

A photograph of a woman smiling warmly while holding a baby. The woman is wearing a patterned headscarf and a dark top. The baby is wrapped in a patterned blanket. The image is overlaid with a dark blue semi-transparent filter.

The Political Economy of Direct Health Facility Financing in Tanzania

Knowledge & Learning Case Study

Before you begin

Case Study Purpose

The purpose of a Knowledge & Learning Case Study is to impart a country's experience so that other countries can learn from it.

The Tanzania team has reflected upon their experience in order to share their successes, challenges, and lessons learned. We hope that you will use and adapt this knowledge and learning in your own country to:

- **Gain a view** of Tanzania's real-world experience with Direct Health Facility Financing
- **Identify** challenges or setbacks you might face when undergoing similar processes
- **Consider** new ideas and perspectives
- **Build competence** around a technical topic
- **Foster discussions** within your country team
- **Compare and contrast** Tanzania's situation with your own country's context

Focus Questions

Think about these questions as you review the case study. After reviewing the case study, we recommend you discuss these questions and others with your country team:

- What **political economy factors** facilitated and/or inhibited the introduction, adoption and implementation of Direct Health Facility Financing (DHFF) in Tanzania?
- How did DHFF become a **nationally-owned initiative**?
- What **challenges** were faced along the way?
- What were the **keys to success**?

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1

Political Economy of Direct Health Facility Financing in Tanzania

Case Study Introduction

Background

The Government of Tanzania has made important strides in improving maternal and child outcomes. Infant mortality has decreased by almost 50% between 2006 and 2010, and under-five mortality diminished by 42.5% between 2000 and 2010 (DHS, 2010). Maternal mortality nevertheless remains high at 556 maternal death per 100,000 live births (DHS, 2015). Progress on some indicators has been mixed, and large regional variations persist.

Service delivery is constrained by insufficient and inequitably distributed skilled health care workers. The unavailability of operational budgets, frequent drug stockouts and low worker motivation also hamper the capacity of available staff to be effective and have direct bearings on productivity and accountability. In addition, tight budgets and fragmented funding flows continue to constrain the government's response to reducing disparities in health services.

Distance from health facilities and lack of money for user fees continue to be key barriers to health service access. In some regions, 69% of the population lives relatively far from a health facility (DHS, 2016).

User fees are charged at all levels of care and constitute 40 to 50% of the revenue of healthcare providers at all levels of care. (World Bank, 2020). Public health expenditure has increased only marginally since 2010 (i.e., 5.2 percent between 2010 and 2017), and the government covers about 40 percent of total public health expenditures (World Bank, 2020).

The Government of Tanzania is highly committed to improving efficiency and accelerating results. As such, it embarked on a journey of reforms to mobilize and empower primary healthcare facilities and communities to improve the coverage, quality, and accessibility of maternal and child health services. These reforms included adaptations of decentralization by devolution policies such as payment-for-performance, results-based financing, and direct health facility financing.

Case Study Scope

This Knowledge and Learning Case Study focuses on the political economy that led to the introduction, adoption, and implementation of Direct Health Facility Financing (DHFF) in Tanzania. It highlights lessons learned and challenges faced, and the unique steps taken to address them.

What is a Political Economy?

Political economy refers to the interactions and conditions that critically influence and determine the introduction, adoption, and implementation of public policy.

The political economy of public policies focuses on the specificity of the

- **Starting Context** – the influence of past reforms and how they shaped the views and relationships of institutions and actors over time.
- **Decision-Making Process** – the manner through which decisions are made in a particular sector, who is party to these decisions, and who influences policy.
- **Supportive and/or Constraining Environment** – the extent to which a specific policy is championed or contested, and by whom.
- **Ownership Structure** – the way vested interests are balanced and shape accountabilities, responsibilities, and sustainability.

Box 1: Enabling Political Economy Factors for Direct Health Facility Financing

- High level leadership and championing
- Early engagement of the Ministry of Finance and Planning and the President's Office for Regional Administration and Local Governments
- Clear partnership agreements between national and external stakeholders
- Integration through the adoption of a systems approach
- Transparency about the process and the management of funds
- Capacity building and supportive systems and tools to help manage and sustain change, including changes in mindsets and practices.



2

Political Economy of Direct Health Facility Financing in Tanzania
**Toward a Supportive Political Economy
Landscape**

Starting Context | Emergence of a Results Agenda

Tanzania's journey toward Direct Health Facility Financing (DHFF) was conditioned by the evolution of the country's results-driven agenda and its experience with decentralization by devolution policies, including Payment-for-Performance and Results-Based Financing.

Payment-for-Performance

AGENDA- SETTING

This journey started in 2005, against the backdrop of high-level political commitment and drive to build momentum for the achievement of maternal and child health through the rapid introduction of a performance incentive framework.

POLICY MAKING

In 2006, drawing from early successes in Rwanda and Haiti, the government of Tanzania decided to crystalize this commitment into a payment-for-performance model (P4P), through a bilateral partnership with the government of Norway. Tanzania's first P4P model was designed by the Ministry of health, Community Development, Gender, the Elderly and Children (MOHCDGEC) and the Ifakara Health Institute with the expectation of an immediate national scale up – without piloting.

POLICY DIALOGUE

Health development partners were generally reluctant to support the P4P model. They were particularly concerned with the lack of evidence on the effectiveness of P4P in low-income settings; the inadequacy of selected indicators and results verification arrangements; the readiness of the health system to accommodate such a reform at national level; and Norway's motives to reenter the Tanzanian health sector, which it had recently exited. In this context, Norway started engaging directly with health development partners to address these concerns and galvanize support. This process of engagement and health development partners' influence culminated in an agreement to first pilot the model. This new articulation was contrary to Tanzania's policy against "piloting." As a result, Tanzania rolled out P4P unilaterally in 2007, but its success was significantly impeded by design challenges (e.g., indicator selection) and inadequate arrangements (e.g., verification mechanism). The disagreement between the need to pilot the project or not strained relations between health development partners and the government of Tanzania, whose leadership and priorities had been undermined.

Starting Context | Emergence of a Results Agenda

Payment-for-Performance

REFRAMING With results remaining high on the domestic political agenda, the P4P model was piloted in the Pwani region in early 2011. This pilot project sought to generate the evidence required to inform a national scale-up. As the government of Tanzania had minimal authority over project funding, exclusively channeled through Clinton Health Access Initiative (CHAI) and did not have the independent resources required to deploy unilaterally, it was largely dependent on CHAI and Norway to execute the project. In this context, the Pwani Pilot was largely viewed by national actors and development partners as a standalone donor-driven project without much national ownership.

DECISION MAKING

An impact evaluation carried out in 2012 indicated that the P4P pilot had positive effects on institutional deliveries and the uptake of antimalarial drugs during antenatal care visits (i.e., two indicators out of eight). It also highlighted significant process changes, including increased availability of drugs and supplies, enhanced supportive supervision, and improved provider attitudes during delivery. Health development partners generally deemed results to be inadequate to establish impact and inform an expansion at national level. Steadfast in its commitment, the MOHCDGEC made a political decision to continue planning for a national expansion.



Starting Context | Integration of the Results Agenda

In 2013, to address the concerns and gain the support of national stakeholders and health development partners, the MOHCDGEC operated a conceptual shift from a P4P project to an integrated system strengthening Results-Based Financing (RBF) program. This conceptual shift was supported by the World Bank, who emerged as a key champion of RBF in Tanzania.

Results-Based Financing

ADVOCACY Drawing from lessons learned, including the impact evaluation of the Pwani pilot, emphasis was placed on stakeholder engagement to build awareness for results-based financing (RBF) as well as on evidence to ensure contextual feasibility and appropriateness. Carried out through the organization of a national RBF forum, this was an important activity that helped policymakers make informed decisions about the use of RBF and its possible design in Tanzania.

POLICY DIALOGUE

Another critical— and related— activity led by the World Bank was the organization of various stakeholder consultations to ensure that the design of the RBF program is tailored to local realities. This process was initiated in 2013 and supported by a multistakeholder national RBF assessment team tasked with providing recommendations for the design of an integrated and system strengthening RBF program.

The involvement of all relevant stakeholders in the design of the national RBF program helped mitigate resistance, facilitate a better understanding of the mechanism, and foster ownership at national and sub-national levels. It also helped ensure RBF is embedded in Tanzania's institutional fabric. RBF uses Tanzania's health information management system and facility financial accounting and reporting system; mobilizes existing governance structures, including Health Facility Governance Committees (i.e. community-based structures empowered to ensure health facilities are accountable for results and responsive to local needs); and is harmonized with other reforms, including the Star Rating System developed as part of Big Results Now to assess health facility performance against minimum service delivery and quality standards, and drive improvements.

PILOTING & ROLL OUT

In 2015, the national RBF program was piloted in Shinyanga region, and a national roll out was initiated in 2016, first covering the nine regions with the poorest health outcomes and highest poverty index through a phased approach to roll out.

Starting Context | Country-Owned Results Agenda

The favorable political economy landscape gradually created by payment-for-results and results-based financing was extended to Direct Health Facility Financing through a broad-based domestic result driven reform, namely Big Results Now.

Big Results Now!

AGENDA- SETTING

Championed by the President of Tanzania and approved by the Tanzanian Cabinet in 2012, Big Results Now (BRN) is the result of an adaptation and customization of Malaysia's Big Fast Results model – with the technical support of Malaysia's Performance Management & Delivery Unit (PEMANDU) and other technical partners. BRN initially focused on the agriculture, water, sanitation, education, energy, and transportation sectors. BRN was generally perceived as an appropriate and effective approach by key stakeholders. In this context and based on positive experiences in other sectors, health development partners actively lobbied to extend BRN to the health sector to help address entrenched bottlenecks and scale up their support.

POLICY DIALOGUE

BRN was initiated in the health sector in 2014 through the organization of a strategic participatory process, the "Health Lab." This process brought together experts with a wide range of competencies to diagnose constraints, identify strategies/innovations and develop costed implementation plans to tangibly realize Tanzania Development Vision 2025 health targets. Importantly, the "Health Lab" helped establish wide and shared recognition that lagging performance stemmed from a lack of autonomy and accountability over access to and use of resources at service delivery level. This created a convergence of interests among key stakeholders and strengthened political commitment toward the development of aligned strategic solutions

POLICY MAKING

Within this context, experts from a wide range of institutions explored how best to leverage Health Basket Fund resources to improve efficiencies at service delivery level throughout the country, particularly focusing on government governance and accountability structures. Informed by evidence, including early successes in Kenya, this exploratory process led to a shared political and strategic decision to introduce Direct Facility Financing in Tanzania. In 2015, the Government of Tanzania and HBF health partners signed a Memorandum of Understanding (MOU), marking the formal adoption of DHFF in the country and establishing the modalities through which general revenue from the HBF would be allocated, disbursed, and managed. As a result, DHFF became the first national initiative to scale-up financial autonomy for primary healthcare providers.



3

Political Economy of Direct Health Facility Financing in Tanzania

Leveraging Political Economy “Capital”

Why Tanzania Opted for DFF?

Direct Facility Financing (DFF) refers to the direct provision of government and/or external funds to frontline providers and health facility managers so they can manage their own money and innovate based on the achievement of results and context-specific health priorities.

DFF comes on top of input-based mechanisms, with payments made directly from a national fund to health care facilities. As with Performance-Based Financing, DFF funds are commonly used to finance smaller non-salary recurrent operating expenditures, such as facility operating costs and supplies, with the bulk of facility input costs (salaries, capital expenditure and medicines) being funded separately or provided in kind.



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DFF is designed to fundamentally shift the way financial resources are

- **Allocated**, shifting from input-based payments (i.e., rigid budget line items such as drugs and supplies) to output-based payments (e.g., number of institutional deliveries) to enhance equity, incentivize continuous improvements and innovations, galvanize trust in the community, and ultimately, foster increased service utilization.
- **Disbursed**, directly channeling external funds to health facility bank accounts to extend beyond local government structures and reach the frontlines.
- **Managed**, transferring financial and management decision-making authority from districts to health facilities and their governance structures to vest them with the autonomy required to deliver high quality services and meet local needs and make them accountable for funds and results.

DFF also scales up accountability and ownership by **mobilizing** and **empowering communities** to make health facilities accountable for results and enhance the likelihood that local needs are met.

In Tanzania, DFF is referred to as **Direct Health Facility Financing** because of its link to the Health Basket Fund.

Political Economy Catalyst | Results-Based Financing

While results-based financing and direct facility financing emerged from different processes, they have gradually become more aligned.

Both RBF and DHFF aim at improving healthcare quality and efficiency and at mobilizing resources at health facility and community levels to enhance service delivery. While RBF places greater emphasis on results and health service utilization, DHFF focuses on reducing inefficiencies generated by time wastage and delays in the existing system by making funds available at the frontline.

RBF and DHFF both

Include output-based payments

Channel money directly from MOF to health facility bank accounts

Plan annually through the PlanRep tool.

Directly involve Health Facility Governing Committees in planning processes.

Account and report through the FFARS

Verification

They diverge with regard to

RBF

Payments are 100% performance-based (i.e., 25% incentives for staff and 75% operations)

Quarterly disbursements based on verified result

Budgeting based on facility business plans, with possibility of making capital investments
"Bottom-up" and needs-based planning

RBF not fully integrated to FFARS to maintain spending flexibility

Quarterly verification of results in all facilities at the outset

DHFF

Payments combine a base tranche (70%) with performance tranche (30%) to facilities for operations

Semi annual disbursement based on annual figures.

Budgeting based on health facilities' annual health plan and estimated costs
"Top down" and rules-based

Accounting and reporting functions integrated into Financial Accounting and Reporting System (FFARS) - *Integral part of budget*

Annual audit on random sample of facilities (25%)

Political Economy Catalyst | Implementation Prerequisites

The similarities between the two mechanisms enabled DHFF to benefit from the proof of concept provided by Results-Based Financing (RBF) and leverage the political capital it generated.

RBF notably helped catalyze:

Institutional Arrangements. DHFF replicates the separation of function established for and tested during RBF, with the fundholding function held by the Ministry of Finance and Planning; the regulatory function assumed by the Ministry of Health, Community Development, Gender, the Elderly and Children; the purchasing role played by the National Health Insurance Fund; services delivery led by public health facilities; and program oversight provided by the Presidents' Office for Regional Administration and Local Government. The RBF verification function and DHFF auditing function are carried out by the Internal Auditor General (IAG). DHFF and RBF institutional arrangements are aligned with Tanzania's devolved decision-making structure and context.

Governance Arrangements, including endorsements for the inclusion of local communities through health facility governance committees to improve planning and accountability and bringing priority setting closer to the beneficiary. This contributed to strengthening the relationship of communities and health facilities as well as fostering ownership at the community level.

Integration. DHFF leverages the strong support galvanized for integration during RBF. It builds on existing mechanisms and structures, including national and district health management information systems and public financial management systems. It also draws on Big Results Now's Star Rating System to ground the process in evidence and ensure the preparedness and measure the performance (evolution) of health facilities. In addition, DHFF was supported by the Prime Vendor System, which was initiated during RBF and continued through DHFF based on successes and lessons learned. The Prime Vendor System was leveraged to provide a "one stop shop" for health facilities to procure the essential commodities and supplies they need. In turn, the integrated nature of DHFF contributing to strengthening political commitment among stakeholders and fostering ownership at national and subnational levels.

Blueprint for Capacity Building of all actors to help mitigate resistance, foster an understanding of the mechanism, and change practices throughout the health system / at all levels. In addition, DHFF deploys assistant accountants to support the financial management of resources by providers and assist in the generation of financial reports.

Political Economy Catalyst | Implementation Prerequisites

Direct Health Facility Financing leveraged the national policy entrepreneurs who emerged in the context of RBF to establish some of the prerequisites to its implementation, including:

Stakeholder confidence in the capacity of health facilities to manage funds – an aspect of concern among deputies at the Prime Minister’s Office for Regional Administration and Local Government (PRO-RALG) during the advent of RBF.

Political commitment at national level, with the Permanent Secretary of the Ministry of Health, Community Development, Gender, the Elderly and Children (MOHCDGEC) and the Permanent Secretary at the PO-RALG championing DHFF.

Health Facility Bank Accounts, with the

- i. Permanent Secretary of the PORALG officially asking Ministry of Finance and Planning (MOFP) to help grant all health facilities a bank account
- ii. MOFP – working hand in hand with the Bank of Tanzania – taking an active role in ensuring that health facilities could open bank accounts at no cost.

Appropriate financial controls. Deputy Accountant General actively supporting the design of financial arrangements and ensuring they are integrated in existing national financial controls and accounting mechanisms. This includes the development and dissemination of Facility Financing Accounting and Reporting Systems (FFARS) and implementation guidelines.

Auditing modalities, with the Auditor General harmonizing its auditing mechanism with the health management information system and the district health management system (DHIS2).

Task shifting, with PO-RALG helping vest regions and councils with a new role focused on technical support, supervision, mentorship, and capacity building functions, rather than administrative and financial roles.

Tailored planning, through the complementary use of Comprehensive Council Health Plans and i Health Facility Plan.

Box 2: Learn more about the operationalization of DHFF in Tanzania:

- [Ottar Mæstad](#), et al. 2021. [Direct Financing of Health Facilities. Experiences from financing reforms in Tanzania](#), Bergen: Chr. Michelsen Institute
- [Ottar Mæstad](#), Peter Binyaruka. 2021. [Towards harmonised financing of frontline health service providers in Tanzania](#). Bergen: Chr. Michelsen Institute



4

Political Economy of Direct Health Facility Financing in Tanzania

COUNTRY TEAM REFLECTIONS

Reflections | Keys to Success

The Tanzania team has reflected upon their experience in order to share their successes, challenges, and lessons learned.

These reflections were captured during key informant interviews with in-country stakeholders operating mainly at national level, including government officials and technical and financial partners

Reflections | Keys to Success

What factors were instrumental in the adoption of RBF and subsequently DHFF by the Government of Tanzania?

Commitment from country leadership

Commitment at the highest level helps enhance consensus, coordination, and collaboration at all levels. This is particularly important in a devolved setting as it ensures a snowball effect cascading of change. Sustained leadership complemented by the investment of domestic resources is critical to ensure DHFF remains a country-led and country-owned mechanism.

Identify and leverage champions within the system

The Permanent Secretaries of the MOHCDGEC and the PO-RALG were enthusiastic advocates for scaling up decentralized funding, autonomy, accountability, and ownership. Their willingness to participate at both a high level and technical level was instrumental in obtaining the commitment and engagement of other national and subnational stakeholders.

Generating new ideas requires the

- **Engagement of a wide range of stakeholders, including across sectors.** The fact that the Ministry of Finance and Planning was involved from the onset is a clear key to success.
- **Staying within the system**, also aligning with the way money flows in-country, to establish the foundations for long-term sustainability.
- **Clarity of purpose.** Whether a partner belongs to the HBF or not is not as important as their contribution to a common objective.

Reflections | Keys to Success

What advice would you give a country considering adopting RBF and/or DHFF?

Capacity Building.

Capacity building is critical at all levels, and it should be supported by clear (and understood) indicators and continuous supportive supervision.

Memorandum of Understanding.

A clear memorandum of understanding between the government, development partners and health facilities is essential to create interdependency and a clear understanding of common targets.

Performance-oriented mindsets.

Capacity building exercises need to also focus on stimulating a performance-oriented mindset among health workers. RBF not only changes the way business is carried out, but also the way business is being thought.

Transparency.

Transparency especially in financial management is instrumental in enhancing confidence and ensure the success of the initiative, as it increases buy-in as well as helps create confidence, including with donors (renewed funding). Capacity building is instrumental in attaining transparency, as it enables health facilities to better manage and report on funds.

Reflections | Keys Concerns

What challenges remain?

Inequitable resource distribution

RBF provides funds at local level for health facilities and the Health Basket Fund (HBF) focuses on the council level, which encompasses several health facilities. As such, it is possible that some health facilities receive funding from both sources, while others might not receive funding from any sources.

Sustainability.

DHFF is mostly donor funded. This poses a sustainability challenge: What happens in the event of the HBF ending? One option currently envisioned is to make provisions to mobilize and invest domestic resources in DHFF.



Political Economy of Direct Health Facility Financing in Tanzania

DISCUSSION

Discussion

- **What** aspect of the country's case did you find most interesting? Why?
- **What** new things did you learn?
- **Did** this case broaden your perspective about a particular issue or topic? Which one?
- **Which** of the challenges described could you most relate to?
- **What** is different from your own situation?
- **Which** of the strategies employed did you find the most innovative?
- **Which** strategies could be tried in your country? How would they need to be adapted?
- **What** questions do you still have?

