel and infrastructure remain costly, and are mainly supported through government funding, they are vital for strengthening the health system to enable service delivery. With regard to infrastructure, the focus on



improved quality, availability of care and implementation neglects the fact that access to services remains inequitable across Tanzania. The focus on results and service improvements ensures that those able to reach service providers access the required health service and can continue to do so. However, now discussions are turning to the vulnerable who are not able to access healthcare. This may be a result of distance, or other factors; however, council plans need to incorporate service and infrastructure allocation based on the most vulnerable located at great distances. Such elements encourage a system strengthening approach.

## 5.5 Equality, equity and UHC

The NEHCIP is embedded within the discussion of achieving UHC, albeit with the NEHCIP being under debate and a shift towards a minimum package. There is a need to return to concepts of equity. This includes introducing a degree of flexibility in the EHB accessed by citizens without introducing discrimination. Key informants raised the idea of introducing different cards and packages for different client groups at different levels of facilities, arguing that the EHBs needed to be flexible to different needs. They suggested different packages based on what one can afford and needs: *So in Tanzania... 60% or more of people are informal and they go primarily to informal health providers. ... So with those groups where we think about how do we get these 60% of Tanzanians to adhere to an insurance, that's when we think, what kind of packages would you get? If you can only buy the 'basic card' you get CHF and if it's much more you get a specialized operation* -- KI development partner, 2017

This needs to be assessed for its equity implications and demands more sophisticated financing of options that also integrate those in the informal economy.

## 5.6 Stakeholders and the division of labour

The EHB implementation is embedded within a complex network of actors. For effective implementation all players involved must be recognised: traditional, formal/informal, providers and purchasers. The new health financing direction includes new purchasers: the insurers, Ministry of Finance and Economic Affairs, NHIF and more. This division of labour between the purchasers and providers is important to clarify. Purchasers, on the one side, need to be aware of the health reality in Tanzania. For example, who are the vulnerable (how much will they cost) and how will they be exempted, and how will such funds be reimbursed? Further, what will be the public financial management of funds and reliable sources, including all council funds and off-budget support? On the other hand, for purchasers, improved (and flexible) plans need to be made to ensure implementation.

The facilitators, and barriers, for moving NEHCIP to practice identified in *sections 4 and 5* are summarised in *Table 8* overleaf.

## 6. Conclusion

EHBs in Tanzania remain complex and under debate. The current EHB, NEHCIP-TZ defines a set of key services that all citizens are entitled to access at different levels, in the public and private sector. Moving NEHCIP from policy to practice, includes a range of actors, multiple financing streams and political decision making. NEHCIP has evolved over time, first being a pilot project before being scaled up into a national programme from 2000. NEHCIP has been integrated in the HSSP IV and effectively into the health planning process. It is integrated within the current health system and aims to strengthen it – relying on key personnel, institutions, roles and responsibilities, to act on the plans and health areas prioritised. Budgets, plans and reports are built on NEHCIP, but NEHCIP relies on improving local government capabilities and capacities. NEHCIP is a movement towards universal healthcare – and although no evaluations have been conducted to measure how far we have reached – this report identifies the key implementation procedures and barriers faced.

**Table 8: Facilitators and barriers of NEHCIP-TZ**

	<b>Facilitators</b>	<b>Barriers</b>
<b>Design</b>	<ul style="list-style-type: none"> <li>• NEHCIP has evolved over time, built through reviews and consultations</li> <li>• Interconnected with key health policies/ strategy/ vision/ standards or quality</li> <li>• Design used a health systems perspective</li> <li>• Designed from strong data systems: such as the HMIS. EHB contributes to continued use of these monitoring systems</li> </ul>	<ul style="list-style-type: none"> <li>• Keeping up with the evolving BoD</li> <li>• NEHCIP has not resulted in the development of specific sector EHBs: defining costs and implementation procedures (i.e., National Essential Health Sector HIV/AIDS Intervention Package)</li> <li>• Large vulnerable group</li> <li>• Sustainability concern: limited investment in tertiary levels</li> </ul>
<b>Finance</b>	<ul style="list-style-type: none"> <li>• Positive outcomes where EHB receives additional government funding: i.e., vaccines</li> <li>• Shift towards direct facility financing</li> <li>• Development of Health Financing Strategy defining a minimum EHB to be provided to all citizens</li> </ul>	<ul style="list-style-type: none"> <li>• Inaccurate costing; however, the costing is a positive start</li> <li>• Costing did not use a health-systems approach</li> <li>• The resource gap identified; and funding not trickling down to districts/facilities</li> <li>• External funding does not always support core systems improvements (i.e., data, management, MandE). The health sector remains heavily dependent still</li> <li>• Health Financing Strategy yet to be approved</li> </ul>
<b>Implementation</b>	<ul style="list-style-type: none"> <li>• Integrated into health planning (i.e., CCHP), expenditure reporting and resource allocation</li> <li>• The councils and district levels are central to implementation of EHB</li> <li>• Formal platforms to enable collaboration between government and external</li> </ul>	<ul style="list-style-type: none"> <li>• Communication gap in dissemination. Lack of clarity between: a) what is provided; b) private/public sector; and c) service providers – purchasers</li> <li>• Systems approach not used: need to include funding for strengthening essential management, infrastructure and HR</li> <li>• Criticism over planning process, power is central, and decentralisation not efficient</li> </ul>

Source: Authors compilation.

Tanzania's NEHCIP seems to be a tool for guiding, organising and planning service delivery down to the community level and standardising the services provided. On a positive note, the package highlights the burden of disease and has strengthened evidence-based decision making and budgeting procedures. But the concern comes in fiscal space – to ensure policy moves to practice, costs and resource pools need to be identified; data on need have to be correct; and interventions for improved quality are required. On the financial side a resource gap is shown, and considering limitations in the costing exercise, the full resource gap may not be captured. A re-costing exercise is required that incorporates the full cost of processes, staff and medicines.

With development of the MBP packages, more information is now available on how funds will be accessed to provide minimum benefit services. However, time is required to ensure individuals utilise, trust and see the benefit of a MBP (plus). Mitigation is also required to ensure that a dual health system does not develop, with minimum benefits varying dramatically. Such changes in health financing are important in terms of enabling internal domestic resource mobilisation. The MBP package also represents the realist shift in Tanzania, moving away from providing free services to a more practical discussion on how to set up pre-paid mechanisms to ensure the wish list of services can actually be provided. The upcoming health financing strategy, SNHI and DFF, are not only about increasing health revenue and pooling funds but also about strategic health purchasing, including a shift to output-based provider payment systems. This shift is inherent in SNHI and is intended to better match payment to MBP services, increase provider autonomy, and increase efficiency or value for money.

On the service side, more discussion is required on how to ensure the services are actually provided and at good quality. Improving management, technical capacity, availability and planning at the service provider level require attention. Service delivery goes in line with accurate and effective planning that uses a health-systems' perspective, recognising, and accounting for, the necessary commodities, infrastructure, human and financial resources. Planning also needs to be improved by taking a multi-sectorial approach. The health sector and planning teams need to better communicate with other sectors. Just as health needs to be in all policies, health needs to be in all plans (WHO, 2013). Such improvements complement the strengthening of decentralisation in Tanzania's health sector, by investing in district health services, ensuring accountability in health facilities and distributing funds directly to facilities. However, more evidence is required to evaluate the impact on NEHCIP delivery.

Monitoring and evaluation are required to: a) recognise the progress made for accessing NEHCIP and b) provide insight on the quality of services delivered. Tanzania has different means available to check the progress of reducing the burden of key diseases and ensuring the entire population is receiving essential health services. This includes: externally led programmes (i.e. Star-rating assessments, results-based financing), national strategies with indicators to monitor progress (HSSP 4) and data systems (i.e., HMIS). The National Essential Health Sector HIV/AIDS Intervention Package states the EHB, specifically for the HIV/AIDS sector, has "increased the percentage of HIV-positive women receiving ARVs to prevent mother-to-child transmission, as well as the number of persons with advanced HIV infection receiving ARVs" (URT, 2009:30). However, this goes to show how outcomes of health priority areas will vary. Vertical funding and the importance of external funding result in varied outcomes in what NEHCIP services are accessed and at what quality.

This report has identified numerous challenges in mainland Tanzania that delay implementation of the EHB. By taking a historical perspective on EHB evolution, this report summarises key activities feeding into strengthening and weakening Tanzania's health system. The EHB has evolved over these phases, but continues to remain founded in core health principles of equity, promotive care, ensuring access and availability. The debate now comes in terms of clarifying core services (what data to use, and how to define need); how to ensure fiscal space is available and whether there are sufficient public financing mechanisms to support NEHCIP implementation. Health sector planning is inherent in NEHCIP service delivery. However, there also needs to be a shift away from emphasis on service provision. For example, service providers beyond the primary care level need to integrate hospital care, specialised care providers and the private sector. Attention is also needed in areas where there is no access to facilities and on improving availability in current facilities. Lastly, a management focus is key. Although the package calls for improved management, the KIs discussed how greater effort and resource allocation were needed in the area of health sector management, across different implementation levels.

In conclusion, we highlight the following points:

- Tanzania's NEHCIP has come a long way, embedded in concepts of equity and social determinants of health, utilising evidence for decision making and connecting policies with decentralising planning. However, steps need to be taken towards strengthening NEHCIP implementation.
- A re-costing exercise needs to be conducted and thought given to innovative financing for healthcare.
- Training and capacity building are required to improve and strengthen management within facilities across different levels, including improvement in public financial management and ensuring social accountability from service providers.
- Improved integration into plans is needed to ensure quality assurance within the services delivered.

This requires reinvesting in a social determinants approach, changing the environment to prevent ill health and promote improved well-being. The approach is emphasised in NEHCIP and HSSP IV, but has received less investment and prioritisation.

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## Acronyms

<b>BRN</b>	Big Results Now
<b>BOD</b>	Burden of Disease
<b>CCHP</b>	Comprehensive Council Health Plans
<b>CD</b>	Communicable Disease
<b>CHF</b>	Community Health Fund
<b>D-BY-D</b>	Decentralisation by Devolution
<b>DFP</b>	Direct Facility Financing
<b>EHB</b>	Essential Health Benefits
<b>EQUINET</b>	Regional Network for Equity in Health in East and Southern Africa
<b>HMIS</b>	Health Management Information System
<b>HSSP</b>	Health Sector Strategic Plan
<b>IHI</b>	Ifakara Health Institute
<b>IDRC</b>	International Development Research Centre, Canada
<b>KI</b>	Key Informant
<b>LGA</b>	Local Government Authorities
<b>MBP</b>	Minimum Benefit Package (and MBP Plus)
<b>MOHSW</b>	Ministry of Health and Social Welfare
<b>MOHCDGEC</b>	Ministry of Health, Community Development, Gender, Elderly and Children
<b>NCD</b>	Non-Communicable Disease
<b>NEHCIP-TZ</b>	National Essential Health Care Interventions Package – Tanzania
<b>NGO</b>	Non-Government Organisation
<b>NHIF</b>	National Health Insurance Fund
<b>NSGPR/ MKUKUTA</b>	National Strategy for Growth and Poverty Reduction
<b>NPEH</b>	National Package of Essential Health
<b>PO-RALG</b>	President's Office of Regional Administration and Local Governments
<b>PHC</b>	Primary Healthcare
<b>PHSDP / MMAM</b>	Primary Health Services Development Plan
<b>RMNCH</b>	Reproductive, Maternal, Neonatal and Child Health
<b>SNHI</b>	Single National Health Insurance
<b>SWAP</b>	Sector-wide Approach
<b>TARSC</b>	Training and Research Support Centre
<b>TEHIP</b>	Tanzania Essential Health Interventions Programme
<b>THE</b>	Total Health Expenditure
<b>UHC</b>	Universal Health Coverage
<b>URT</b>	United Republic of Tanzania
<b>WHO</b>	World Health Organisation



**Equity in health** implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

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