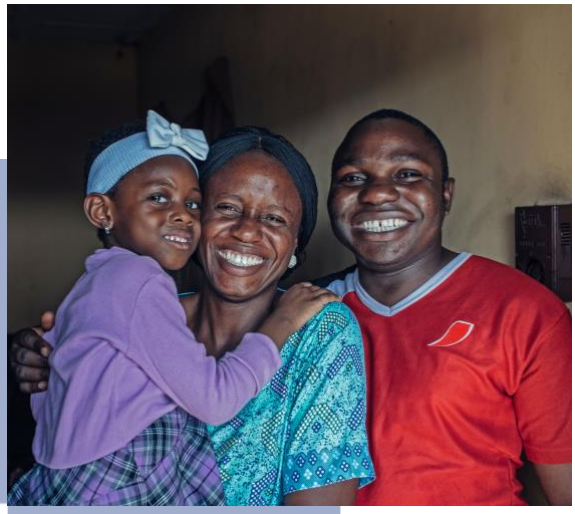
SHOPS PLUS

# Tanzania Private Health Sector Assessment Update

## Health markets snapshots and future priorities



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**Submitted to**: Gene Peuse
Senior Public Private Partnership Advisor
USAID Tanzania, Dar es Salaam

**About SHOPS Plus**: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government health priorities and improves the equity and quality of the total health system.

**Cover photo**: KC Nwakalor

Abt Associates Inc.
6130 Executive Boulevard
Rockville, MD 20852 USA
Tel: +1.301.347.5000
abtassociates.com

American College of Nurse-Midwives | Avenir Health
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Iris Group | Population Services International | William Davidson Institute at the University of Michigan

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## Health markets snapshots and future priorities

This report is made possible by the support of the American people through the United States Agency for International Development (USAID).The contents of the report are the sole responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

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# Acronyms

| | |
|---|---|
| **ADDO** | Accredited Drug Dispensing Outlet |
| **APHECOT** | Association of Private Health Colleges of Tanzania |
| **ARV** | Antiretroviral medicine |
| **CHF** | Community Health Fund |
| **CSSC** | Christian Social Services Commission |
| **eGA** | e-Government Authority |
| **FBO** | Faith-Based Organization |
| **GOT** | Government of Tanzania |
| **HMIS** | Health Management Information System |
| **HSSP** | Health System Strategic Plan |
| **iCHF** | Improved Community Health Fund |
| **LGA** | Local Government Authority |
| **mCPR** | Modern Contraceptive Prevalence Rate |
| **MOHCDGEC** | Ministry of Health, Community Development, Gender, Elderly, and Children |
| **NGO** | Nongovernmental Organization |
| **NHIF** | National Health Insurance Fund |
| **PLHIV** | People Living with HIV |
| **PMTCT** | Prevention of Mother-to-Child Transmission |
| **PMTI** | Private Medical Training Institute |
| **PO-RALG** | President's Office – Regional Administration and Local Government |
| **PPP** | Public-Private Partnership |
| **PRINMAT** | Private Nurse-Midwife Association of Tanzania |
| **PSA** | Private Sector Assessment |
| **SARA** | Service Availability and Readiness Assessment |
| **SHOPS** | Strengthening Health Outcomes through the Private Sector |
| **SHOPS Plus** | Sustaining Health Outcomes through the Private Sector Plus |

| | |
|---|---|
| **SLA** | Service Level Agreement |
| **TIRA** | Tanzania Insurance Regulatory Authority |
| **TMA** | Total market approach |
| **UHC** | Universal health coverage |
| **USAID** | United States Agency for International Development |

# Introduction

In 2012, the Government of Tanzania (GOT) and its donor partners came together to chart a new path forward for Tanzania's health system. Under the leadership of the Tanzanian Ministry of Health and Social Welfare's Public-Private Partnership Technical Working Group, the U.S. Agency for International Development (USAID) and the World Bank funded the global Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct a private sector assessment (PSA). This process and the resulting document helped Tanzanian stakeholders map opportunities and gaps for strengthening public-private engagement for health and created a roadmap of short- and long-term steps for improving private sector engagement across the health system building blocks.

The 2012 PSA was a truly participatory process, with public and private sector leaders helping to shape the scope of work. The SHOPS assessment team relied on a mix of secondary analysis of Demographic and Health Survey data, an extensive document review, and over 100 stakeholder interviews to document the private sector's role in the health system, identify current gaps and challenges, and recommend opportunities for investments. The results of these efforts were shared with a wide swath of public sector stewards, private companies and health care providers, donors, and implementing partners. These actors helped to validate the assessments findings and prioritize recommendations for the final strategic road map.

Since the 2012 PSA, the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) and USAID have worked to implement many of the recommendations identified in the initial assessment. This brief draws on a review of available government policies, reports, and other documents to update the original assessment. The goal is to identify where progress has been made in the various health areas, where more needs to be done, and where new opportunities and challenges have emerged. It is intended that this update can provide suggestions for areas of future investment in public-private engagement for health in Tanzania.

## Key findings from 2012 assessment

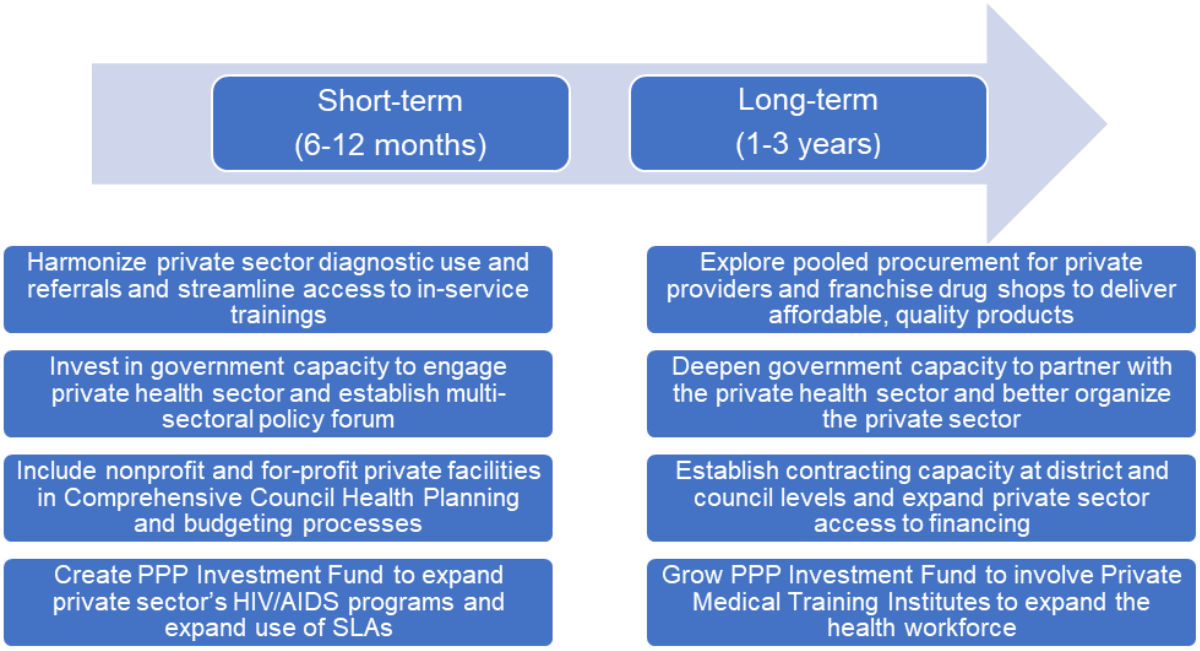
The 2012 PSA highlighted the private sector's presence and contributions throughout Tanzania's health system. Importantly, the report mapped over 1,700 private outlets and health facilities across the various levels of the health system to demonstrate the private sector's size, reach, and diversity. The report also used DHS data to identify the private sector's contributions to key health areas. This analysis found that the private sector was an important source of health care for clients in urban and rural areas, from all socioeconomic backgrounds, and across all major health areas (HIV, family planning, child health, etc.). Private nonprofit facilities were much more present and provided a larger share of services in rural and peri-urban areas, while for-profit facilities had a larger footprint in urban areas.

Overall, the PSA found that Tanzania had already developed a comprehensive regulatory framework and mobilized political commitments to further public-private engagement in the health system. At the time of the assessment, though, efforts to capitalize on this framework and will remained nascent, under-resourced, and limited in scope. The private health sector faced additional challenges: the government's main health financing programs that purchase services from private providers (the National Health Insurance Fund (NHIF), the Community Health Fund (CHF), and service level agreements (SLAs) that target specific services) benefitted a limited number of people. The majority of private clients relied on out-of-pocket payments. The private

supply chain was also fragmented and operated with weak oversight, leading to concerns about high costs and poor quality of medicines and health commodities at private outlets.

However, opportunities existed to better use the private sector's resources. The PSA team noted opportunities to decentralize public-private engagement to the regional and council level. The assessment also highlighted how donors could help strengthen the ability of private medical training institutes to produce more well-trained high quality health workers. Finally, the report highlighted opportunities to link private providers to donor-funded training and to harmonize the use of diagnostic equipment in the private sector to bring costs down. Following consultations with public and private stakeholders, the PSA team produced a strategic roadmap for strengthening public-private partnerships (Figure 1).

**Figure 1. Strategic Roadmap for Strengthening Public-Private Partnerships in Tanzania**




## Efforts to implement PSA recommendations

Following the conclusion of the PSA, USAID/Tanzania moved to support the MOHCDGEC to operationalize its recommendations across the health system. The mission's investments included:

- **SHOPS** and its follow-on project **SHOPS Plus** to improve the enabling environment for private sector, strengthen private sector human resources for health, increase and improve private sector service delivery in key health areas, and increase private provider access to finance;
- the **Global Health Supply Chain – Technical Assistance** project to strengthen and better leverage the private sector supply chain to improve access to essential medicines and health products;
- and the **Health Policy Plus** project to strengthen the health financing programs that could contract with private providers and help reduce financial barriers to care in the private sector

# The evolution of Tanzania's private health sector since 2012

Since the PSA, Tanzania's health system and broader society have undergone many changes (Table 1). Between 2011 and 2019, Tanzania's population has grown larger by 27 percent, wealthier by 27 percent, and more urban by 20 percent. At the same time, the country has made impressive gains in key health areas. The modern contraceptive prevalence rate (mCPR) among married women increased from 29.3 percent to 37.4 percent. And while the number of people living with HIV (PLHIV) increased by 300,000, the percentage of PLHIV on lifesaving antiretroviral therapy more than tripled.

### Table 1. Evolving context – key metrics in Tanzania

| | 2011 | 2019 |
|---|---|---|
| Population | 45.7 million | 58.0 million |
| Per Capita GDP (PPP, constant 2017$) | 2,098 | 2,660 |
| Urbanized population | 28.8% | 34.5% |
| Life expectancy | 59.5 years | 65.0 years (2018) |
| mCPR (Married Women) | 29.3% | 37.4% |
| # of PLHIV/ART coverage | 1.4 million/20% | 1.7 million/75% |

Source: World Bank DataBank; AIDSinfo database

The increased population, wealth, and urbanization, combined with the increased number of Tanzanians accessing health care, points to a growing market of potential clients for the private health sector. Reflecting this growth, the number of registered private outlets has also increased substantially. As of April 2021, Tanzania's National Health Facility Registry included 3,589 operating private health facilities nationwide (Table 2). Almost one quarter of these are in Dar es Salaam (900 facilities), followed by Arusha (237) and Kilimanjaro (189). The private sector's presence is most limited in Katavi (25), Lindi (25), and Songwe (37). The majority – 71 percent – of these facilities are for-profit, followed by faith-based and nongovernmental organizations (NGO).

### Table 2. Private Health Facilities in Tanzania, by level and ownership

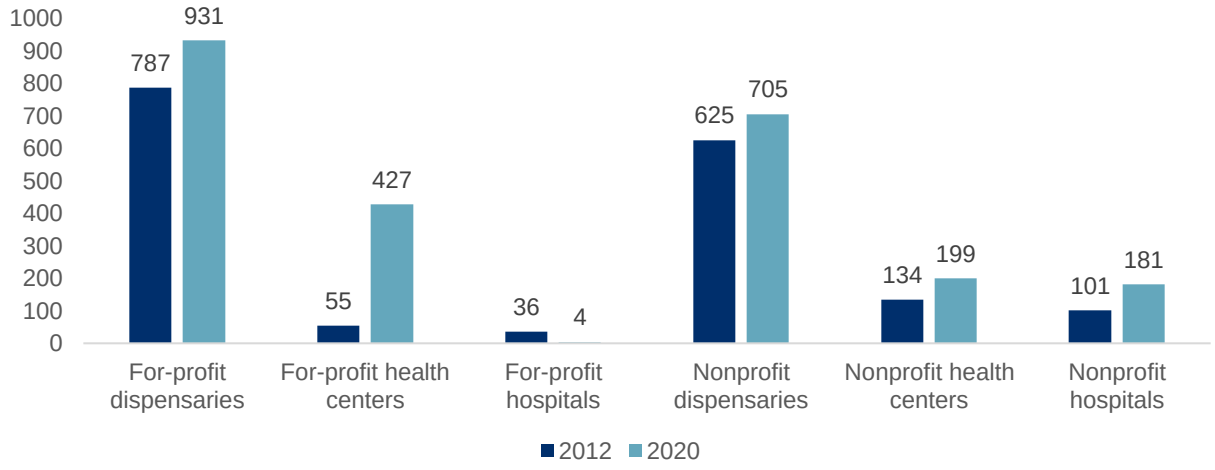
| | FBO | NGO | For-Profit | Total |
|---|---|---|---|---|
| Dispensary | 662 | 43 | 931 | 1,636 |
| Health Center/Clinic/Polyclinic | 172 | 23 | 353 | 548 |
| Maternity/Nursing Home | 1 | 3 | 74 | 78 |
| Hospital | 117 | 64 | 4 | 185 |
| Laboratory | 3 | 1 | 86 | 90 |
| Other | 3 | 0 | 171 | 174 |
| Total | 964 | 75 | 2551 | 3589 |

Source: Tanzanian National Health Facility Registry; accessed 30 April 2021

Since the 2012 PSA, the number of private facilities has more than doubled (Figure 2). Most of this growth occurred in the profit sector, especially among lower-level facilities. Part of this growth may be explained by limited hiring in the public sector. As a result, recent medical graduates have had to turn to the private sector for employment – either by opening their own dispensaries or by partnering with an investor to open a health center or clinic. In the latter case, the investor provides the capital needed to secure the facility site, equipment, other resources, while the medical personnel provides the professional license needed to register and operate

the facility. Notably, the number of private for-profit hospitals has declined in the past decade despite the growth that occurred in the rest of the sector. Importantly, financial support from donors – channeled through government contracts and service level agreements – has fueled growth in the number of faith-based health facilities. Faith-based organizations (FBOs) now operate 23.3 percent of the country's health infrastructure, including 41 percent of hospitals (Maluka et al 2018).

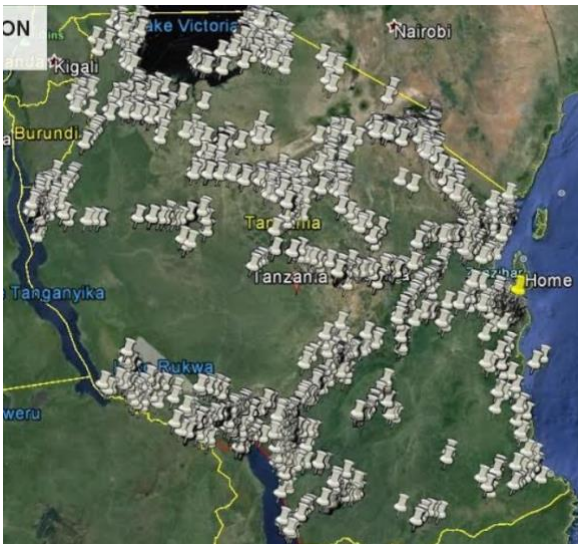
**Figure 2. Changes in private health infrastructure, 2012 to 2020**




Source: Tanzanian National Health Facility Registry, accessed 30 April 2021; SHOPS Plus, 2013.
Note: Nonprofit facilities include both NGO and FBO facilities for ease of comparison with 2012 numbers

Tanzania has also experienced changes in the number of private medicine retail outlets. One of the biggest changes has been the continued expansion of accredited drug dispensing outlets (ADDOs). Originally started in 2003 as part of a pilot program to professionalize and expand the role of informal drug shops, ADDOs represent a substantial opportunity to increase access to priority medicines. The 2012 PSA highlighted that over 2,000 drug shops were accredited to offer an expanded range of over the counter and prescription medicines. The assessment report noted that ADDOs faced many challenges to their sustainability and recommended that stakeholders work to improve the ADDO model's business viability as it further scaled. To that end, Pharmacy Council, SHOPS Plus, and others have helped strengthen ADDO networks. Technical assistance activities included institutionalizing ADDO business and technical trainings, leveraging mobile technology to strengthen quality oversight and increase reporting, partnering with financial institutions to improve access to financing, and supporting the creation of regional ADDO associations to strengthen coordination. As a result of this support, the number of ADDOs grew to 14,036 by August 2019 with a nationwide reach (Figure 3) (Pharmacy Council Nd.).

**Figure 3. ADDO distribution**




Source: Pharmacy Council, Nd

The 2020 Service Availability and Readiness Assessment (SARA) measures the availability of priority products and services in the public and private sectors. The report highlights the differential availability of products and services based on health area and facility ownership. For example, malaria services are available at high levels across the health system, with 99-100 percent of public and private facilities offering these services. Other health areas show stark differences in availability. Public facilities nearly universally offer family planning, primarily injectables, condoms, and oral pills. A slightly smaller percentage (72 percent) of nonprofit and NGO facilities offered family planning services. However, more than half of these facilities offer a broad range of modern methods, including both short-acting methods and long-acting reversible contraceptives. For-profit facilities were the least likely to have family planning – only 37 percent offered any kind of method and those that did were most likely to offer short acting methods only, such as oral pills or condoms.

The availability of any type of FP at private for-profit facilities declined between 2013 and 2020 (Table 3). Between the 2013 and 2020 SARA reports, the percentage of private for-profit facilities offering FP overall declined, while availability of specific methods (oral pills, IUDs, implants) increased slightly. This decline is possibly related to a reduction in support for family planning-focused social franchises. Additionally, private health facilities face high staff turnover. For example, SHOPS Plus found that up to 30 percent of facilities it trained saw a loss of trained staff within one year of the trainings.

### Table 3. Percent of facilities offering FP methods, 2013 and 2020, by ownership

| | Combined oral contraceptives | | Progestin-only injectable contraceptives | | Male condoms | | IUD | | Implant | | Emergency Contraceptives | | Any FP method | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | '13 | '20 | '13 | '20 | '13 | '20 | '13 | '20 | '13 | '20 | '13 | '20 | '13 | '20 |
| Government | 83 | 89 | 65 | 90 | 83 | 96 | 19 | 35 | 26 | 72 | 52 | 60 | 95 | 99 |
| Nonprofit | 50 | 58 | 50 | 58 | 50 | 58 | 29 | 57 | 29 | 54 | 35 | 55 | 64 | 72 |
| For-profit | 28 | 33 | 23 | 22 | 27 | 30 | 15 | 29 | 15 | 28 | 21 | 17 | 47 | 37 |

Source: 2013 and 2020 SARA reports

HIV service availability varied broadly by sector. Services related to prevention of mother-to-child transmission (PMTCT) of HIV are much less available in the private for-profit sector (40 percent) compared to the public sector (93%). There is a much smaller gap for HIV counseling and testing: 93 percent of public facilities, 88 percent of NGO and nonprofit facilities, and only 64 percent of private for-profit facilities offer it. Care and support services for HIV are most widely available among nonprofit/NGO facilities compared to public or for-profit outlets. Across the board, HIV services have become increasingly available in Tanzania, regardless of facility ownership (Table 4). However, for-profit provision of HIV care and treatment services still substantially lags nonprofit and public provision. A key challenge here relates to policies that limit the ability to charge for core HIV-related services (e.g., antiretroviral therapy) with the goal of promoting clients' access to lifesaving services without financial barriers. However, the policies limit for-profit facilities' ability to cover investments in training, commodity procurement, and other inputs needed to offer the service, and thus limit their interest in the services.

### Table 4. Percent of facilities offering HIV services, 2013 and 2020, by ownership

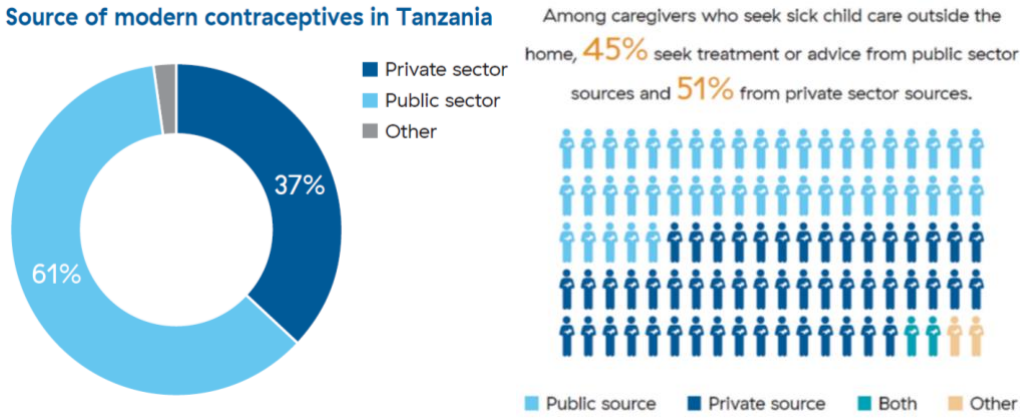
| | HIV Counselling and Testing | | PMTCT | | Care and support | |
|---|---|---|---|---|---|---|
| | 2013 | 2020 | 2013 | 2020 | 2013 | 2020 |
| Government | 75 | 93 | 87 | 90 | 43 | 58 |
| Nonprofit | 51 | 88 | 21 | | 30 | 70 |
| For-profit | 31 | 64 | 35 | 40 | 7 | 31 |

Source: 2013 and 2020 SARA reports

The 2016 DHS provides insight into the private sector's role in the delivery of many of these services. While the private sector's market share has slightly increased from the 2012 PSA in some areas, the general sourcing patterns identified in that report are still present. Private outlets provide family planning to more than one-third (37 percent) of women and couples using a modern method and provide treatment to approximately 51 percent of sick child cases where the caregiver seeks treatment outside the home (Figure 4). Both numbers represent slight increases from the 2012 PSA, when just over 30 percent of family planning clients and less than half of caregivers seeking treatment for child health issues went to private outlets.

For both family planning and child health products and services, non-clinical outlets like pharmacies and ADDOs serve the majority of clients (Figure 4) (SHOPS Plus, 2018a; SHOPS Plus 2018b). For family planning, urban, younger, unmarried users are more likely to access their method from a private source. While more than twenty percent of the poorest users access their method from a private outlet, half of the wealthiest women do as well (SHOPS Plus, 2018a). For child health services, poorer caregivers are slightly more likely than wealthier ones to seek care from a private outlet (56 percent compared to 52 percent) (SHOPS Plus, 2018b).

### Figure 4. The Private Sector's Role in Family Planning and Child Health




Sources: SHOPS Plus, 2018a; SHOPS Plus, 2018b

## Improved enabling environment

In order to further leverage and better support the private sector, the GOT has established new coordinating platforms for public-private engagement at the national and sub-national levels. At the national level, the Public-Private Partnership (PPP)-Technical Working Group and the health ministry's PPP Coordination Team lead public-private engagement and dialogue for policy and

planning. In April 2014, building on one of the recommendations from the 2012 PSA, Tanzania launched a new Public-Private Health Forum to elevate public-private dialogue in the health system. The Forum is tasked with promoting transparent and open dialogue, coordinating stakeholders, facilitating knowledge exchange, and establishing private sector linkages into the public policy process. While initially successful in its early years, the Forum has yet to develop and implement a strategy to finance its operations, putting its sustainability at risk. To date, the Forum has helped create a stronger policy framework for the private health sector by incorporating their perspectives and considerations into several new policies and strategies. Illustrative examples include:

- *The Health System Strategic Plans (HSSP) IV and V*, which recognize the private sector's growth, and prioritizes the use of PPP and public-private contracting mechanisms to better leverage private health workers and resources. HSSP IV identifies the limited involvement of private for-profit facilities in SLAs as a key area for improvement. HSSP V also calls for harmonizing registration, licensure, and accreditation systems to steward and oversee public and private providers to assure quality and improve access.
- *The PPP Strategic Plan (2015-2020)*, which sets the goal of "delivering equitable and quality health services in Tanzania through private sector investment." The plan's four components include ensuring that the policy and legal environment supports PPPs; establishing functional public-private dialogue structures; developing an operational plan to guide PPP development; and increasing private sector investment and financial contributions. Among other things, the strategic plan emphasizes strengthening the role of the President's Office-Regional Administration and Local Government (PO-RALG) to support development and implementation of PPPs at the local level by developing guidelines and supporting LGAs to use them with private sector partners.
- *The Health Policy Implementation Strategy 2020-2030*, which builds on the aforementioned policies and includes a specific chapter on integrating the private sector to increase its involvement in the health system.
- *The Tanzania One Plan*, which tasks the Reproductive and Child Health Section at the MOHCDGEC with expanding the availability of family planning services specifically in private health facilities (compared to private retail outlets).

Because of Tanzania's decentralized governance system, policy implementation largely falls under the authority of LGAs overseen by PO-RALG. SHOPS Plus has been working with PO-RALG and other national level stakeholders to develop and use tools that LGAs can use to promote routine public-private engagement at the council level. Under SHOPS Plus, these efforts have culminated in eleven sub-national workshops developing action plans to apply a total market approach (TMA) to strengthen private markets for family planning products. PO-RALG has expressed its commitment to continue rolling out these workshops and planning tools to the remainder of LGAs and to operationalize TMA principles beyond the life of SHOPS Plus.

The 2012 PSA highlighted the limited availability of routine data from the private sector as an important gap to address. HSSP IV and HSSP V both prioritized strengthening the national health management information system (HMIS) and adopting the web-based DHIS2-platform to strengthen oversight of the health system. The private sector is required to share monthly reports with CHMTs, but these are generally paper-based and involve only private clinical facilities. While the DHIS2 platform accommodates reporting from ADDOs and private laboratories, these outlets have not been equipped with the tools to do so. SHOPS Plus has therefore supported relevant local stakeholders such as the Reproductive and Child Health Section at the MOHCDGEC, the National Malaria Control Programme, University of Dar es Salaam, and the Tanzanian e-Government Authority (eGA) to provide ADDOs with the trainings and tools needed to submit regular family planning reports for the first time. SHOPS Plus also

initiated discussions with relevant stakeholders to enable community pharmacies to report on their HIV self-testing services as well. Currently, this private sector reporting is done through a USSD mobile reporting format that is accessible even at last mile private sector outlets. Data from this reporting is now shared at the regional and national levels, resulting in increased visibility of non-clinical facilities in data analysis and technical working group meetings.

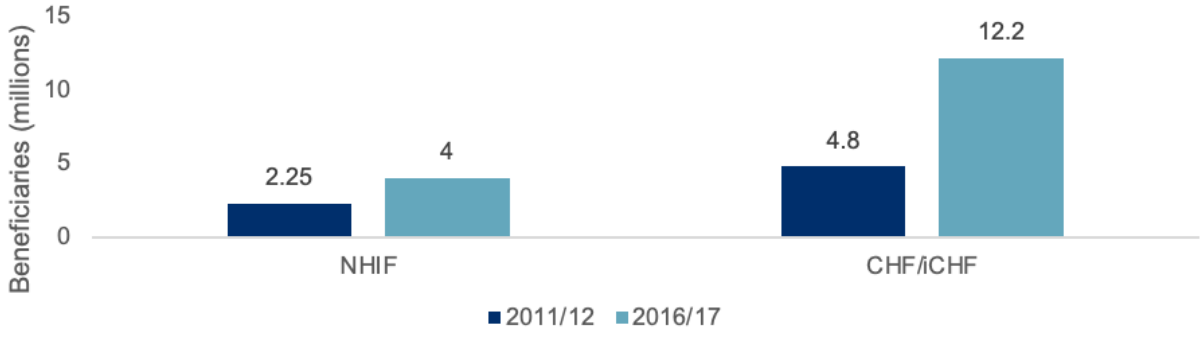
The 2012 PSA highlighted the difficulties that private providers faced in accessing loans and financing to invest in and grow their health businesses. The assessment cited barriers such as high costs and collateral requirements, poor business and financial management skills among private providers and limited awareness among financial institutions of investment opportunities in the private health sector. SHOPS Plus partnered with several financial institutions to deliver solutions targeted at different private sector actors. One such partner was FINCA Microfinance Bank, a financial institution that typically provides targeted loans to small scale organizations to address financing needs. The project worked with FINCA and other financial institutions to better understand the business operating environments and financing needs of ADDOs, private retailers, and women-owned and -operated health enterprises. At the same time, the project trained private providers and retailors to improve recordkeeping and cash management practices, and thereby strengthen their ability to meet banks' lending criteria. SHOPS Plus also worked closely with private provider organizations to help them support their members to navigate the loan application process. This initiative resulted in over $10 million in new private financing loaned to private providers.

## Updates in health financing

The 2012 PSA highlighted the need to increase enrollment in public health insurance schemes to reduce reliance on donors and address high out-of-pocket costs. To that end, the assessment recommended increasing the use of strategic purchasing mechanisms to purchase services from private providers.

Since 2012, Tanzania's health financing programs have remained fragmented, although the number of people covered has continued to increase. By 2018, approximately 34 percent of Tanzanians had some form of insurance: 7 percent through NHIF, 25 percent through iCHF, 2 percent through private schemes, and less than 1 percent through the Social Health Insurance Benefit for pensioners and their families (NHIF, 2018; Haazen, 2012; Wang and Rosemberg, 2018). Most of the recent growth has come through increases in population coverage by NHIF and the iCHF (Figure 5). Much of this growth is credited to reforms to the iCHF that simplified access to available funds and to government and donor efforts to promote the scheme.

**Figure 5. Number of people covered by public insurance scheme, 2012-2017**




Sources: World Bank, 2020

The GOT remains committed to the principles of universal health coverage (UHC). For example, in 2018, the National Assembly proposed legislation to scale up the NHIF and the iCHF, and over time merge these and other government-sponsored programs into a single national health insurance scheme. While this legislation is still pending, it presents a way forward for the evolution of the health financing landscape. In the meantime, an estimated 24 percent of health expenditures are still made out of pocket.

**NHIF**: The NHIF has continued to increase its coverage of formal sector public and private employees, with funds pooled nationally (Box 1). Membership in NHIF increased 40 percent between the 2013/2013 and 2016/2017 fiscal years. The NHIF faces challenges to its financial viability. For example, it reported a 16 percentage point increase in claims ratio[1] between 2012 and 2018, from 47 to 63 percent, respectively, indicating that claims costs are rising faster than premium revenue. The scheme has accumulated a substantial reserve over the last decade that is beginning to decline. One analysis forecasted that as of 2018, the NHIF could deplete its reserves and operate in deficit by 2025 (Lee et al, 2018). Upcoming reforms will need to consider a combination of interventions to maintain the financial viability of the scheme over the longer term. Some will likely include changes to how, and how much private providers are paid, when and how clients can access higher levels of care, and what services remain covered.

**Box 1. NHIF at a glance**

- Established in 1999
- Mandatory membership for formally employed workers
- Voluntary membership for informal sector workers and retirees
- Mandatory members contribute 3% of salary with 3% employer match
- Voluntary members pay TZ1.5 million annual premium
- Additional subsidized scheme for retirees who contributed for at least 15 years

*Source: NHIF, 2018*

**iCHF**: To reduce financial barriers to quality health care for people in the informal sector, the MOHCDGEC piloted the iCHF in the Kilimanjaro region with support from the PharmAccess Foundation in 2014. The original CHF program began in 1996 as district-level health schemes that targeted the informal sector. CHF typically operated in rural areas, with a similar program known as TIKA targeting urban areas. One limitation of the former CHF schemes was that they covered services only from public providers. CHF also only covered services at a local health center. The new iCHF model included several reforms in its administration, resource pooling, provider network, and covered benefits. Two noteworthy changes include expanding the benefits to secondary facilities and opening the scheme to contract with private, primarily faith-based, facilities. In 2015, 72% of iCHF enrollees in the Kilimanjaro pilot accessed health services from a faith-based private provider. The MOHCDGEC has scaled the program nationwide, combining the old TIKA/CHF schemes and having NHIF assume their administration. Unlike the NHIF, which pays fee for service, the iCHF pays public and private healthcare facilities on a capitated basis. Private providers receive a 50% higher capitation rate compared to that of public providers. This higher rate helps offset additional costs they bear (e.g., taxes), and the absence of subsidies paid to public providers for inputs such as salaries or rent.

**Service contracts**: Recognizing their potential to improve the availability of quality health services, the 2012 PSA recommended increasing use of SLAs between local government authorities (LGAs) and private providers. Eligibility guidelines for private providers to participate

[1] Claim ratio: a key indicator of the financial sustainability of a health insurance scheme. Claim ratio measures the cost of claims as a percentage of net premium. Over time, a sustainable scheme must have sufficient funds to pay clams as well as cover administrative costs, and fund investments such as for information systems or new facilities.

in these public-private contracts have been somewhat ambiguous. Mostly, LGAs have established SLAs with faith-based providers. However, some local councils struggle to meet financial obligations of those agreements, i.e., to pay contracted providers timely and fully. The private-for-profit sector still lacks sufficient organization to enter into large-scale service agreements arrangements with LGAs.

**Private health insurance:** The private insurance market has grown since 2012, consistent with overall economic growth. The Tanzania Insurance Regulatory Authority (TIRA) reported an 8.6 percent increase in gross premiums, to TZS 692 billion in 2018. Of this, health insurance accounted for approximately 22% of premiums. However, in 2018, health insurance premiums declined by 1.9%, in contrast to other lines of insurance. Health insurers reported growing losses, and uncertainty over pending health financing reforms, particularly the proposed legislation for a single national health insurer. A growing number of private employers that have traditionally provided private health insurance to employees and their families are opting to only contribute to the NHIF. That said, there should remain a role for the private health insurance sector to contribute to UHC goals in Tanzania (Box 2). In other countries, this role changes as the country moves toward UHC, and is primarily complementary or supplementary to much larger publicly financed programs with the greatest potential to scale [citation: Kimball et al].

### Box 2. Digital innovations in the private insurance market

Tanzania's private health insurance sector is innovating in areas of product design and distribution. In 2019 SHOPS Plus contributed to a pilot launch of Jamii, a cashless and paper-less mobile-enabled simple private health insurance product sponsored by Edgepoint (a digital intermediary) in partnership with Jubilee Insurance and Vodacom Telecom Company. Jamii provides limited benefits when clients access inpatient and outpatient services for all conditions. The product provides low-cost, easier to understand and use health insurance to uninsured populations, regardless of health status. SHOPS Plus provided technical assistance on client education, sales, and distribution activities with a focus on PLHIV. Jamii demonstrated the importance for health insurance, especially when voluntary, to deliver tangible value to clients and its potential to increase access for clients using technology platforms and trusted, known distribution partners like a mobile network operator. For Jamii, one product innovation was to include nearly all conditions, and to pay benefits for more common outpatient, in addition to inpatient, care. The pilot showed where challenges persist to delivering innovative, low-cost health insurance that "sticks" for both clients and health providers. A major challenge for Jamii was how to streamline processes for enrollment, premium collection, and renewals. Another was how to reduce incidents where clients were treated as inpatients for services that could be delivered on an outpatient basis, to maximize their benefits and/or the provider payment. This form of moral hazard contributed to claim costs, and the scheme was not financially viable in the pilot phase.

**Corporate Social Responsibility**: The GOT is currently not financing all subsidies needed to cover the poor. Several other complementary financing mechanisms are available in the private sector, including fundraising activities targeting businesses and corporate social responsibility (CSR) programs. A typical private firm can potentially contribute about 0.1 percent of its revenue to CSR. According to the Tanzania Private Sector Foundation about TZS 3 billion or $1.3 million can be raised at CSR fundraisers during stronger periods of economic growth (Lee et al, 2018).

## Inputs for quality products and services

Private healthcare providers need access to the inputs that allow them to deliver high quality services. These inputs break down into two general qualities: access to clinical trainings to keep staff skills up to date and access to high quality medicines and products.

## Training

The 2012 PSA identified limited access to clinical trainings as a key barrier affecting the ability of private providers to increase their service offerings, especially HIV/AIDS. This gap included challenges in both pre-service and continuing medical education. Tanzania has 74 private medical training institutions (PMTIs), including 51 affiliated with a faith-based organization. More than half of these PMTIs focus on training nurses and midwives (Table 5).

### Table 5. Health Training Institution by Ownership

| Training Institute | Faith-based | Private | Total |
|---|---|---|---|
| Doctor of Medicine | 6 | 2 | 8 |
| Dentistry | 1 | 0 | 1 |
| Clinical Officer | 3 | 3 | 6 |
| Clinical Assistant | 0 | 3 | 3 |
| Pharmacy | 1 | 2 | 3 |
| Nursing and Midwifery | 35 | 7 | 42 |
| Paramedical Laboratory | 4 | 5 | 9 |
| Paramedical Radiology | 1 | 0 | 1 |
| Health Record | 0 | 1 | 1 |
| Total | 51 | 23 | 74 |

Source: MOHSW, 2014

To strengthen their educational programs and improve the service readiness of their graduates, SHOPS Plus supported the development of a partnership with the Association of Private Health Colleges Tanzania (APHECOT). This partnership provided clinical practicum opportunities for nursing and midwifery students at PMTIs. Prior to this partnership, practicum slots were mainly available in public health facilities where students at public training institutes were prioritized for placement. SHOPS Plus and APHECOT worked with the Private Nurses and Midwives Association (PRINMAT), the Christian Social Services Commission (CSSC), and other private hospitals in Dar es Salaam to set up a pilot practicum program that would place students from private PMTIs in private health facilities. The pilot improved pre-service education by increasing hands-on training experiences in private hospitals. Based on this experience, the MOHCDGEC's Director of Nursing is updating national training guidelines and public sector training.

SHOPS Plus has also worked to strengthen private providers' access to in-service clinical trainings. In partnership with GOT trainers, Council Health Management Teams, and PRINMAT, SHOPS Plus helped 1,591 private providers access trainings on new clinical areas, such as basic and emergency maternal, obstetric, and neonatal care, family planning, child health, and nurse-initiation and management of antiretroviral therapy. As part of these efforts, SHOPS Plus linked the trained providers to commodity supplies and connected them to public counterparts for supportive supervision and data sharing. While these efforts are still preliminary, they point to a potential path forward for increasing access to training and commodity supply on a larger scale for the private sector.

## Medicines and health products

Since the 2012 PSA, Tanzania's supply chain for medicines and health products has undergone several changes. The private sector has seen the exit or transition of previously dominant social marketing organizations, as well as the entrance of new actors. The public supply chain has also changed how it engages the private sector.

***Transitions in social marketing organizations***: Social marketing organizations have long been an important source of family planning products in Tanzania. Several market assessments indicated that for many short-acting methods, especially condoms and oral contraceptives, social marketing organizations dominated the private market with little presence of commercial brands. Over the past several years, though, development partners have begun to reduce funding to social marketing organizations and to increase funding for more sustainable business models. PSI, formerly the leading social marketing organization for family planning products and condoms, exited the market. SHOPS Plus supported one local social marketing organization, T-MARC, to make this transition to a more sustainable social enterprise model. SHOPS Plus assisted T-MARC to analyze the financial viability of its basket of products and to improve its branding, cost recovery, and procurement. T-MARC has diversified its product basket and revenue streams and increased the scale of its operations. The technical assistance has strengthened the company's capacity to conduct needed analyses to better balance its health impact and financial viability.

***Emergence of new private actors and products***: Tanzania's private supply chain also saw the entrance of new players and new products. DKT, a global social marketing organization, entered the Tanzanian market in 2013 operating on a sustainable, cost-recovery basis. DKT has quickly grown its presence in the private FP market. By 2019, the company reported selling 12.8 million condoms, 1.3 million oral and emergency contraceptives, and 7,000 long-acting methods, resulting in over 333,000 couple years of protection (DKT Tanzania 2020). As T-MARC has shifted to a new sustainable model, it has also introduced new emergency contraceptive brand extensions that are sustainably priced, and is looking to introduce a new injectable contraceptive and blood-based HIV self-test. Several commercial companies have introduced new products in recent years. This list includes Mfalme brand condoms, six commercial oral contraceptive pill brands (three currently sold and three more registered but not yet on the market), and eight active emergency contraceptive brands. These changes have helped improve the sustainability of private supply chains for family planning.

***Changes in government procurement and distribution to the private sector***: The GOT has sought to partner with the private sector to grow markets for priority health products and services. The Health Promotion and System Strengthening project, with funding from the Swiss Agency for Development and Cooperation, supported government partners to pilot a prime vendor model that allowed public facilities to procure medicines and health commodities from a private supplier when the Tanzanian Medical Stores Department experienced stockouts. The prime vendor model helped increase medicine availability at the facility level by 40 percent between 2013 and 2018, leading to nationwide scale-up (Jazia 2019). In addition, the GOT has expanded the use of SLAs and commodity partnerships to distribute government-managed commodities through private outlets. These efforts have typically taken place at the council level and involved local officials giving private providers access to donated or government-procured commodities (typically implants and antiretroviral (ARV) medicines for HIV). This model addresses gaps in the private supply chain, where private providers typically lack access to these products. In return for this access, private providers agree to submit regular reports on commodity use, provide the commodity for free, and charge a small service fee to cover their non-commodity costs. Pilot efforts have been generally successful at introducing the services in more private facilities and expanding access. However, the model's reliance on donated commodities makes it a short-term solution. Possible longer-term reforms for consideration include strengthening private markets or integrating commodity financing into national health insurance programs.

***Applying a TMA to strengthen commodity markets for FP***: SHOPS Plus, development partners, and the GOT have increasingly worked to apply a TMA to strengthen commodity

markets. This work mainly consisted of integrating private sector data and representatives into national quantification and procurement exercises and supporting the GOT to integrate TMA principles into national level policies and guidelines. With support from PO-RALG, regional and council level officials received training and assistance to develop action plans to help operationalize these principles in their programs. This work has helped to create space for private sector actors to increase their activity in the family planning market. The two main importers of commercial condoms in the country increased their annual supply from 2.5 million to 5.5 million between 2017 and 2019.

# Looking forward

## Opportunities

Since the 2012 PSA, more opportunities for increased private sector participation in health in Tanzania have emerged.

**Growing number of private health enterprises and innovators.** There are currently double the private facilities in Tanzania than the number SHOPS Plus identified in 2012. This substantial growth indicates increased viability of owning and operating private facilities and a potentially growing market. Pending transitions of traditionally donor-funded social marketing organizations to more sustainable social enterprises (e.g., T-MARC) also create new opportunities for a sustainable, quality, affordable private supply chain.

**Modification of reporting tools for use by private providers.** Since the initial assessment, the MOHCDGEC and its development partners have worked to modify public sector reporting tools to better capture services delivered and products distributed in the private sector. Examples include mobile platforms for ADDOs and the expansion of the public sector's web-based DHIS2 reporting platform, which have enabled more private providers to share more data on a routine basis, resulting in a more complete national database.

**Leveraging the devolved health system**. Tanzania's decentralized health and governance system gives authority to LGAs to implement health policy. This structure means that public-private engagement is increasingly operationalized at the local level, closer to where private providers themselves are located. Collaborating with PO-RALG, SHOPS Plus capacitated CHMTs to begin operationalizing TMA principles that aim to increase private sector participation in local health systems.

**iCHF and NHIF contracting of private providers**. Since the 2012 assessment, the updated NHIF and iCHF have empaneled additional private providers. Although these schemes have increased GOT's financing for purchasing services from private providers, approximately 75% of Tanzanians are uninsured and face financial barriers to accessing care, especially from private providers. There are future opportunities for NHIF and iCHF to further expand contracting, and to improve the administrative ease and enhance the financial viability of the schemes to participating private providers.

## Challenges

Ongoing challenges to increase private sector engagement in health are detailed below.

**Uncertain sustainability of markets for priority health products.** Certain commodities like ARVs, injectables and implants are not readily available in the private sector. The commodity partnership models that SHOPS Plus has supported for ARVs and implants has helped to increase the private providers' access to products they cannot easily source through the private supply chain. The reliance on donated commodities and the small scale of these pilots creates some uncertainty about the long-term sustainability of these models. Efforts to improve the sustainability should focus on either increasing GOT funding of the necessary supply quantities or strengthening the ability of private supply chains to source and distribute affordable products. Addressing this challenge will require more in-depth examination of root causes behind the

existing market gaps and tailored interventions to address market access, financing, policy, and other causes.

**Potential reductions in government support and subsidies for faith-based facilities.** Government contracts have been a substantial source of revenue that helped fuel the growth in the number of FBO facilities. However, funding of services and commodities provided under these contracts has remained largely dependent on donor funds. Recent reductions in government support and subsidies may reduce the availability of FBO health services especially in rural areas. At the same time, the government is planning to build new public facilities in many areas where these contracted FBO facilities operate. These plans would work at cross-purposes with stated national policies to support public-private partnerships.

## Updated priority recommendations

In response to identified opportunities and challenges, the following recommendations highlight proposed approaches for improved private sector engagement in health.

**Increase contracting between NHIF and iCHF and private providers.** The number of private for-profit dispensaries and health facilities has increased substantially in the past decade. With this increased footprint, it is important to consider how to best provide financial protection to clients who prefer to access health care in the private sector, especially the poor. Contracting additional private providers and a wider range of them (i.e., non-FBO facilities, and those located in underserved communities) can enable the NHIF and iCHF to reduce financial barriers to access as the schemes continue to scale their population coverage.

**Support initiatives to improve stewardship and sustainability of the private health sector.** As the GOT works to better integrate private providers into the health system, it should consider how stewardship mechanisms can address quality and financial access concerns in the private sector. One example is to review and update private provider accreditation requirements, such as continuing professional development points for providers and annual reaccreditation systems for ADDOs. Additional consideration should be paid to standardizing private provider reimbursements under iCHF and NHIF to align incentives between the government and private providers for quality, efficiency, and sustainability. Finally, stewards at the regional and council level should work with private providers in their localities to increase their capacity to monitor their performance under contracts by identifying performance indicators, setting targets in contracts, and building provider capacity to conduct internal quality assurance audits..

**Invest in health sector innovators and health enterprises in Tanzania.** Tanzania's private health sector has seen a substantial growth in technical innovators and for-profit enterprises. These organizations have emerged in various areas, including digital health, supply chain innovations, and e-pharmacy, and they are already changing how Tanzanians access health products and services. USAID is already helping T-MARC transition to a social enterprise, and there are other early-stage enterprises that would benefit from similar types of technical and financial assistance. Examples include digital health organizations like Daktari Mkononi; supply chain innovators such as Pharmlinks and Medpacks; and mobile reporting and telemedicine companies such as Mobile Afya and Lyfplus. USAID should consider how to identify and support such organizations through future programming. Potential programs could include challenge funds, health business incubator programs, or matching businesses with experts who could provide pro bono technical assistance.

**Explore private sector solutions to improving supply chain-related gaps.** The private sector plays an important role in the sale and distribution of health commodities in Tanzania.

Still, a pervasive obstacle is the inconsistent and lack of availability of particular commodities in the private sector. SHOPS Plus recommends that new and innovative solutions be explored to improve supply chain procurement, bolster infrastructure, and troubleshoot logistics challenges. Part of this effort should explore opportunities to pool procurement for non-networked providers who may face high costs and limited access to new or more expensive products.

**Scale the use of innovative digital reporting for private sector providers to report data to DHIS2.** Since 2012, there have been demonstrated improvements in public reporting tools that permit private sector reporting, like USSD mobile reporting among ADDOs. Scaling and integrating the private sector into reporting systems, like DHIS2, is critical to maintain and improve more comprehensive national health reporting.

**Deepen access to finance opportunities for smaller private providers.** Access to finance is a critical component for sustaining and supporting private providers to grow as the number of clients seeking health care in the private sector grows as well. SHOPS Plus's work with FINCA and ADDOs demonstrates how private-private partnerships can increase the amount of private capital available to private providers. USAID and other donors should continue supporting business relationships between private providers and private financial institutions and other providers of credits (e.g., suppliers offering credit to facilities purchasing equipment and commodities).

**Support private sector strategies to introduce and scale up new models for multi-month ARV dispensing, as well as new HIV-prevention products.** Over the past several years, government regulators have incorporated private sector perspectives in the development of new HIV self-testing guidelines. As new HIV products, especially those related to post-exposure and pre-exposure prophylaxis are developed and introduced to the Tanzanian market, donors should seek to replicate and reinforce this collaborative approach.

**Support market development strategies for ARVs and long-acting family planning methods.** One key challenge identified was the lack of availability of ARVs and long-term family planning, like implants, in the private sector. A more robust private sector market would make these commodities more sustainably available and accessible to Tanzanians who are able to pay for them, reducing the bill on the public sector and donors to subsidize these products.

**Support faith-based facilities to adopt new business models that increase their self-reliance.** Faced with the potential threat of declining donor funds that have fueled their growth, faith-based health facilities need to adapt their business models. Donors can draw on lessons from their experience supporting social marketing organizations and NGOs to transition from donor dependency to self-reliance, while retaining their social mission. Support could include assessing FBOs and providing targeted assistance to improve operating efficiencies, introduce new revenue generating products and services, and tap into domestic funding sources.

# Conclusion

Tanzania has made great progress toward improving public-private engagement in the health system since the 2012 PSA. This brief highlights some of the main accomplishments and opportunities to improve access and quality of services through the private health sector. However, challenges remain. Some products – such as implants and ARVs – still only have limited availability in the for-profit sector. Publicly-sponsored health financing programs have started contracting private providers, but the longer term performance and viability of these contracts requires strengthening. Addressing these challenges and others are necessary to continue building on the momentum and progress achieved over the past decade. There is an opportunity for the private sector to do more to improve health outcomes. With a great number of successes achieved already, the past experience points toward a hopeful future for strategic public-private engagement in Tanzania's health system.

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