

WHAT CAN TANZANIA'S HEALTH CARE SYSTEM LEARN FROM OECD COUNTRIES?

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Abstract

Healthcare systems around the world have different shapes that are largely affected by socio-economic and political situations of a particular country. It is essential for the population to have better health services which requires the country to have better health policies, enough funding for health care sector, and a well structured delivery system. Tanzania like any other developing countries continue to face different challenges in healthcare sector greatly influenced by poor economy despite of recent economic improvement. The need to look for alternatives and restructure its healthcare system is crucial .

OBJECTIVE: To describe and characterize Tanzania's healthcare system, following the presentation of different healthcare system models and to find out opportunities and constraints - and thus key challenges - confronting Tanzania in the development of the healthcare system.

METHODOLOGY: The study employed a qualitative approach with descriptive comparative analysis by comparing Tanzania (as a developing country) and Germany (as a developed country) with the intention of identifying key differences and characteristics of Tanzania healthcare system. Data were collected from public documents and literatures as the methods to collect data/information about Tanzania and Germany healthcare system.. Germany was used to contrast and challenge the Tanzania healthcare system. The study used public documents, literatures and case studies.

RESULTS: Based on descriptive comparative analysis between Tanzania and Germany's healthcare systems and models of healthcare financing, the key characteristics and challenges of Tanzania healthcare system were identified. Work force crisis, insufficiency funding mechanism, low enrolment among health insurance schemes and inadequate access to healthcare services were among of the key challenges found to characterise the Tanzania healthcare system. However, this case study used examples from successful developing countries to illustrate alternative ways of developing its healthcare system.

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ABBREVIATION AND ACRONYM

AAR	AFRICAN AIR RESCUE
ATP	ABILITY TO PAY
CHIF	COMMUNITY HEALTH INSURANCE FUND
CIT	CORPORATE INCOME TAX
EU	EUROPEAN UNION
GDP	GROSS DOMESTIC PRODUCT
GNP	GROSS NATIONAL PRODUCT
HIV	HUMAN IMMUNODEFICIENCY VIRUS
KCMC	KILIMANJARO CHRISTIAN MEDICAL CENTRE
MOHSW	MINISTRY OF HEALTH AND SOCIAL WELFARE
MOL	MINISTRY OF LABOUR
MUHAS	MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
NHIF	NATIONAL HEALTH INSURANCE FUND
NSSF	NATIONAL SOCIAL SECURITY FUND
OECD	ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT
ODA	OFFICIAL DEVELOPMENT ASSISTANT
OOP	OUT OF POCKET
PHI	PUBLIC HEALTH INSURANCE
PMO- RALG	PRIME MINISTER OFFICE-REGION ADMINISTRATION AND LOCAL GOVERNMENT
PIT	PERSONAL INCOME TAX
RHMT	REGIONAL HEALTH MANAGEMENT TEAM

SHIELD	STRATEGIES FOR HEALTH INSURANCE FOR EQUITY IN LESS DEVELOPED COUNTRIES
SHI	SOCIAL HEALTH INSURANCE
SHIB	SOCIAL HEALTH INSURANCE BENEFIT
TIKA	TIBA KWA KADI/ TREATMENT BY CARD
TB	TUBERCULOSIS
URT	UNITED REPUBLIC OF TANZANIA
VAT	VALUE ADDED TAX
WHO	WORLD HEALTH ORGANIZATION

Chapter 1.0 INTRODUCTION

The trend of healthcare system in Tanzania raises many questions and interest on understanding challenges behind the healthcare system. Lack of trained staffs, insufficient fund to run the healthcare sector (Kwesigabo, et al., 2012), poor coverage by most of health insurance schemes (Bultman, et al., 2012) and lack of organised healthcare structure are some of the challenges mostly mentioned in Tanzania.

There are no single and common principles on the organization and structures of healthcare system across the world's but preferably health policy objectives, healthcare financing and the delivery system are the most important aspects in any healthcare system. The healthcare systems all over the world have different shapes which are influenced by , nation's history, traditions and political systems (Lameire, et al., 1999).

This thesis presents different healthcare models and applies these models as a point of departure for characterizing key elements of Tanzania's healthcare system. Moreover, the thesis includes a systematic comparison between Tanzania (as a developing country) and Germany (as a developed country) with the intention of identifying key differences in health system characteristics.

The aim of the comparison is to identify key challenges that Tanzania is confronted with regarding the development of the healthcare system. The comparison with Germany is also used to discuss the general problems and challenges based on the design and operation of a developing country's healthcare system on models found in developed (OECD) countries. This discussion may also illustrate why Tanzania may have to look at alternative ways of developing its healthcare system.

The basic research questions:

(a) Based on a presentation of different healthcare system models, how can we best describe and characterize Tanzania's healthcare system?

(b) Based on systematic comparisons with Germany, what opportunities and constraints - and thus key challenges - confront Tanzania in the development of the healthcare system?

1.1. BACK GROUND

The healthcare system in Tanzania has a long history with origins from the colonial era to the present. At the time of colonial rule many African countries including Tanzania, "organized their health system primarily to benefit a small elite groups of colonials and their workers" (McIntyre et al, 2008:872). These elite groups were purposely given priority so as to facilitate all colonial related activities especially administration activities in particular.

After independence in 1961, the Tanzania government provided medical service free of charge at the public health facilities (McIntyre et al, 2008). "The government chose to be the sole provider of social services under the socialist ideology" (URT,2008:6) and therefore it developed "a national health system that committed itself at providing the mostly non urban population with access to health service"(Kwesigabo et al, 2012:36).

The health service in Tanzania expanded rapidly following the Arusha declaration of 1967 (Smith and Rawal, 1992). As the result of the declaration, private individuals and firms were restricted to own investments in production of goods or provision of services (Teskey and Hooper 1999). Under the socialist ideology popularly referred to in Swahili as "Ujamaa" (family hood) the Tanzanian government remained the main provider of all services.

Private owned health services provider were entirely banned in 1977 under Private Hospital (Regulation) Act" (URT, 2008:39) and user fee were removed, this is because the main focus was to develop a wide range of primary healthcare facilities across the country (McIntyre et al, 2008).

One notable development witnessed at that particular time was for instance the deployment of specialised doctors to central facilities serving as the basic health service point since most people from the rural areas would prefer to first seek the audience of a traditional healer. (Kwesigabo et al, 2012).

However the "Ujamaa" policy- strategy to dominate the health care service provision faced challenges and therefore it could not last longer due to the world economy crisis in 1970's. Therefore, Tanzania economy experienced a serious deterioration in 1970's and early 1980's (URT, 2008). Before 1970, the rate of economic growth was at 4.5 per cent but from the mid-1970s the rate decreased to 2.5 per cent (Shitundu and Luvanda, 2000:70).

The economic crisis in Tanzania was a result of decline in the terms of trade balance, rise in oil prices, rise in food prices, the war with Uganda, droughts of 1973-1974 and 1981-1982 and the collapse of East Africa Community in 1977 (Maliyamkono and Bagachwa,1990). All these led to the rise of inflation rate to 36 percent in 1984(Bureau of Statistics). "The country's economic instability challenged the government and caused the failure to provide social service to its citizen" (Mallya, 2005:183) and thus new reforms were inevitable

The major reform that took place was the introduction of Structural Adjustment Programs (SAPs) under the guidance of the World Bank and International monetary Fund (McIntyre et al,2008) Whereby the Government had to cut its expenditure on social services like health (Enos, 1995). Such economic reforms led the decline of government budget and hence decline of health budget by more than a third between 1980 and 1987 (World Bank,1995).

Such, macroeconomic policies, embedded in neoliberal ideology, aimed mainly at reducing the government spending to address budgetary deficits, introducing cost recovery mechanism through "user fee". This led to the increase of gap and "inequalities in access and utilization of health service"(McIntyre et al,2008:872).

In 1990's some new reforms in the health sector took place which led to the additional component of financing such as introduction of risk sharing strategy through community based health fund in the rural areas and health insurance for employed people, cost sharing which included sharing of drug revolving fund, out of pocket payment, however during that time, these health insurance covered only 1 per cent proportion of the population in Tanzania. (McIntyre et al,2008,and URT,2008) .

Nearly ten years after the introduction of both private and public insurance schemes, the Tanzanian health sector experiences a lot challenges such as insufficient and poor technology and communication, unsatisfactory health financing strategies the beneficiaries are few in number because services are distributed according to ability to pay rather than need for health care and the insurance schemes cover mostly of rich people than the poor.

Chapter 2.0. LITERATURE REVIEW AND THEORIES & METHODOLOGY

2.1. Literature Review

The main objective of health care is to avert or diminish the consequences of a disease. Sometimes this means prevention or cure; sometimes it may be slowing the disease's progress or preventing the disease; sometimes it may be only the alleviation of symptoms or dysfunction (Hunink et al, 2001).

According to Olsen, health care can "refer to those resources society uses on people in ill health in an attempt to cure them or care for them" (Olsen, 2009:6). This can be prevention care, cure or rehabilitation. Every society requires enough resources for its population but the financial ability of its people is imperative.

The right to access to healthcare services is stated in the world health assembly resolution 58.33 from 2005 which recommends that everyone should be able to access health services and not be subjected to financial hardship as a result of lack of it. However, millions of people in developing nations experience severe financial hardship due to poverty (Haazen, 2012).

Despite many health interventions and understanding on health issues, most of developing countries face many challenges in achieving better access to healthcare services, this has led the failure of African nations in attaining the Abuja declaration on time framework, further confirming the evidence of poor financing mechanism in Africa (WHO, 2001). There subsist social, economic and political problems that in one way or another have made the situation more precarious. The only existing alternative solution is to look for alternative. The OECD achievements on better health care system offer a viable- alternative solutions. Despite the fact that some the OECD countries such as Mexico and Turkey faces some challenges while others have made historical progress in the overall health care system (Hurst,2000).

Germany as the member of OECD has enjoyed enough access to healthcare due to its successful healthcare system that has high level of financial resources and physical facilities (Grosse-Tebbe, et al., 2005). This is one among other important areas where Tanzania could adopt the most viable aspects. The Tanzania healthcare system for a long time have been lacking enough financial resource and physical facilities (Haazen, 2012).

As Germany struggles to deal with rapid growth of health expenditure (Hurst, 1992). In 2007 it was reported that, the total costs in health care had "increased nearly threefold between 2002 and 2004, from €89,684 million to €224,941 million" (Brin, et al., 2007:51). On the contrary a report on medicine coverage and health insurance by Tanzania's ministry of health, indicates that one of the major challenge facing healthcare in Tanzania is " uncontrollable rise in medical expenses especially medicine due to lack of price regulatory in the country for medical care" (URT, 2008:30).

The majority of rural and urban poor people in Tanzania have little access to healthcare compared to those rich people and informal sector workers, this has created inequality in service delivery (Kuwawenaruwa & Borghi, 2012), Unlike Germany where the population enjoys equal and easy access to a healthcare services (Grosse-Tebbe, et al., 2005).

The challenges in access to health care services have increased the demand for traditional and alternative healthcare services in Tanzania. Traditional medicine is considered easily accessible compare to modern/conventional medicine although they are complementary to each other. They are cheaper and found in local areas. According to Tanzania National Health Policy; "it is estimated that about 60 per cent of the population use traditional medicine and alternative care system for their day-to-day healthcare" (URT, 2003:23).

According to Docteur and Oxley (2003:8); "Fostering access to health-care services has been a fundamental objective of health policymaking in OECD countries". Such success came as a result of strategies that involved universal insurance coverage of essential care and later by eliminating financial barriers, ensuring adequate supply and addressing disparities related to social characteristics.

Furthermore, based on Docteur and Oxley explanation, it is true that universal care has been essential to most of OECD countries. Germany is one of the OECD members that have "achieved universal care and access to basic high quality which is largely independent of patients' ability to pay" (Hurst, 1991:63).

Millions of people in most of developing countries such as Tanzania are pushed to incur the cost of health care service which obviously makes those with enough money to access better health care while those who cannot afford remain ill without health service help or die. This is indicated in the report on medicine coverage that 60% of health insurance program are

privately owned which implies that only few people (rich ones) can afford to register for such types of insurance program (URT, 2008).

According to Russell, in developing countries, many people expect to contribute to healthcare from their own pocket as the result of ability to pay (ATP) principle and affordability of health care has become a critical policy issue (Russell, 1996:219). This principle of payment contributes to the increasing gap between the poor and the rich people and extremely poverty in most of developing countries.

However, many studies focuses only on cash income as the only determinant of ATP, it is urged by Russell that people need to look beyond cash income especially in less developed countries. The society needs to consider other potential resources such as cash assets, education and ability to recognise resources effectively which are mostly available among the poor (Russell, 1996).

Carrin et al (2005:779) sees the problems that are more persistence with regards to health care in most of developing countries to be "infrastructure, capacity to collect contribution and organize reimbursements to manage revenues and asset and to monitor the necessary health and financial information and these problems may be acute when countries have significant inequality of income and assets".

As far as Tanzania healthcare service is concerned, there is a growing inequality of income and assets which in turn accelerates corruption in many of health centres and among health officials, the richer gets service faster compare to the poor, although it is the mission of the government to "facilitate the provision of equitable, quality and affordable basic health service to all people by 2025" (URT, 2003:4).

Lewis (2006) in her study on 'governance and corruption' in public health care system sees and informs us on the need for good governance in health institutions. In most of developing countries, one of the major challenges in health service delivery is corruption, which is so rampant.

A world bank study on making health financing work for the poor people by Haazen (2012), indicates that population dynamics and demographic change are among another challenges facing many of the developing nations. Change in population numbers and demographics are

important because they indicate the need for more strategies to meet the population demands such as infrastructure, policy reforms, and better living standard.

Population growth in most of developing countries like Tanzania increases the burden of cost to the Government however even the well developed nations like Germany experiences some difficulties due to population growth. According to Brin, et al., (2007:48), In 2007 Germany had a population of 82 million people, where the population density amounted to 230 person per square kilometer, compare to an EU average of 116", however due to its powerful economy Germany has insured 87% of its population (Grosse-Tebbe, et al., 2005) unlike Tanzania where only 18.1% of population is covered (Kuwawenaruwa & Borghi, 2012).

However, the central discussion is mainly on the financing mechanism of the health care where most authors consider it as an important aspect in any health care system. The main question has always been on the clear definition of what should consist the financing part and how the health system should be financed.

Böhm et al (2013:260), finds a clear definition of what "health care system" means. According to Böhm health care system "is all about the delivery of health service for which someone has to raise money. In additional to that, the author clarifies more on what constitutes the health care system, in which it is defined by three functional process, which includes service *provision*, *financing* and *regulation*", however other authors such as Carrin et al (2005) gives more important concepts of *government stewardship* and the *creation of the necessary investment and training resource for health* as what constitute health care.

In the economic development world, the least developed countries faces challenges in these three areas (service provision, financing and regulation). There is a clear link between health care system and economic development. In other words the income determines the health status of an individual personal. "And since income is linked to health status (as premia in some systems), financing can fall disproportionately on low income households, potentially hindering access where costs serve as financial barriers". Docteur and Oxley (2003:6).

In regard to financing of the health care system, most of the population in developing countries relay much on public financing, despite of the fact that there is an increasing number of private funding. For instance according to Haazen(2012:12); the Tanzania health care system is still "run under the implicit assumption that a major part of the financing of

health care facilities runs through the national health budget", where by the largest portion of money is channelled to support HIV/Aids and Malaria program.

African countries depend on donors to assist their economic development including health as one of the potential area. A report by World Bank indicates that the OECD countries gives at least 0.7 percent of their GNP as official development assistance (ODA) to help developing countries to attain "The 2001-Abuja Declaration" in which each African country among 27 countries signatories had to allocate at least 15 percent of their annual budget to improve health care, only Tanzania have managed to reach that percent (WHO, 2001:1).

A review on Tanzania 2010/2011 public expenditure indicates that "government funding has remained the dominant source of health sector financing but the share of foreign financing in health has increased noticeably during the period under review" (URT,2012:13)

The reliance on aid for drugs (Smith and Rawal, 1992) and other health related project is one of many indicators that prove the inability to Tanzania health sector and provide better service, under financing of health budget and poor regulations of the health care system. Such depends syndrome have been increasing a day after day and thus determine how health care system is not under the accurate course and therefore some changes are needed.

Despite of relying on aid Tanzania and Africa in general, the region still has several problems that if solved could reduce the rate of dependence on donor. The most challenging thing is corruption. A study on governance and corruption in public health care systems indicates that corruption is the source of poor performance and service delivery, mainly because of lack of concern on government principles in health care delivery. As quoted;

"The problem with the lack of concern for basic governance principles in health care delivery is that well-intentioned spending may have no impact. Priorities cannot be met if institutions don't function and scarce resources are wasted. Bribes, corrupt officials and mis-procurement undermine health care delivery in much the same way they do for police services, law courts and customs whose functions become compromised by the culture of poor governance and corruption" (Lewis, 2006:3)

In addition, like many other African states, the design and implementation of health policies are also still inefficient and unproductive. A health policy is both -how health services are provided and the production of health itself (Hurst, 1992). Provision of health service is all

about the ownership and production of health is what is produced and its accessibility, for both are still challenging in most of developing countries like Tanzania.

Health policies works better when the financing system is strong enough to support the health agenda, and the well financing system cannot be achieved without access to health service- a mixture of promotion, prevention, treatment and rehabilitation (WHO,2010). Tanzania has experienced "underfunding syndrome" due to the fact that some units such as health promotion, education service gets less than one third (including donor funding) of their total budget (Mtui and Osoro 2011:4).

Tax-funded and social health insurance financing is another challenging issue in most of developing countries such as Tanzania. This situation can be explained by different factors affecting the region but the most mentioned reasons are political instability that is linked to economic insecurity (Carrin et al, 2005). However, Tanzania has not experienced the so called "political instability" rather than economic insecurity indicated by high level of dependence in health care financing (Haazen, 2012).

A review on Public expenditure indicates that the foreign funding still accounts for a dominant 88.8% share of the development budget in health interventions. The Ministry of Health and Social Welfare review on health suggest that this trend points to a potential threat to the sustainability of health sector financing in case of unanticipated declines in donor funding in the sector (URT,2012).

However, by comparison with previous years, there is a slightly satisfactory performance of health care budget execution throughout the review period. The government financing for health care is decreasing as proportion of total finding from 69.1 percent in 2005/06 (actual) to 53.9 percent for 2010/11(estimated) (URT:2012).

Due to under financing of health care activities many low income countries have remained reluctant in achieving financial protection. A study on community based health insurance in developing countries shows that many low income countries experiences difficulties in achieving universal financial protection (Carrin et al ,2005) with only "5- 10% of the people are covered in the Sub-Saharan Africa and South Asia" (WHO,2010:10). This is different with most OECD countries, spending on health is a large and growing share of both public and private expenditure.

Health spending as a share of GDP had been rising over recent decades but has stagnated or fallen in many countries in the last couple of years as a consequence of the global economic downturn but there is high satisfactory performance on the universal coverage (OECD,2014). However, "these persistent problems and new challenges present governments, voters and consumers with increasingly difficult choices. Some observers are predicting breakdown for those countries with high public shares of total health expenditure" (Hurst, 2000:75).

While most of developing countries are struggling to achieve the universal coverage for their populations(WHO,2010) and even aggressively struggling to reach the Abuja declaration of allocating at least 15% of their annual budget to improve the health sector(WHO,2011) , the OECD countries have long been enjoying the total coverage of their population. According to Docteur and Oxley (2003:8); "With the exception of Mexico, Turkey, and the United States, all OECD countries had achieved universal (or near-universal) coverage of their populations by 1990.

However, it is unlikely to say there is no a single low or middle income country that is not trying to achieve the universal coverage as some of the OECD members. The 2010 World health report on health system financing indicates a great stride made by some low and middle countries that have made closer to universal coverage, for example countries such as Brazil, Chile, China, Mexico, Rwanda, and Thailand have recently shown a hope to reach the universal coverage (WHO, 2010).

A study on health care system; *Lesson from the reform experience* by Docteur and Oxley (2003:6) indicates that "Private health insurance is the dominant form of basic coverage in the United States and Switzerland, and covers a sizeable minority of the population in Germany and the Netherlands. However in Hungary, Japan, Korea, Mexico, and most Nordic countries, private health insurance policies are not commonly used, although in other countries, private health insurance is used to fill gaps in the benefits package (a supplemental policy) or absorb out-of-pocket payments (complementary insurance)".

It is theoretically and practically not viable for Tanzania to adapt all development aspects in the health care sector from Germany although there are key aspects that Tanzania could learn. The reason is due to the fact that Germany is highly advanced in financing its health care system and thus most of its citizen depends largely on public support rather than private in other words there is a strong state control of the health care (Busse & Riesberg, 2004). Even

though, for those that have largely invested on private funding are basically advanced and its scheme's benefits attract majority of people, this is different with private health schemes in most of developing countries. Why is this the case with developing countries such as Tanzania? Simply because, most of financing schemes are closely related to ability to pay (Docteur and Oxley (2003).

Despite of the fact that, Germany has enjoyed highly and advanced financing models for their health care systems, there is an emerging challenge and that developing countries such as Tanzania cannot experience or learn due to the fact that its "per capital spending is still low and falls shortly of the WHO recommended targets of USD 54 to address health challenges"(URT, 2012). Financial spending disasters are mostly reported as the problem facing Germany. There is "unacceptably increase in health expenditure (Hurst, 1992:7), while "150 million people suffer financial catastrophe annually and 100 million people are pushed below poverty line in low and middle income countries"(WHO, 2010:10).

In additional to that, according to Busse & Riesberg, (2004:30), there are legal challenges in relation to health protection that hinder the services in equal way as quoted "The German consitution also known as Basic Law, requires that living condition shall be of an equal standard in all Länder, however, health promotion and protection is not mentioned. This is different with the former German Democratic Republic where article 35 of the constitution named health protection as a statr objective"

Generally the literatures have identified a number of different issues that are most important to be considered. Some key challenges on African states' healthcare systems, and Tanzania in particular. The Germany as a member of OECD can offer important and a crucial way forward in reforming the Tanzania healthcare system. New reforms are needed to contain the whole population and priority financial protection among the people.

2.2 THEORETICAL/ ANALYTICAL FRAME WORK

The theoretical frame work for this study is presented by models of healthcare financing which defines a kind of healthcare system that one country has and the forms of financing. There are four models that could identify key characteristics and challenges confronting Tanzania healthcare system.

According to Lamier there are three main models of health care based on source of financing namely; Beveridge, Bismarck and Private insurance model (Lameire, et al., 1999) See figure no.1 below. However there is also a new model, that is out pocket model (Wallace, 2013) see figure no.2 (page. 13). Majority of the world healthcare systems falls in out-pocket model of health financing. There is high out pocket payment and low level of government investment in health in countries that depend on out-pocket to finance their healthcare system(WHO, 2013). In addition to that out- pocket expenditure constitute over 50% of the private health expenditure in 38 African countries (WHO,2006).

THREE MAIN HEALTHCARE MODELS IN EUROPE, US AND JAPAN

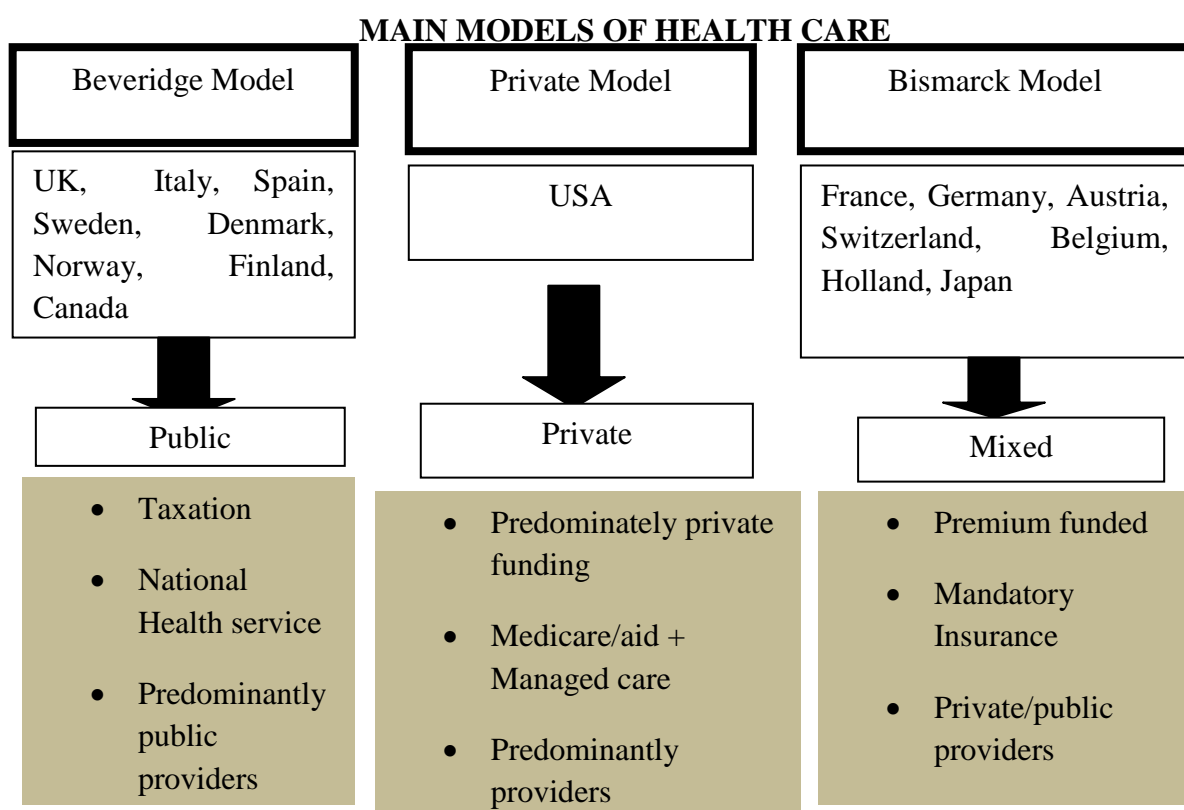


Figure 1: Models of health care in Europe, US and Japan Source : (Lameire, et al., 1999:3)

THE OUT POCKET MODEL

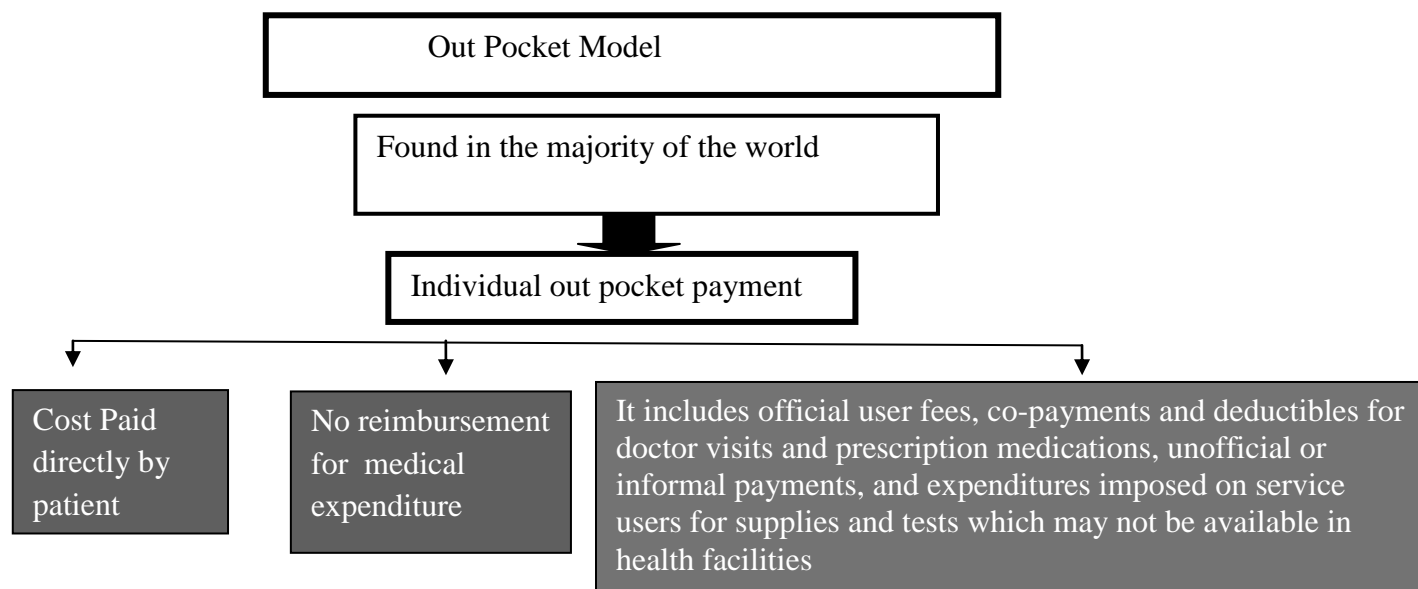


Figure 2: Out-pocket Model; Source Wagstaff & Doorslaer (2003).

1. BEVERIDGE MODEL

The model was designed by National Health service creator Lord William Beveridge (Wallace, 2013). Beverage model is also known as public model, simply because it is financed by the government through tax payment and it provide healthcare services to all citizens. It is a socialised medicine model (Wallace, 2013). This model is considered to be the cheapest model in case of administrative cost, offers universal coverage, the provider reaches the poor as well as the rich (Olsen, 2009).

The model is characterised by National Health Service, due to the fact that, services are provided by public health providers such as hospitals and community doctors and its healthcare budget is always competing with other spending priorities (Lameire, et al., 1999).

In additional to that, according to Olsen,(2009:121); There are four main common characteristics related to administrative cost of the healthcare;

"First, when 'health taxes' independent to individual risk are included in an existing tax system, there are no additional costs involved with revenue collection. Second, providers of healthcare faces no costs of collecting reimbursement from the insurance company or

sickness fund. **Third**, there are no cost involved in designing insurance package for different risk groups or employment groups. **Fourth**, as every citizen is entitled to care, there are no cost involved in checking patient eligibility".

2. PRIVATE MODEL

Private model is also known as 'Private insurance model' in which the funding system is based on premiums paid into private insurance companies(Lameire, et al., 1999) but the premiums are based on ratings which means the higher the individual risk, the higher the premium (Olsen, 2009).

It is the funding style of insuring individual which is predominately private or profit insurance plans (Wallace, 2013), with exceptional of social care through Medicare and Medicaid. (Lameire, et al., 1999). Within this private model, those who are voluntarily participating in a private risk pool are protected against the financial cost of ill health while those who are not, are offered inferior service or no service at all (Olsen, 2009).

Such kind of health financing system based on individual rating is costly to manage and involves inequitable access to health care as the result, its coverage is so limited to people who have taken insurance but the choice of doing so is voluntary (Olsen, 2009).

3. THE BISMARCK MODEL

The Bismarck Model is also called Social Insurance Model (Olsen, 2009) or 'mixed' model (Lameire, et al., 1999) which uses insurance system financed jointly by employer and employee through payroll deduction (Wallace, 2013) and it was first introduced in Germany more than one hundred years ago and since then it has been established in more than sixty countries in which most of them are high income countries (Olsen, 2009).

It is called the 'mixed model' because it uses both private and public providers (Lameire, et al., 1999) and it is funded through payroll contribution proportional to wages, like an earmarked health tax (Olsen, 2009). The health insurance plans do not intend to make profit and its coverage is universal (Wallace, 2013) and there is flexible spending on healthcare (Lameire, et al., 1999).

According to Olsen (2009:120); There are some general features that characterise the social health insurance (SHI) model.

"First, the SHI is designated for group of workers or employees, and thus initially limited to the formal sector of the economy. Second, there is a direct link between being a contributing member of the scheme and being entitled to healthcare. Third, it is founded in notion of solidarity between workers and their families, involving high level of cross subsidization. Fourth, the management of the system has some degree of autonomy from the government."

4. OUT -POCKET MODEL

This is a new model and not much have been written about it, however, it is found in the majority of the world. The out -pocket model (OOP) is used in countries that are too poor or disorganized to provide any kind of national healthcare system (Wallace, 2013). The payment to health service is based on ability to pay, thus those that have money can get access to healthcare services and those who can not afford remain sick or die (Wallace, 2013).

Moreover, with this model of paying healthcare, people pay the cost of services directly to the point delivery and there is no reimbursement for medical expenditure. and more important it includes official user fees, co-payments and deductibles for doctor visit and medical prescription and is expenditure imposed on services users for supplies and tests which may not be available in health facilities(Wagstaff & Doorslaer, 2003).

In countries where there is out- pocket payment system patients pay for some types of health, in full or in part and thus the patient is regarded as the source of funding (Olsen, 2009).

Out -pocket payment is 'full' when there is no any other means to pay for healthcare services, when no insurance, and no cross subsidization and OOP is 'part' when patient payment is being referred to as co-payment, co-insurance, or co- funding, which means that a third part payer is also involved in the financing (Olsen, 2009). However, the funding differ from one country to another, some "from as low as 10% or 15% in North Europe to more than 50% in poor countries" (Olsen, 2009:128).

According to Olsen (2009:127): There are two main reasons on when Out pocket payment is significant ; One, OOP is important when the "public purse cannot afford to pay for all healthcare. Two, unnecessary demand will be deterred when people pay for themselves"

However, according to Hurst (1992)Out pocket payment is used where income is inadequate or where health expenditure is unexpected and catastrophic and it is universally used for three reasons; for over-counter medicine, for cost sharing and private medical care. Out pocket payments accounts for about half of total health spending, with an increasing portion of that total being channelled through various public and private prepayment schemes (World Bank, 2011).

The four models presented above will indentify and categorise key challenges and characteristics of Tanzania's healthcare system.

2:3 METHODOLOGY

2:3:1 Introduction

The aim of this study is to describe and characterize the Tanzania's healthcare system and to find out what opportunities and constraints - and thus key challenges confronting Tanzania in the development of the healthcare system. This section will explain in detail how the research was conducted. First, the choice of qualitative research will be discussed. Then, it will be explained how the data were collected and, finally, how data were analyzed.

2:3:2 Choosing a research Methodology.

In social science the choice of methodology depends on the nature of the study and the intended information to be gathered. Whether it is a qualitative or quantitative approach, what determined the suitable methodology is the research questions to be studied. In order to find the answer on related to research questions: characteristic, constraints and challenges of healthcare in Tanzania. The qualitative approach could help to answer these questions.

2:3:3 Qualitative Approach

According to Strauss and Corbin (1990:17) Qualitative research can be defined as "any kind of research produced by findings not arrived by means of statistical procedures or other means of quantification". This means that qualitative study is based on understanding information given through words, in-depth understanding, experience and documents. For example this study on healthcare system is rooted in acquiring information from documentation such as case studies, thesis, international reports, organizations and other academic paper.

Denzin and Lincoln (2008:14); states that "the word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity or frequency". The use of statistical data or numerical information have not been opted in this study for the reasons that it aims at looking how policies and management of health care have been designed and the possible yielded better or worst health care services.

2:3:4 Features of Qualitative Research

According to Yin, qualitative research/approach has five features that distinguish it from quantitative approach. These are;

- "It strive to use multiple source of evidence rather than relying on a single source alone
- It cover the contextual condition within which people live
- It contributes insights into existing or emerging concepts that may help to explain human social behaviour.
- It represent the views and perspective of the people
- Studying the meaning of people's lives under real world condition".

Yin, (2011:7)

METHOD:

" A document can be defined as a data that consist of words and/or images that have become recorded without intervention from a researcher. Documents typically contain text, but often also numbers and various forms of visualisation, such as photographs, graphs, and diagrams. Many different types of documents can potentially be relevant to in relation to the problem". (Justesen & Mik- Meyer, 2012:118).

Documentation

The main method for data collection is documentation method, this source includes reports from national and international organizations, journal article, books, conference proceedings and article in periodical. According to Justesen & Mik- Meyer, (2012:118).

Comparison Method

The study used comparative method to compare Tanzania and Germany healthcare systems, however, Germany is used as contrast to find out opportunities, constrains and key challenges confronting Tanzania healthcare system.

According to David Collier, comparison (comparative method) "is a fundamental tool of analysis" Such analysis sharpens our power of description and it help to formulate new concepts that arises out of discussion mainly based on suggestive similarities and differences (Collier, 1993:104).

Comparative Method; refer to as "the methodological issue that arise in the systematic analysis of a small number of cases" but while according to Lijphart, Comparative method includes analysis of small numbers of cases , entailing at least two observation but unfortunately it only permit few applications of convention statistics (Collier, 1993).

Case Study

Information regarding this case study were gathered from documents such as public document and literatures. However, some case studies were involved to offer experience on areas where I found Tanzania could not be able to adapt from Germany perspective.

According to Yin, case study research is one of the several forms of social science research which is preferred especial when we are interested to know the answer of research question(Yin, 2014), for instance the question on why and how constraints and challenges confront the development of Tanzania healthcare system.

In additional to that "Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more method. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytical frame - an object - within which the study is conducted and which the case illuminates and explicates" (Gary, 2011:23)

Through public documents and literatures, different challenges and characteristics were identified and new alternatives for restructuring the Tanzania healthcare system were recommended. The key differences were discussed and the reasons to why Germany is compared were stated.

OECD

OECD is the Organisation for Economic Co-operation and Development with 34 member countries - from North and South America to Europe and the Asia-Pacific region born on 30 September 1961, when the Convention entered into force. The organization includes many of the world's most advanced countries but also emerging countries like Mexico, Chile and

Turkey (Hurst, 1992). OECD works also very closely with other countries as the development partner, such as China, India and Brazil aiming at developing economies in Africa, Asia, Latin America and the Caribbean. Russia is negotiating to become a member of the OECD, and the organization has close relations with Brazil, China, India, Indonesia and South Africa through “enhanced engagement” programme. Together with them, the OECD brings around its table 40 countries that account for 80% of world trade and investment, giving it a pivotal role in addressing the challenges facing the world economy (OECD, 2014).

In regard to health care, most OECD countries have organized the financing of their health care systems in such a way that the healthy support the sick, the young support the old, and the rich support the poor" (Hurst,2000:751).

Germany was chosen for comparison due to the following reasons;

First, the Germany health insurance is one of the oldest health insurance system compare to other OECD countries, it become compulsory in 1883. This can offer a lesson to Tanzania's health care system in which the idea of health insurance is still new.

Second, the question of co-payment which is popular in Tanzania is also found in Germany in which it was introduced in 2004. The idea of cost sharing has been rising in most of developing countries since the introduction of Structural Adjustment Program(SAP).

Third, Internationally Germany health care system has a highly level of financial resources and physical facilities compare to other countries, this could give a way on how to raise money for health care and ensure enough health facilities in Tanzania.

Fourth, is an idea of corporatist where such professional organisation are integrated and work to provide services. This is the new idea compare to Tanzania health care system, where there are number of professional organisation but they are not included in the provision of health care services.

Fifth and last is a concept of pluralist source of financing for healthcare financing. German's health care system relay on pluralist source of financing which is more similar to Tanzania, where its health care system is based on multiple source of financing, despite of differences by nature of pluralist.

CHAPTER 3.0 A SYSTEMATIC COMPARATIVE ANALYSIS ON TANZANIA AND GERMANY HEALTH CARE SYSTEM

The study aims at comparing Tanzania health care system and Germany health care systems. The comparison with Germany is aimed to contrast and identify differences and thus too be able to say something about challenges of Tanzania healthcare system. The comparison is based on three aspects; *i)Health Policy objectives, ii)Financing of the healthcare system and iii)Delivery system*. However, before looking at these three aspects we need to understand the economic and general health situation, Organizational structures and administrative levels within these two countries; Tanzania and Germany.

3.1 ECONOMIC AND HEALTH SITUATION

1. TANZANIA : ECONOMIC AND HEALTH SITUATION

Tanzania is following a mixed type of financing the health system where tax financing dominates about 70% of public financing. Taxation is complemented by user fees in the form of cost sharing in government health facilities (WHO, 2004). With estimated per capital of about 260 US dollars in 2000, Tanzania is among the poorest country in the world with a GDP of about 4 percent per annual. It has a high annual population growth rate at 2.8 per cent. The country economy is based on agriculture, which accounts for 75-78 percent of the total export earnings that meets only one third of Tanzania's import requirements (URT, 2003).

Tanzania experienced economic growth of between 5 and 7 % per year from 2000 to 2008 until the global financial crisis hit the economy in 2009. Between 2001 and 2007, the incidence of income poverty fell slightly in mainland Tanzania, as did the depth and intensity of poverty (Haazen, 2012).

The health sector is one of the Tanzania's government priorities; it is reflected in the annual incremental increase in budgetary allocation to the sector. Presently the share of the annual budget is 11% and which is set to rise to the target of 14% .The development vision of 2025 is an access to quality primary care for all (URT,2003).

The Tanzania health care system is divided into seven administrative levels that is national, zonal, regional, district, ward and village level , where the flow of services go all the way

through, while each level performs its duties as directed by the Tanzanian Ministry of Health and Social Welfare.

In 2008 Tanzania ranked 201 among 229 countries in terms of per capital GDP with estimated population of 44.8 million people in 2010. It is reported that the Tanzania health care system faces shortage of trained staffs, low motivation of staffs, lack of effective staff supervision, poor transport and communication infrastructure and shortage of drug and medical equipment (Kwesigabo et al, 2012).

Tanzania like many other developing countries faces many development challenges, from social, economy and political development. Health aspect is one of the most challenging issue that needs enormous consideration in the region.

2. GERMANY: ECONOMIC AND HEALTH SITUATION

The foundation of the currently Germany health care system dates back to 1883, when nationwide health insurance became compulsory although social health insurance system is currently the main scheme and it is characterised by three co-existing schemes (Grosse-Tebbe & Figueras, 2005).

However, before the introduction of social health insurance, the Germany health care system was based on families and church as the main health service provider but due to increasing number of people and urbanization during the 19 century, the system could not cater all the needs and the solution was to introduce Social health insurance (SHI) (Brin et al, 2007).

Social health insurance (SHI) is one of the possible organisation mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community health insurance and others (Doetinchem et al, 2010).

Social health insurance represents a dominant role of societal actors in healthcare regulation and financing, whereas services are mainly delivered by private for profit providers. Within the OECD context four Germany-speaking countries belongs to this system type: Austria, Germany, Luxembourg, and Switzerland (Böhm et al, 2013).

According to Busse and Riesberg (2004) in December 2003, Germany had 82.5 million inhabitants, 66.6 million in the western part, and 13.5 million in the eastern part and 3.4 million in Berlin. Since reunification, the population in the eastern part decreased from 15.9

million in 1991 to 13.5 in 2003, attributable to migration to the west and the very low birth rate in the east".

In 2003 about 87% of Germany citizens were covered by statutory health insurance; based on income membership and was mandatory for about 77% and 10% for voluntary. However, 10% of the population took private insurance, and 2% were covered by government schemes while 0.2% were not covered by any third party-payer scheme (Grosse-Tebbe and Figueras, 2005:21).

In 2002, health expenditure in Germany comprised 10.9% of its gross domestic product (GDP), and 79% was covered by public funds ranking the country the third among countries in the OECD, in the same year Germany total per capital expenditure when calculated in US \$ PPP amounted to US \$ 2817 and it was ranked the fifth among the OECD in terms of public per capital expenditure (Grosse-Tebbe and Figueras, 2005).

3.2 ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE LEVELS

1. TANZANIA: ORGANIZATION STRUCTURE OF THE HEALTHCARE SYSTEM IN TANZANIA

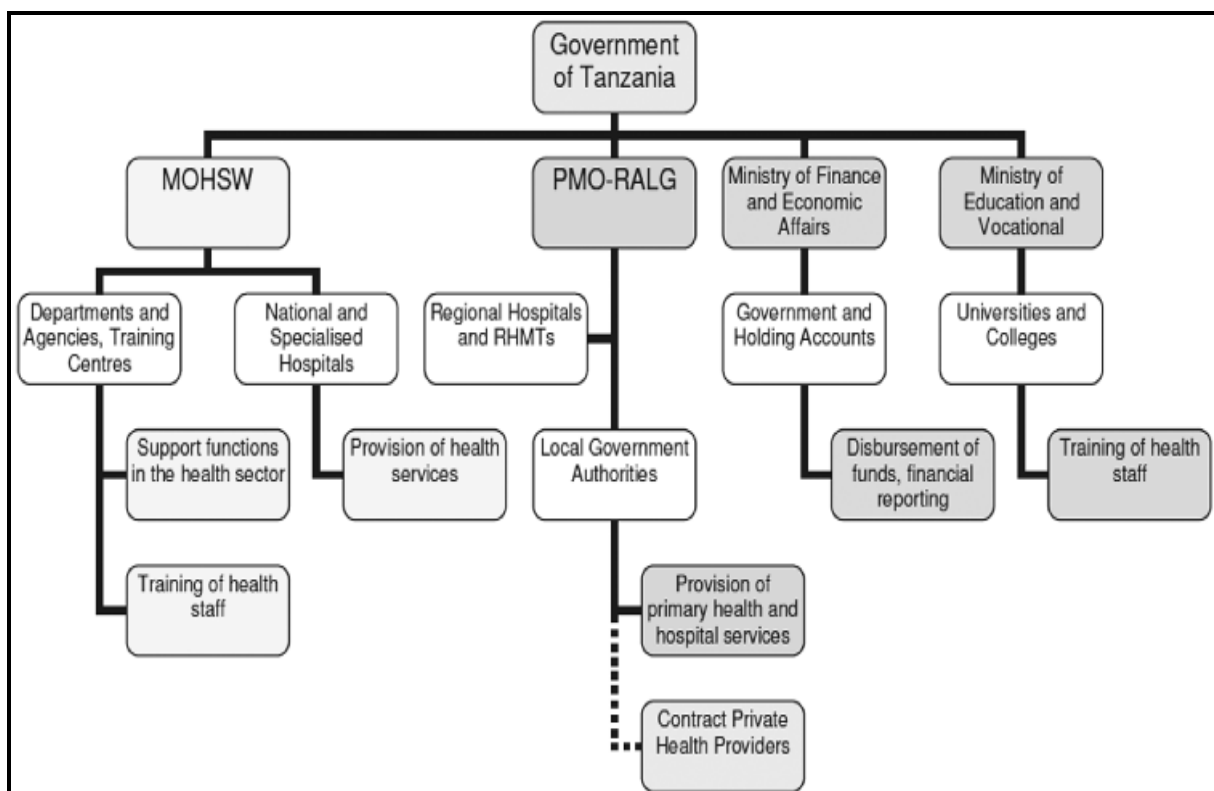


Figure 3: Structure/ Organization of the healthcare in Tanzania

Source: Tanzania, URT (2008, 12), cited from Haazen (2012:11)

Notes: **MOHSW** = Ministry of Health and Social Welfare;

PMO-RALG = Prime Minister's Office, Regional Administration and Local Government;

RHMT = Regional health management team.

ADMINISTRATIVE AND SERVICE LEVEL STRUCTURES

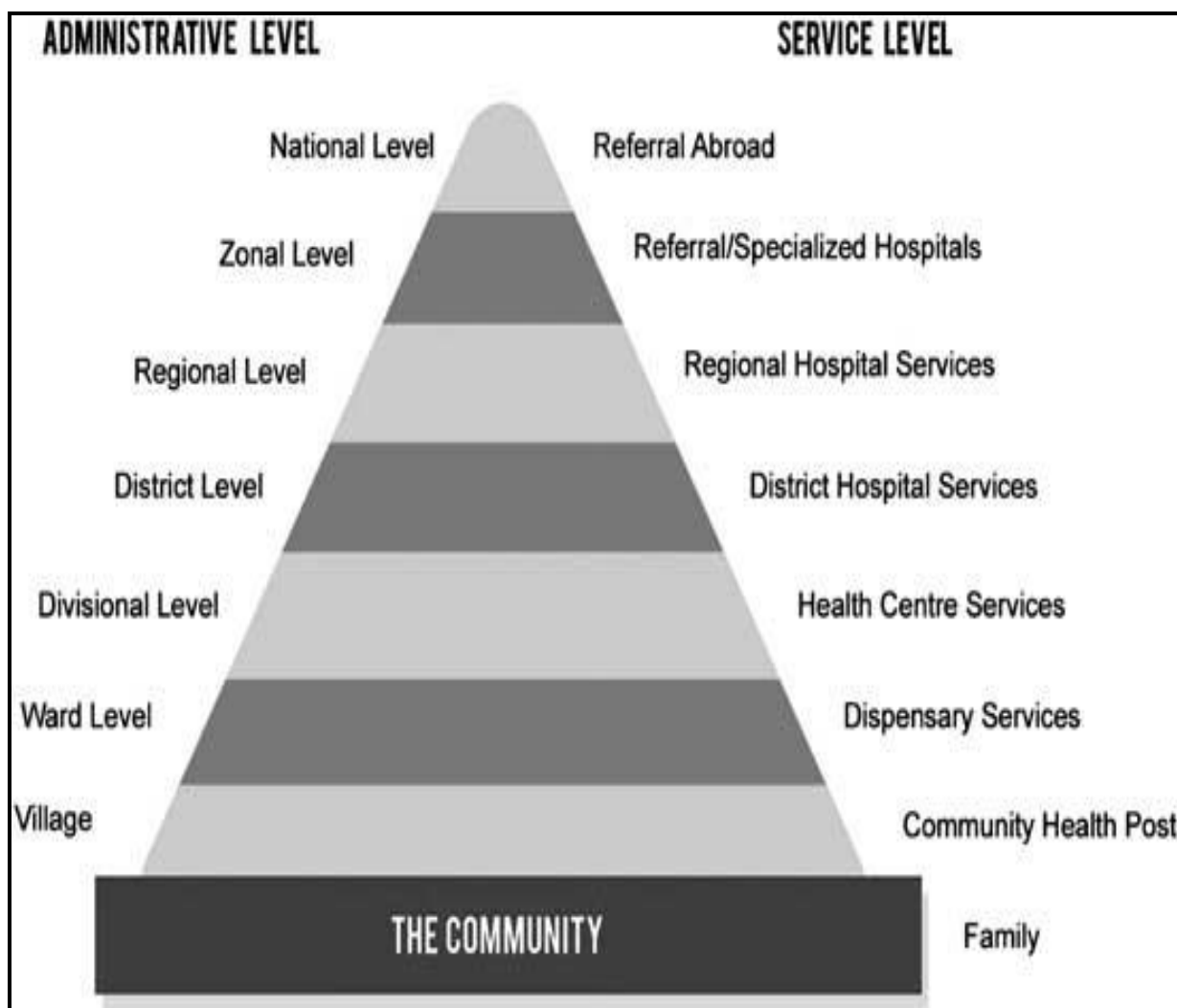


Figure 4: Hierarchy of health services provided in Mainland Tanzania.

Source: United Republic of Tanzania, Ministry of Health (opted from Kwesigabo et al, 2012:37)

2. GERMANY:

ORGANIZATIONAL STRUCTURE OF THE HEALTHCARE SYSTEM IN GERMANY

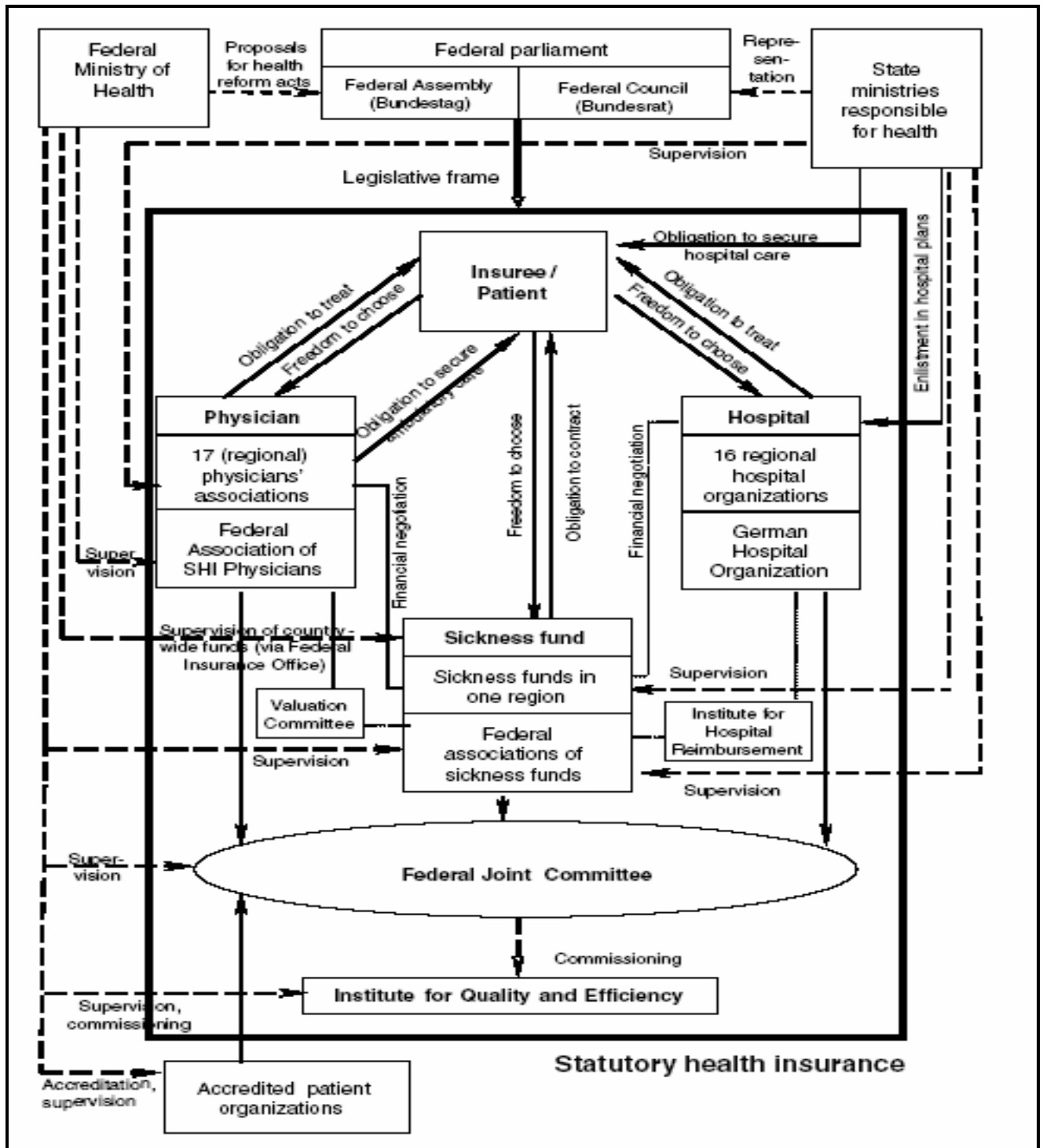
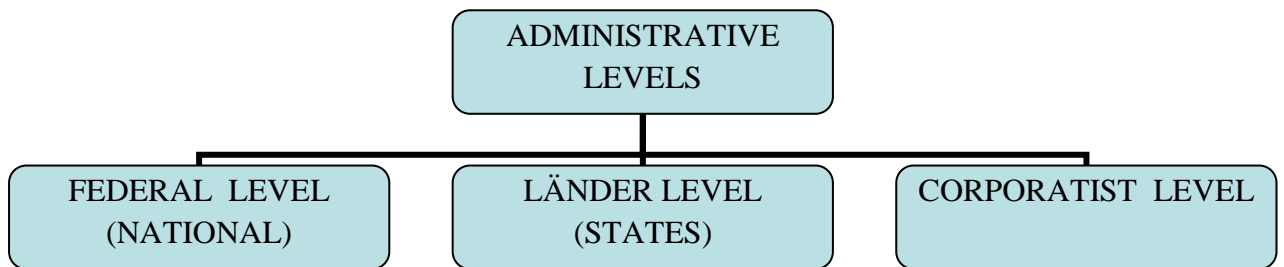


Figure 5: Source: Health care systems in transition, Busse Riesberg(2004:31)

ADMINISTRATIVE AND SERVICE LEVEL

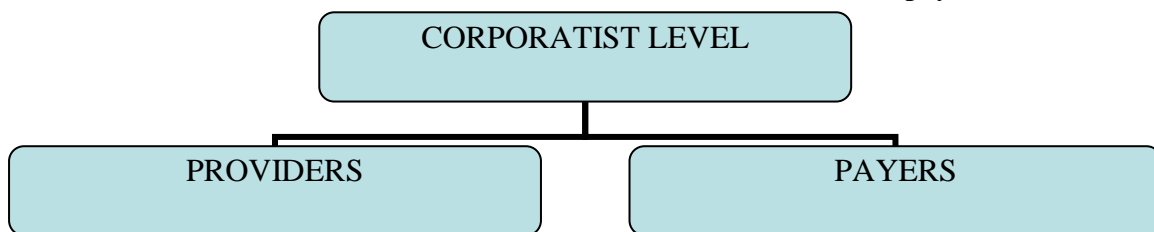
The Germany healthcare system is divided into three administrative levels: Federal(National), Länder (states) and Corporatist Level.



The Germany health national level includes; the Federal Assembly, the Federal Council and the Federal Ministry of Health and Social Security as the key actors (Busse and Riesberg 2004).

The federal structure is represented mainly by the 16 state governments also known as Länder and, to a very small extent, by the state legislatures. In 2003, 13 out of the 16 *Länder* Governments had a ministry with “health” in its name. (Busse & Riesberg, 2004).

According to Busse and Riesberg(2004:29); "corporatist bodies includes the self regulated structures that operates the financing and delivery of benefits covered by statutory health insurance within legal frame work" At this level two actors are involved, these includes providers of health services and payers or consumers.



Providers for the statutory health insurance scheme, corporatism is represented by the SHI-affiliated physicians’ and dentists’ associations on the provider side and the sickness funds and their associations on the purchasers’ side. "These bodies have assumed the status of a quasi-public corporation and are based on mandatory membership". (Busse and Riesberg 2004:34).

The payer’s side as actors is made up of autonomous sickness funds organized on a regional and/or federal basis. By January 2004 there were 292 statutory sickness funds with 72 million insured people (about 50.7 million members plus their dependants) (Busse and Riesberg 2004).

3.3 HEALTH POLICY OBJECTIVES:

TANZANIA- HEALTH POLICY OBJECTIVES

The Tanzania health policy objectives are outlined in the National Health Policy of 2003. The following are policy objectives

1) **Adequacy and equity to maternal and child health services;** The aim of this policy objective is to reduce the burden of diseases, maternal and infant mortality and Increase life expectancy through provision of adequate and equitable maternal and child health service (URT,2003). Since the time when the policy came into effective, there are still significant geographical inequalities in mortality and inequalities in morbidity rate among age groups likely caused by HIV/Aids (WHO, 2004) .

However, there are some improvements that have been observed since the policy came into effect. For example, a report on health sector performance profile of 2010 indicate that maternal mortality rate has dropped from 578 in 2004/05 deaths to 454 deaths per 100,000 live births in 2009/10 although this is still below the MDG goals of 264 per 1000,000 births and there are still challenges in some part of the country (URT, 2011).

2) **Availability of drugs and medical supplies;** To ensure the availability of drugs and medical supplies and infrastructures (URT, 2003). Access to medicine is one of the biggest challenge and there is uncontrollable rise in medical expenses (URT, 2008). However, not all cases related to drugs and supplies are seemed challenging. Medicine related to vaccination and its supplies have been improving and thus it has reduced the child mortality rate. For instance, there increase supply of ARV's in the country and the measles vaccination whose performance was 88% in 2008 and it has increased to 91% in 2009, this is above HSSP III target of 85% although some regions like Arusha, Mara, Kigoma, Kilimanjaro, Ruvuma, and Pwani are still below the target (URT, 2011).

3) **Availability and accessibility of healthcare services;** Ensure that the health services are available and accessible to all people in the country (urban and rural areas) (URT,2003). There is increasing inequality in service availability between rural and urban, as well as between the rich and the poor (Kuawenaruwa & Borghi, 2012). There is a big discrepancy among the health services in Tanzania. Some services are largely available in some regions than other regions, for example health facilities- (delivery service) in Dar es salaam are highly

available and accessible for about 90% compare to Manyara (30.8%) and Mtwara (24.2%) which is below the 2015 HSSP III target (URT, 2011).

4) **Capacity building of human resources;** This objective intend to focus on training and make available competent and adequate number of health staff to manage health service with gender sensitive at all levels (URT, 2003). Since independence, Tanzania healthcare system has been facing a shortage of enough trained and competent health staff. Skilled birth attendants were not enough for years however, the report on health sector performance indicate that there is improvement in number among skilled birth attendants, "less than half (46%) of births or deliveries were attended by skilled attendants; whereas the 2010 TDHS reports that 51% of deliveries were attended by skilled attendants, indicating a slight increase" (URT, 2011:21). This is the results of government strategies to ensure enough skilled health staffs are available in the health facilities.

5) **Community Sensitization:** The community should be sensitized on common preventable health problems, and improve the capabilities at all levels of society to assess and analyse problems (URT, 2003). Community sensitization is vital in developing countries like Tanzania. Under this policy objective, the government seek to make the community responsible in understanding health problems and be to find the solution when necessary. There is an increase of community sensitization especially on HIV/AIDS and Malaria diseases.

6) **Create and Promote awareness:** Awareness should created through family health promotion and awareness among government employees should be promoted to adequately solve health problems. There is increasing awareness among many Tanzania communities and families in general. Such an increase is indicated by the high number of people testing for HIV/AIDS, TB, and Malaria. Most families are aware on how and where to go for the test and what medicine are supposed to be used. Knowledge on how to prevent against Malaria is increasing among most of families and Malaria cases have been dropping.

7) **Promote Public- private partnership;** Public and private partnership should promoted and sustained in the delivery of health services (URT, 2003) Public and private partnership is very important, especially at the moment when the country still depend on donors for funding healthcare system. Tanzania public healthcare system is still unable to deliver enough service and therefore private partnership is important. This has been done, and now there is a growing partnership between the public and private institutions in service delivery.

8) **Traditional medicine promotion;** Traditional medicine and alternative healing system should be promoted and regulate the practice (URT, 2003). Promotion for traditional medicine and healing system continue to be another most important policy objective of the Tanzania government. The existence of Traditional Medicine institute and registration of all traditional service providers is an indicator of government strategy to promote health sector (Shemdoe & Mhando, 2012).

GERMANY- COMMON HEALTH POLICY OBJECTIVES

Most of the OECD countries have the same health policy objectives. According to Hurst (1992:60) "OECD countries share similar health policy objectives". However, these are common objectives that most of the advanced health care system stands for. Germany health policy objectives falls in the same common objective as most of western countries

1) **Adequacy and equity in access to care-**; There should be some minimum of health care available to all citizens and treatment should be in accordance with need, at least in the publicly financing sector (Hurst, 1992:61). Germany population enjoys equal and easy access to a health care system offering a very comprehensive benefits packages at all levels of care (Grosse-Tebbe, et al., 2005:23) "The system has managed to achieve comprehensive healthcare coverage and provides for equal access to a high volume of advanced medical service" (Jakubowski, 1998:39)

2) **Income Protection;** Patients should be protected from payments for health care which threaten income sufficiency and the payment for protection should be related to individuals' ability to pay. This will involve insurance, saving and income redistribution. The Germany funding and access to statutory health insurance is based on solidarity; the contribution are made according to ability to pay and all people receive same benefits. (Schmidt, 2006)

3) **Macro-economic efficiency;** Health expenditure should consume an appropriate fraction of GDP

4) **Micro-economic efficiency;** A mix of services should be chosen which maximizes a combination of health outcome and consumer satisfaction for the available share of GDP expanded on health service(allocative efficiency. In additional, cost should be minimized for

the available share. The benefit should not only take account health of the individual patient but also his or her satisfaction (Hurst, 1992:61). "Patient satisfaction with the accessibility of family practitioners is relatively high in Germany compared to other European countries" (Busse & Riesberg, 2004:103).

5) **Freedom of choice for consumers** ; Freedom of choice should be available in public sector as well as in private sector arrangements (Hurst, 1992:61) "Traditionally, the majority of insured people had no choice over their sickness fund and were assigned to the appropriate fund based on geographical and/ or job characteristics". (Busse & Riesberg, 2004:60).

6) **Appropriate autonomy for provider**; The doctors and other providers should be given the maximum freedom compatible with attainment of the above objectives, especially in matters of medical and organizational innovational (Hurst, 1992:61)"The German system has put more emphasis on free choice, ready access, high numbers of providers and technological equipment than on cost effectiveness or cost containment per se" (Busse & Riesberg, 2004)

3.4 HEALTH FINANCING SYSTEM

Tanzania Health Financing System

Tanzania is following a mixed type of financing the health system. where tax financing dominates about 70% of public financing (WHO, 2004)The Tanzania healthcare system is largely financed by tax which dominates about 70 of public financing. The financing system is complimented by general taxation (user fees in the form of cost sharing in government health facilities), national health insurance, community health insurance and donor funding (Bultman, et al., 2012).

1. PUBLIC FINANCING

The Tanzania healthcare system is financed by public which consists general taxation and donor support to the health sector through general budget support or basket funding. The share of public financing has been increasing over time especially donor funding from 2006, while general taxation contribute slightly similar proportional (Bultman, et al., 2012)

a) Taxation

Taxation as a source of financing has been considered to be the most equitable financing source as it pools funds from all individuals (Bultman, et al., 2012). It is also considered a highly progressive source of financing (Mtei & Borghi, 2010). Taxation tends to pull funds from all individuals, "with the less poor contributing a higher proportion of their income, while each individual benefits from its financing source regardless of how much they contribute" (Bultman, et al., 2012:28)

According to the SHIELD Report, general taxation is comprised of different source taxes; these include Personal Income Tax (PIT), Corporate Income Tax (CIT), and Value-Added Tax (VAT) (Mtei & Borghi, 2010:10). However, the Value Added Tax (VAT) is the major source of tax revenue, accounting for about 34% of total tax revenue in 2010/2011 (Bultman, et al., 2012).

According to Tanzania National health policy, "the central government is the main financier of the health services, where the local government finances health through council tax collection and other earnings which enhance sustainability and ownership of health services" (URT, 2003:27). Although, it was estimated that the government financing decreased a proportion of total funding from 69.1% in 2005/06 (actual) to 53.9% for 2010/11 (estimated) (Haazen, 2012).

b) Donor Funding

Tanzania for a long time has been depending on donors for its development budget. Depending on donors is one of the features of most of the developing countries' health care systems. However, donor funding is one of the most significant sources of financing the healthcare system in Tanzania. "It shares characteristics with Taxation, except that the burden is borne by the tax payer in the donor countries" (Bultman, et al., 2012).

2. OUT OF POCKET PAYMENT (OOP)

Out of pocket payments are payments made or incurred by individuals or households when accessing health services although it is considered as the most inequitable financing source with wealthier people benefiting much more than poorer people because it depends on how much an individual pays (Bultman, et al., 2012).

There is a significant role that OOP plays in the financing of healthcare in Tanzania, however, its share in the total financing has been declining from about 47% in 2001 to approximately 23% in 2007 probably because of the increase in public funding (Bultman, et

al., 2012). One challenge with OOP is that, it does not pool risk across the ill and healthy and this is the reason that out pocket payment pushes a significant proportional of the population into poverty and it is estimated that about 4% of the population is driven into poverty (Bultman, et al., 2012).

3. HEALTH INSURANCE

The government introduced cost sharing policy in 1993, and this was the beginning of the rise of health insurance idea in Tanzania (URT, 2003). Health insurance as the part of cost sharing policy is also a prepayment mechanism that allows for a reduction in the risk of catastrophic payment and impoverishment caused by out-pocket payment made at the first point of service and at the moment of use (Bultman, et al., 2012).

Apart from government funding, health insurance is another important funding mechanism that is considered to be equitable, sustainable in generating revenues to the health sector and improving access to health care especially for the most vulnerable populations (Bultman, et al., 2012).

Despite of the fact that, it is the government objective to achieve universal coverage, there is a big challenge out of health insurance. Health insurance in Tanzania is fragmented with three ministries; Ministry of health and social welfare(MOHSW), Ministry of Labour(MOL) and Prime Minister office. (PMO-RALG). Each of these has its own scheme, implemented differently, not cooperating and even sometimes competing in the are of social mandatory insurance (Bultman, et al., 2012).

The health insurance schemes in Tanzania are estimated to cover about 15% of the total population and its contribution in total healthcare financing is increasingly becoming significant, amounting to about 4% despite of low enrolment. However, it is National Health Insurance Fund(NHIF) only that cover public servants who are in reality a small part of population and Community Health Insurance(CHIF) which cover also small proportion of workers in the informal sector. (Bultman, et al., 2012). There is a big gap in coverage between the richest and poor groups, in 2008, 12% of the richest groups were insured compared to 4% of the poorest groups (Borghi & Joachim, 2011).

The currenty Tanzania objective in regard to health insurance coverage is to achieve national coverage of about 30% and insurance based-financing for about 10% of total health care financing by 2015 (Bultman, et al., 2012).

Health Insurance Schemes in Tanzania

a) National Health Insurance Fund (NHIF)

NHIF was introduced in 1999 for civil servants which covers 5% of the population. The scheme involves also private firms and formal sector employees. The scheme is compulsory; it covers all public employees (McIntyre, 2008). It covers employees and their spouses and up to four children or legal dependents and it currently covering 2.5 million people equivalent to 5% of the population (Bultman, et al., 2012). The scheme is managed by the board of directors, appointed by the Minister of Health. .. This is the largest scheme in Tanzania (Kuwawenaruwa and Borghi (2012).

The NHIF has only one pool and in order to extend its pool has increased its coverage from central Government civil servants only, to retired public employees, police, prison staff, immigration officers, and fire and rescue service staff members, as well as to all employees in the public sector (parastatals, agencies and statutory bodies) covered by the definition in the HNIF Act of "public servant", However the current statistics shows an average membership growth rate of 11.3% each year." (Bultman, et al., 2012:31).

Contributions

According to Bultman, et al., (2012:31) NHIF members "contribute 6 % of their salaries per month, equally shared with the employers, in the form of premiums. Contributions are directly deducted from the employees' salary and remitted to the NHIF".

Benefit Package

There is a wide range of benefits offer provided by these includes basic diagnostic tests, drugs, outpatient services, inpatient services, and minor and major surgery, with a list of exceptions. However, "the Minister of Health has the mandate to exclude services from the package such as Services provided by disease control programmes of the MoHSW (e.g. HIV/AIDS, TB, childhood vaccinations" (Bultman, et al., 2012:31).

According to Tanzania regulatory insurance review, the NHIF benefit package are provided by accredited facilities. All public providers are automatically accredited, regardless of quality, however, private providers must follow specific guidelines to qualify and to enter into a service agreement with NHIF (Bultman, et al., 2012).

Specific guideline/criteria for private provider accreditation include the following:

- availability of human resources, equipment, and facilities in accordance with MOHSW guidelines;
- acceptance of a formal program of quality assurance prescribed by the NHIF;
- acceptance of NHIF standard payment mechanisms and fees;
- adherence with NHIF referral guidelines;
- acceptance of reporting requirements; and
- recognition of the rights of the patient. (Bultman, et al., 2012:32).

Until 2011, there were a total of 5,673 health facilities (69.2% of all health facilities in Tanzania) were accredited to provide services for the NHIF members. Although about 80% of the accredited facilities are dispensaries, 10% health centres, 4% hospitals and 6% pharmacies and drug dispensing outlets (Bultman, et al., 2012:32).

Provider payment

Providers are paid for these services on an Fee For Service basis through a reimbursement / billing system; "health facilities provide the service, submit a claim to the NHIF, the NHIF assesses and verifies the claim, and pays after approving" (Bultman, et al., 2012:32).

b) National Social Security Fund (NSSF)

NSSF is one of the largest pension funds in the country which offers health insurance to NSSF members who contribute 10% of their gross salary to the NSSF. This fund offers health insurance benefit (SHIB) as an independent body within the NSSF. Membership for this scheme is mandatory for private and parastatal employees and covers up to 5 dependants (Kuwawenaruwa and Borghi (2012).

As from 2011 there were a total of 74,000 beneficiaries of SHIB, which includes principal member dependants. This small enrolment has been connected to different factors contribute These includes;

- a)Private sector employers offering their own health benefits arrangements to their employees,
- b)Lack of public knowledge about the scheme.
- c)Increasing widespread belief among members that being an SHIB members may lead to a reduction in pension.
- d)Lack of accredited health facilities in some areas, which also acts as a disincentive to enrolment. (Bultman, et al., 2012:33).

Contributions : There is no separate premium contribution to SHIB, all members access health services which are financed by their 20% contributions to the NSSF, collected through payroll. (Bultman, et al., 2012:33).

Benefit Package: Its benefit package includes the majority of outpatient services, such as consultations, basic and specialized diagnostics, simple and specialized procedures, and drugs on the National Essential Drug List. Other services includes standard inpatient services like hospital admission (overnight stay), consultations, simple and specialized procedures, and referrals to a higher level and to specialized hospitals (Bultman, et al., 2012:33)

Provider-payment: Contrary to the NHIF, the SHIB uses a capitation model to pay accredited health providers. The members have freedom to pre-select and register at a single facility from which health care will be sought. The facility is then paid a flat amount per member per year to provide services. (Bultman, et al., 2012:33)

Finances: "SHIB finances are included in the general accounts of NSSF. It is therefore difficult to assess the financial situation of the SHIB itself". (Bultman, et al., 2012:33).

c) **Community Health Fund (CHF)**

This is the largest scheme for the informal sector operating in rural districts but has been initially administered by the Ministry of Health and Social welfare since 2009. NHIF has taken over the management of this scheme. It was established as an alternative to user fee at the point of service (World Bank, 2011)

According to Bultman and Kanywanyi "the district residents (usually informal workers and farmers) can join a CHF on a voluntary basis and can get access to health care without paying user fees. The MOHSW, PMO-RALG and the NHIF provide regulatory oversight to CHF/TIKA". (Bultman, et al., 2012:34).

Membership

There were 108 districts that had a functioning CHF out of a total 133 districts by January 2012. Although, by September 2011 a total of 573,000 household were registered with CHFs, representing around 3,438,000 members out of an estimated population of 42.6m in 2010/11,

around 8.1%. The scheme under Health Sector Strategic Plan III sets a target of 30% for CHF enrolment for 2015 (Bultman, et al., 2012:34).

Contributions : The Members of CHF pay flat rate contributions, which is between TShs 5,000(3 USD) and TShs 20,000 (11 USD) per household per year. Those who cannot afford the membership fee can benefit from an exemption policy as stipulated in the national health policy . The funds raised are paid to the Council and are doubled by a “matching grant” from the national budget (Health Basket Funds). The NHIF tends to get the money late or, and sometimes gets less than the required amount.

Benefit package ;The benefit package is locally determined at the Council level and typically includes all services provided at the primary care level, that is to say out- and in-patient services offered at dispensaries and health services. The inclusion of services at the District Hospital is at the discretion of the Council; some Councils include services there to make the benefit package more attractive, although, some do not in order to limit the costs to the Council (Bultman, et al., 2012:).

Provider-Payment ;"Total income from CHFs is estimated to be between TShs 1bn and TShs 3bn. With this, it provides only a very small part of total sector financing, i.e. less than 0.7%" (Bultman, et al., 2012:35).

Finances ;"The membership contributions and the matching grants go into the cost-sharing account of the Council and typically become part of the Council's health budget that is spent in accordance with the Comprehensive Council Health Plan. There is typically no connection between payments to health facilities and either the number of services provided to CHF members or the amount of CHF members enrolling at a specific facility" (Bultman, et al.,2012:35).

d) **Nongovernment non-profit (micro-insurance)**

These are typically sponsored by religious groups, informal groups, and associations. They seek to strengthen informal sector communities by providing better access to health care, improved quality of care and ways to promote comprehensive health care services at affordable prices. However such schemes are still infancy (World Bank, 2011). The good

example of these is VIBINDO (the umbrella organization of informal sector operators in Dar es Salaam region) and UMASITA (Tanzania informal sector community Health Fund).

e) **Private Health Insurance (PHI)**

As the health sector took place in the mid-to-late 1990's, private insurance became popular with most private companies. Approximately 120,000 people are covered by private health insurance but this number represents only a small percentage of the overall population of Tanzania (World Bank, 2011). Some of the well-known health insurance companies include Strategies Insurance, AAR Insurance and Medex insurance (Bultman, et al., 2012).

GERMANY: HEALTH FINANCING SYSTEM

HEALTH FINANCING

The Germany health care system follows the Bismarck '*mixed model*' of health- funded mainly by premium-financed social/mandatory insurance. It is usually financed jointly by employers and employees through payroll deduction. This model results in a mix of private and public providers and allows more flexible spending on healthcare (Lameire et al 1999).

Germany health care model is a model of compulsory social insurance, where all people are eligible to be the member of social insurance. The financing of health care in Germany is dominated by statutory health Insurance(SHI) which cover majority of the population and while others especially rich people are covered by other complementary source of financing.

However, overall expenditure of SHI is only 57% and complementary source of financing contributes 43% of the total health expenditure. (Busse & Riesberg, 2004). Although it was reported earlier that "60% of funding is derived from compulsory and voluntary contribution to statutory health insurance"(Jakubowski, 1998:63). It is noted that there is drastic fall of financing from 60% to 57%.

STATUTORY HEALTH INSURANCE SCHEME (SHI)

Statutory health insurance ensures free healthcare for all via sickness funds (Krankenkassen) financed by a statutory contribution system. The payments for these insurance are based on a percentage of income, which are in part paid by both employee employer (Brin, et al., 2007:12).

Within the statutory health insurance scheme, corporatism is represented by the SHI-affiliated physicians' and dentists' associations on the provider side and the sickness funds and their associations on the purchasers' side (Busse & Riesberg, 2004:34)

The SHI plays a vital role in the German healthcare system because majority of the population are covered by it, it is approximated to contain 90% of the coverage (Brin, et al., 2007), however, its coverage by 2003 was 88% of the population (Busse & Riesberg, 2004) . It is compulsory for all people who earn up to €47,700 p.a. pre tax in other words the membership is based on the earning capacity (Brin, et al., 2007) .

However majority members of Private healthcare schemes are those who earn above the aforementioned income level as an alternative to the SHI. Others use private health while others used such insurance to upgrade the health care services provided by the state. (Brin, et al., 2007:12).

Yet, majority of people in Germany can afford to earn up to €47,700 , and this is the reason why the coverage is high. Within this scheme the rich and poor are put together under solidarity principle.

There are three major pillars of SHI according to Busse & Riesberg, (2004:57); These includes: "Statutory Retirement Insurance (17%)(Medical rehabilitation), Statutory (work related) (1.7%), and Statutory Long Term Care (7.0%)". Look figure no.6, next page.

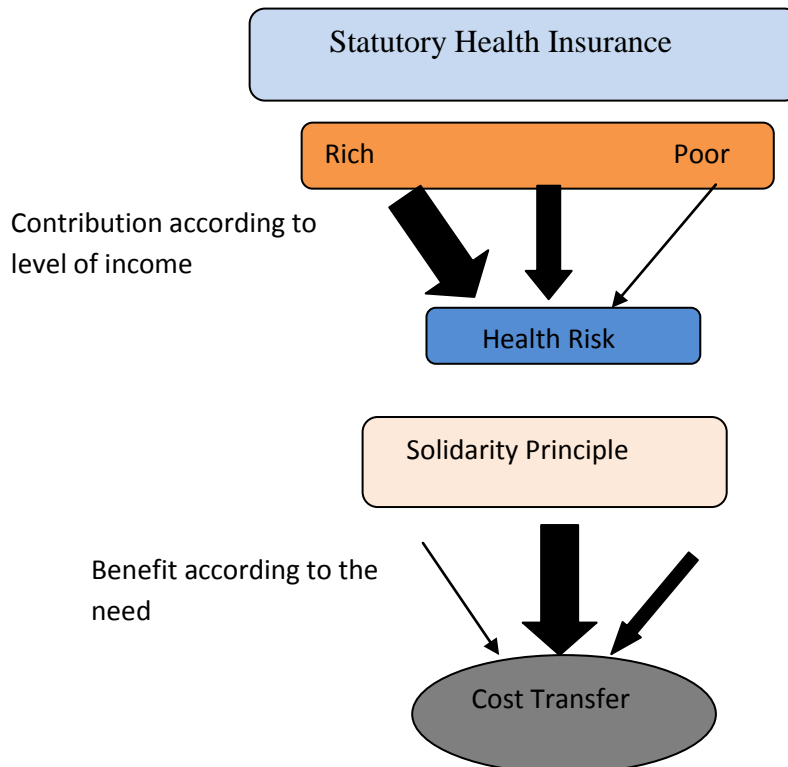


Figure 6: SHI- Source: Obermann, et al., (2013:23)

COMPLEMENTARY SOURCE OF FINANCING

Apart from Statutory health insurance, as the major financier of health care in Germany, there are three other complementary source of financing. These includes Private health insurance, Taxes and out pocket payment in which together contribute about 43% of the total health expenditure.

PRIVATE HEALTH CARE INSURANCES

Private health insurance (PHI) works on two main areas of health protection: first, is to fully cover a portion of the population and second is to offer supplementary and complementary insurance for SHI-insured people. However, between 1975 and 2002, the number of people having full cover had increased from 4.2 million to 7.7 million, representing 6.9% and 9.3% of the population respectively (Busse & Riesberg, 2004).

According to German public law, private health care insurances are for profit organisations, such as publicly traded corporate companies or institution. PHIs are also mandatory members of the national union of private health care insurances also known as (“Verband der privaten Krankenversicherung e.V.”) and are supervised by the state through the

“Bundesaufsichtsamt für das Versicherungswesen” (Federal supervisory office for the insurance system) and the relevant Länder office. (Brin, et al., 2007:12)

"Private health insurances calculate the premiums according to the type of coverage the insurer requests and according to the level of risk he carries for the insurance company. Members of this association" (Brin, et al., 2007:12). As of February in 2007, there were 36 private insurance companies which make up 99% of market share.

In addition to that, a fully privately insured patients is usually enjoying benefits equal to or better than those covered by SHI(statutory health insurance), however. this depends on the kind of insurance package chosen; the good example is the case of dental care which is usually not included in the package (Busse & Riesberg, 2004).

Premiums within the private health insurance market, vary with age, sex and medical history at the time of underwriting. This is different with SHI where there are separate premiums which have to be paid for spouses and children, making private health insurance especially attractive for single (Busse & Riesberg, 2004).

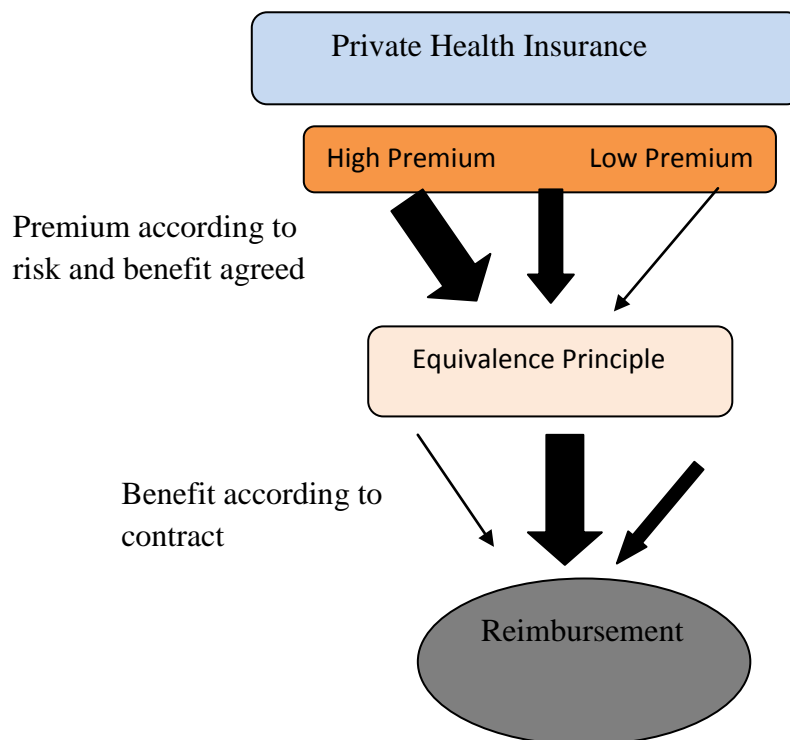


Figure 7: PHI- Source: Obermann, et al., (2013:23)

TAXATION

According to Busse and Riesberg, "taxes are modest source of finance", these taxes are used for various purpose in the health care system (Busse & Riesberg, 2004:72). The Germany Hospital Financing Act of 1972 introduced the so called "Dual financing Principle In Acute Hospital Sector " in which all 'investment costs' were to be paid out of taxes from the state and federal level and that sickness funds or private patients(who may be reimbursed by private health insurance) would be responsible to pay the running cost (Busse & Riesberg, 2004:72).

In additional, taxes are used to fund other different related health care activities such as research activities, University hospital, training and education for medical doctors, dentists, pharmacists, nurses and other professionals in public schools (Busse & Riesberg, 2004).

OUT POCKET PAYMENT

Despite of the fact that the Germany health care financing system is traditionally "The Bismark Model" in nature, there are also elements of "Out-pocket Model" which is used by majority of the world. The model is characterised by co-payment, deductibles for doctor visits and unofficial payments. However, due to the Germany health care regulations unofficial payments are not included in the system, this makes Germanys' out-pocket system different from other health care systems in the world.

The Germany health care system has experienced an increase in out of pocket expenditure as the share of total expenditure. In 1992 Germany had out-pocket expenditure of 10.7% of total expenditure while in 2002 the outpocket expenditure figure rose to 12.2% of total expenditure (Busse & Riesberg, 2004). This indicates that there is increasing number of people who opt for out-pocket payment as the mechanism to access better health care.

According to Busse and Riesberg, Out-pocket payment relate to co-payment for benefit partly covered by prepaid schemes. "Co-payment and corresponding exemption mechanism have a long tradition in Germany health care". The idea of cost sharing was for the first time introduced in Germany in 1923 and has existed ever since (Busse & Riesberg, 2004:73).

However, "co-payment system in Germany is granted either to specific population sub-groups, to people with substantial health care needs, for-example, groups of pregnant,

Children and adolescence up to the age of 18 (except for dentures, orthodontic treatment and transportation) (Busse & Riesberg, 2004:75).

The Health Care Reform Act of 1989 advocated cost-sharing for two main purposes;

- To raise revenue (by reducing expenditure for dental care, physiotherapy and transportation liable to pharmaceutical cost)
- To reward "responsible behaviour " and good preventive practice(dental treatment) with low co-payment. (Busse & Riesberg, 2004:74)

3.5 DELIVERY AND REGULATION SYSTEM

HEALTHCARE DELIVERY & REGULATION SYSTEM IN TANZANIA

1)National Health Service

The NHS is regulated by the Ministry of health and Social welfare, where all activities are centralised to regions and districts and councils. Through the Ministry of Health, emphasise is made on delivery of equitable and quality preventive, promotive, curative and rehabilitative health services at all levels (URT, 2003).

The district health service deals also with interventions aimed at preventing and advocating preventive measure and control of communicable and non communicable diseases. Provision of training to health workers is also a part of the national health service (URT, 2003).

Other service provided by national health service and its three levels includes basic services such as curative care for sick children, child immunization and growth monitoring, STI, family planning and ante natal care services." Curative care for sick children and STI services are, on average, available in all facilities, whereas other services are available in approximately 8 in 10 facilities" (MOSW, 2007:10).

2)Primary Health Care

These are main health care service provider. Health care services are provided both in private and public hospitals but with a huge difference in quality of services. The primary healthcare has been the cornerstone of the Tanzania National Health Policy.

The primary healthcare services are mostly provided by dispensaries and health centres. These health facilities offers outpatient services including reproductive, child health service and diagnostic services, other services includes health education, family planning, immunization services, treatment for TB, Leprosy, mental disorder, out-reach services and mobile clinics (URT, 2003).

Most of health centres provides in-patient services, maternity care, laboratory, and dispensing and mortuary services. They serve about 50,000 people and supervisor all dispensaries in the division where population is higher than 50,000 people (URT, 2003).

3)Secondary Tertiary Hospital Care

At this level, many and highly skilled services are provided, it is considered to be the second level of service in Tanzania health care system. This form of care is provided by district, regional, national, referral and specialized hospitals.

a)District Level: The same activities are also provided at the district hospital, however, it only those services that have not been able successful at health centres, this includes out and in patient care, perform general surgical and obstetric operations (URT, 2003).

b)Region Level; Region hospitals provides all services provided at district level but at very high level of expertise such as specialized treatment in Medical Surgery, Obstetrics and Gynaecology and Paediatric and this includes eye, dental, mental illness, Orthopaedics and trauma. The regional hospital on the other hand offers training to health centres officers and conduct research programs including operational research of health system research in the region (URT, 2003:21).

c)National Level; National Hospitals are supervised by the Ministry of Health through the Board of Muhimbili National Hospital which also act as referral hospital for the Eastern

Zone. The National hospital is equipped with qualified human resources, sophisticated equipment and reliable and adequate transport compare to other levels (URT, 2003).

Zone Hospitals; These hospitals includes Muhimbili National Hospital, and two Voluntary agency hospitals- Bugando Medical Centre(BMC) and Kilimanjaro Christian Medical Centre (KCMC). All offer services such as consultation in Eastern, Western, Northern and Southern Highlands respectively (URT, 2003:).

d)Specialized Hospitals. The Tanzania health care delivery system has only two specialized hospitals which offer treatment for TB and Mentally sick patients. These hospitals are Mirembe Hospital (Dodoma), and Kibongoto (Moshi) and are directly supervised by the Ministry of Health (URT, 2003).

4) TRADITIONAL MEDICINE AND ALTERNATIVE HEALING SYSTEM

According to the Tanzania National Health Policy; The government through the Ministry of health recognizes the role and contribution of traditional medicine and alternative health care. The recognition of traditional medicine is proved by the Traditional and Alternative Medicine Control Act of 2002, which require all individual engaging with traditional medicine to be registered (Shemdoe & Mhando, 2012). It is estimated that about 60% of the Tanzania population uses traditional medicine and alternative care healing system in their day to day life" (URT, 2003:23).

The reason behind the increasing number of rural people dependence on traditional medicine is cost of treatment in most of health centres, accessibility and affordability of health services (Muela, et al., 2000).

Due to the traditional medicine act of 2012, the Ministry of Health established office as the department dealing with registration of Traditional healers. Furthermore, The Institute of Traditional Medicine that was founded in 1974 was given more power and mandate (Shemdoe & Mhando, 2012).

Institute of Traditional Medicine (ITM)

ITM was established by Act of Parliament in 1974, currently located at the Muhimbili University of Health and Allied Sciences (MUHAS). The institute is engaging in research activities in ethno-botanical, anthropological, chemical and biological studies (Shemdoe & Mhando, 2012).

REGULATION

The Government/Central Level

The government is the controller and regulator of the health care activities through the Ministry of health. It offers guideline and remain the main financier. Based on the model of financing, the government provide subsidies to the hospital and to some of the schemes.

Through the Ministry of health, the government collaborates with other organization to assist in the provision, and promotion of health services. Other duties under according to Health Policy includes; monitoring and evaluation of health services countrywide, and policy formulation, health legislation, regulation and control (URT, 2003).

Region & District Level

The region level according to the Health policy, it is under the region secretariat which is responsible for interpreting policies into actions, supervising and inspecting of district health services. The district level, regulate all activities under district health plans, and regular reporting on implementation.

DELIVERY AND REGULATION SYSTEM

DELIVERY & REGULATION SYSTEM IN GERMANY

The Germany health care delivery system has different institutions that work separately in delivering health services. These includes;

- The Public Health Service
- Primary and Secondary ambulatory Care
- Hospital Care (Inpatient Care)

Others includes the following

- Emergence Care
- Hospital Outpatient Care
- Day- Case Surgery
- Integrated Care.

Public Health Care Service

Public health care service carries out different and specific tasks in which most of them are carried out among Länders. These activities includes both "activities linked to sovereign rights and care for selected groups such as surveillance of communicable diseases, health reporting, supervision of hospitals for ambulatory surgery and ambulatory practices of physician and non medical therapeutically professionals" (Busse & Riesberg, 2004:92).

However, there has been changes since 1970's when the rules of the Social Code Book were changed. The book was extended to include more service related activities such as individual preventive services in which were transferred to office-based physicians (Busse & Riesberg, 2004).

Other changes includes Antenatal Care being included in sickness fund's benefit package, screening of Cancer become a benefit for Women over 20 years and men over 45 years(1971), regular check up of children under six years(1989), existing of cancer screening benefits covered by SHI(cervix, genitals, breast, skin, rectum/colon, prostate) have been extended to cover colonoscopy(2003). In additional to that, vaccination services was first under public health officer but now it is carried out by physicians and this has led to improvement of vaccination rate for children (Busse & Riesberg, 2004).

Primary And Secondary Ambulatory Care

Ambulatory care in Germany is mainly provided by private for profit providers which includes a number of professionals such as physicians, dentist, pharmacists, physiotherapist, speech and language therapist, occupational therapist, and technical professionals (Busse & Riesberg, 2004).

Acute Care And Long Term Care

Acute and long term care is another form of services provided within the Germany health care system, in which it is commonly provided by non profit or for profit provider employing nurses, nurse assistant, elderly care taker, Social workers and administrative staff (Busse & Riesberg, 2004). However, since 1991, patients have free choice of physicians, psychotherapists, dentist, pharmacist and nursing care provider. Only access to reimbursed care is available upon referred by physicians (Busse & Riesberg, 2004).

Family Physicians And Specialist Physicians Care

"According to the Social Code Book (§ 76 SGB V) members of sickness funds have freedom of choosing any family physicians who cannot be changed during the quarter relevant for reimbursement services" (Busse & Riesberg, 2004:98). This has increased a number of office based specialist than that of General Practitioners (GP).

Rescue And Emergency Care

Such kind of service is most provided by ambulatory physicians, who provide the major part of health care during regular and non regular hour service. As emergency physicians, are responsible to provide rescue services including non emergency rescue, fire protection, and technical security. (Busse & Riesberg, 2004)

Secondary And Tertiary Hospital Care

The Germany health care system have separate responsibilities among hospital in provision of inpatient and out -patient care. Most hospital in Germany have traditionally concentrated on inpatient care while Acute hospital provides outpatient emergency care. It is only Universities hospitals that have outpatient facilities (Busse & Riesberg, 2004).

REGULATIONS

Regulations within the Germany health care system differ according to levels. Regulations are categorised in three levels, those that applies at federal level, Länder level and Corporatist level.

Federal Level

The federal level regulate different activities such as issues of equity, comprehensiveness and rules for providing and financing social services, all issues of SHI under Social Code Book. Other responsibilities includes the entitlements, rights, and duties of insured covered by statutory health insurance as laid down on Social Code Book. However, health social services are regulated through several statutory health insurance schemes mostly important by SHI (Busse & Riesberg, 2004).

Länder Level

The Länder level in the Germany health care system has two major responsibilities; Firstly includes, maintaining of hospital infrastructure which they do through "hospital plans" and their financing. Second, is public health service(subject to certain federal laws concerning diseases dangerous to public safety (Busse & Riesberg, 2004)

Corporatist Level

All regulation at this level are carried out by two main corporatist actors who are payers and providers. **The payers** are responsible in decision making as defined by Social Code Book. They have obligation to raise contribution from their members and to determine what contribution rate is necessary to cover expenditure. Other obligations includes negotiating prices, quantities, quality assurance measures on behalf of all sickness fund's members (Busse & Riesberg, 2004).

In additional to that, **providers** are responsible in provisional of all personal acute health care services. Corporatist are the only ones with power to offer ambulatory care. The Legal obligation to provide ambulatory care includes the following;

- The provision of out of service within reasonable diseases but not emergency care
- The physicians must provide health service as defined by both the legislature and contracts with the sickness fund.
- The physicians must provide health service defined by both the legislature and contracts with the sickness fund.
- The physicians associations must guarantee the sickness fund that this provision meet the legal and contracted requirements (Busse & Riesberg, 2004:44).

There are clear differences in regulation system, despite of the fact that much of the information on Tanzania side are not available enough to describe the healthcare system. The Germany healthcare system seems to be more constitutionalized compare to Tanzania.

3.6 EVALUATION OF TANZANIA HEALTHCARE SYSTEM

VERSUS

MODELS OF HEALTHCARE FINANCING

All healthcare systems looks different in all aspects; from health policy objectives, health financing to delivery system. However, this section focuses on three main issues

- To evaluate the characteristics of Tanzania's healthcare system against the Models of health financing
- Contrasting Tanzania with Germany healthcare system as the basis for analyzing challenges

The Beveridge model; which is characterised by tax financing is much popular in most of developed or rich countries than in developing countries. Services under this model is for all citizens, it offers universal coverage in which both the rich and poor are covered.

Tanzania healthcare system depends on public fund as the source of financing for its healthcare (WHO, 2004). This public financing includes general taxation and donor funding (Bultman, et al., 2012). However, such general taxation in Tanzania is not stable and sufficient compare to tax based financing system under Bevarage model in most of rich countries. It is the matter of fact that Tanzania like other poor/ low income countries "such system have been difficult to promote due to limited ability to raise stable and sufficient tax revenue" (Olsen, 2009:21).

The Germany healthcare system could fall in this Bevarage model of health financing due to the fact that, its tax system is stable and sufficient enough to provide healthcare system to all of its citizen, however, all rich and poor people in Germany are covered by the Statutory health insurance system which is financed by their payroll contribution. Therefore, neither Tanzania nor Germany falls in this model but rather all Nordic countries and many other

high income countries such as Italy, Spain, Portugal, Australia, New Zealand and Canada falls under Beveridge model of health financing (Olsen, 2009).

The Bismarck Model; The oldest model of health financing in the world, the main character of this model is that, it is enforced in nature, in other words, all people are required to be part of it. People contribute through their certain percentage of their wages and those who cannot contribute are also freely covered, its coverage is universal as well. It is a social insurance model founded on the notion of solidarity between workers and their families (Olsen, 2009).

Tanzania healthcare system depend on social insurance as a complimentary source and not the main source of financing. Although there is a rule of "compulsory insurance" in the NHIF. The National Health Insurance Fund (NHIF) collect payroll contribution from all public servants. All people working in the public sector are obliged to be members of this scheme and currently formal sector employees are also included (Haazen, 2012). Such scheme do not cover those in informal sector which represent a larger percent of the population and those who are poor and cannot afford to pay premiums (Bultman, et al., 2012). NHIF coverage is not universal. Tanzania healthcare system again do not fall in this Bismarck model.

There is high fragmentation among health insurance schemes in Tanzania, this is a challenge to universal coverage (Bultman, et al., 2012). Bismarck Model cannot be applied in most of low income countries like Tanzania because in most cases "contribution is a flat rate(head tax) which can be a burden for the near-poor" (Olsen, 2009:121). Social insurance model require a clear organization and some degree of autonomy from government, all these are still challenges within the Tanzania healthcare system.

The Germany healthcare system falls in this model as its healthcare financing depend on Social Health Insurance (SHI), the system was first established in Germany more than 100 years ago (Olsen, 2009). Germany has all qualities to fall in this model. First, it is one of the developed countries, Second, its population is almost covered for about 87%, Third, the benefit of SHI benefits are not determined by the ability to pay but the need which is based on solidarity principle (Grosse-Tebbe, et al., 2005). This is different with the Tanzania NHIF which has classified its beneficiaries on the basis of "Green card for senior public officers and Brown Cards for other categories of members" which currently constitute 96%, and 4% of the

total Identity Cards, respectively (NHIF, 2012). This indicate the level of unequal access to health services among Tanzanians.

Nevertheless, the Germany SHI do not cover some of the health services such as , Spectacles, Physiotherapy and Dental Services which is different with the Tanzania NHIF which offer these services as the part of funding. Such case is not only in Germany and not only among countries under Bismarck Model but it is also found among countries under Beverage model(tax system) thus, spectacles (optical services), physiotherapy and dental services are not included in the national coverage services.

In additional to that, the Bismarck models is also found in more than 60 countries, in which more than half are rich countries mainly in Europe (Belgium, the Netherland, Luxembourg, France, Austria, Switzerland) and in some Latin American countries (Olsen, 2009).

The Private Model; the model is more privately controlled and do not force people to be the members of the schemes, people are voluntarily participating in health insurance schemes, in which premiums are paid into private insurance companies. It is popular known as the American style of health insurance (Wallace, 2013), however, such model is also found in other countries in which individual need to buy health insurance to get protected against the financial cost and those who cannot afford such insurance usually remain ill or die (Olsen, 2009).

One challenge with this model is that, it is featured with inequitable access to healthcare among the people and thus most of its schemes's coverage is small and limited. Tanzania healthcare system has some elements that characterise this private model. There is a existance of private health insurace in Tanzania in which the most rich groups are covered compare to the poor groups. However, its national coverage is estimated to be only 1% of the population (Kuwawenaruwa & Borghi, 2012).

Even though, the public health insurance schemes in Tanzania such as NHIF and NSSF-SHIB are also more likely to cover only public senior officers with good package compare to other groups, this too may accelerate the service access gap and eventually inequitable and unaccess to fundamental services among the schemes members. In additional to that, in private model those individual with high risks pay higher primiums compare to those without or with low risks (Olsen, 2009). This model is found in USA and those who are out of private heath insurance are usually covered by other tax financed system. However about "50

million out of 300 million of the US population have no health insurance- neither private nor covered by publicly funded systems as the results during the need for health services these 50 million people will have to use their own pockets if they can" (Olsen, 2009:124).

Germany healthcare system is also featured by private health insurance schemes which cover small portion of population for complimentary and supplementary purpose, however, its private health insurance system is different with that of Tanzania, it is attractive for single as it charges additional fee for each dependants (Busse & Riesberg, 2004) while in Tanzania some private health insurance may include a limited number of dependants (Bultman, et al., 2012).

Out-pocket payment; the model is found in majority part of the world where public purse cannot afford to pay for health services (Olsen, 2009). In most cases where income is inadequate OOP is found to be the solution for healthcare accessibility. However, OOP can either be full or part depending on the public financing conditions. In most part of the world OOP come as the part of co-payment for some of the services. For example, in US those who can not afford private health insurance and those who are not covered by public health insurance may opt for OOP and this is limited only to those with ability to pay.

OOP is also found in Germany and its expenditure has been increasing from 10.9% in 1992 to 12.2% in 2002 of the total expenditure (Busse & Riesberg, 2004). Although, such OOP in Germany is part and not full, it is a co-payment mechanism for substantial healthcare needs such as dental, orthodontic and transport (Busse & Riesberg, 2004). While in Tanzania the OOP share has been declining from 47% in 2001 to 23% in 2007 (Bultman, et al., 2012) although the figures indicate high dependence on OOP among Tanzanians who use it as a part or full payment for healthcare services.

Furthermore, OOP as co-payment reduces the demand for unnecessary healthcare needs although such reduction in demand is usually among the poor than rich people, the rich can afford no matter how much is needed as a co-payment (Olsen, 2009). Moreover, the OOP mechanism increases the gap of services among the poor and rich, it does not pool risk across the ill and healthy as the results it pushes people into poverty (Bultman, et al., 2012).

According to Hurst, (1992), this model is the simplest and earliest form of private health care market without insurance but with direct, out pocket, fee for service transaction between consumers and first and secondary level.

3.6.1 Models that best describe

The Characteristics of Tanzania Healthcare System.

As the result of evaluation with a presentation of four models; The two models; Beveridge Model and Bismarck Model could not be able to identify and describe the key characteristics of Tanzania healthcare system due to the fact that all these two models depends on ability of the government to effectively control the tax system and Social health insurance respectively. The only models that could identify key characteristics of the Tanzania healthcare system are the Private model in somehow and the Out-pocket model at large. The mix of the two establishes the model that can best describe the characteristics of the Tanzania healthcare system.

The characteristics of the two models are likely to be found in Tanzania. Apart from NHIF and NSSF-SHIB members, majority of Tanzanians are voluntarily participating in private risk pool for protection against the financial cost of ill health. Due to government inability to provide enough and effective healthcare services, people seek better service in private facilities through their own out-pocket payment.

Tanzania health care system falls in the Out-pocket model of health financing which is much characterised by official user fee, out-pocket payment, co-payment or cost-sharing. The health care system is also featured by un-official payment and payment based on regular doctor visits. However, Tanzania healthcare system has some elements of "Beveridge Model" where Taxation is the source of financing (WHO, 2004).

In 1993 cost sharing policy was established in Tanzania due to the fact that the public funding was not sufficient enough to maintain the existing structure as the result user fees came into effect as an additional source of financing (Haazen, 2012). Not only that, but also user fee was introduced to reduce unnecessary visits to health facilities, and informal payment which also characterise out-pocket model (Haazen, 2012).

Out-pocket payment is an important component for healthcare funding but such mechanism do not contribute to equity in financing system (Bultman, et al., 2012). But rather it increases the gap of access to healthcare services due to income differences among individuals.

In addition to that, the Tanzania healthcare financing system, the fragmentation financiers (Haazen, 2012). proves the existence of high level of cost sharing and prepayment schemes

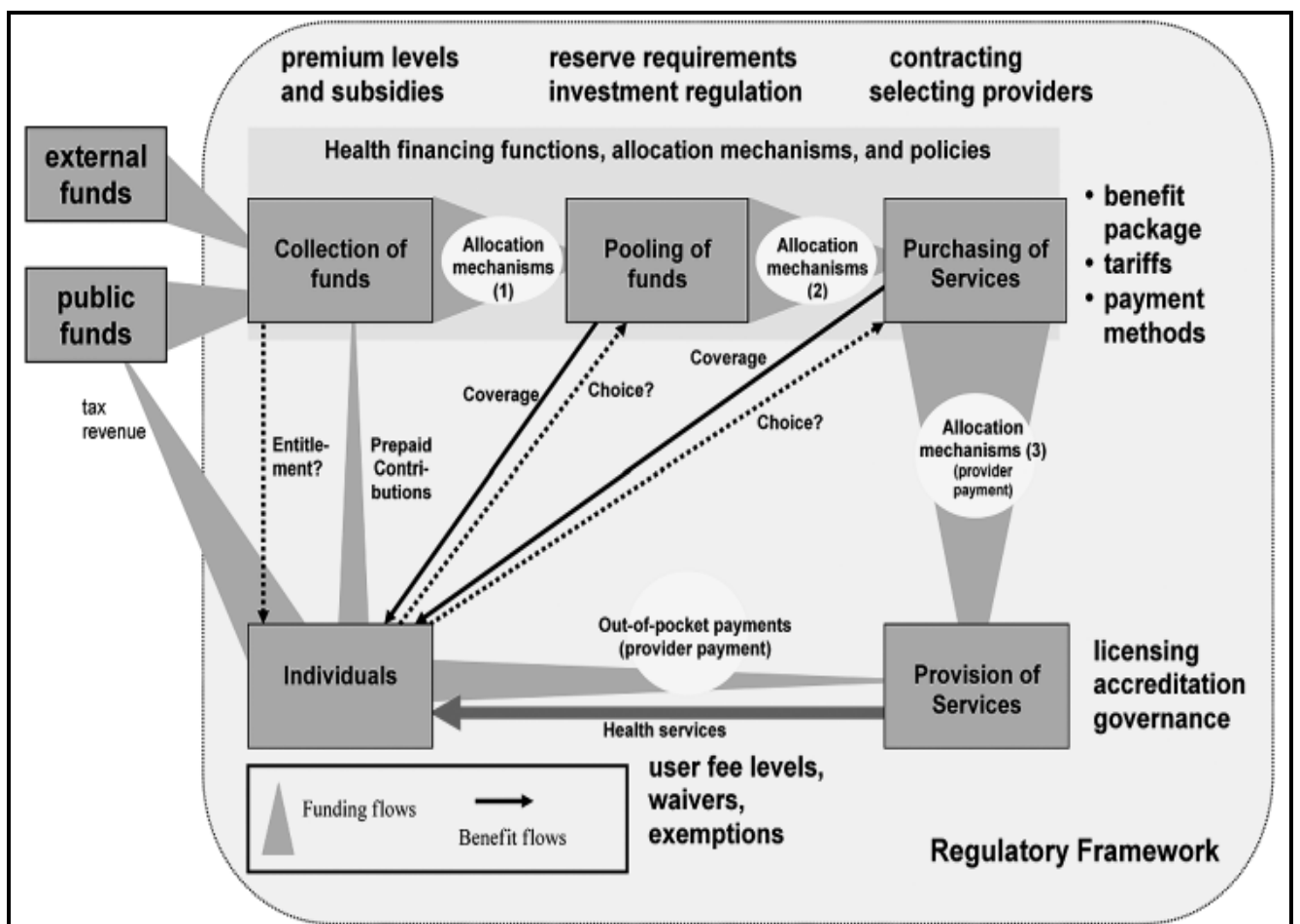
indicates how the healthcare system is characterised by out-pocket payment and insurance schemes which are considered potential for raising additional revenue for the health sector.

However, according to Haazen, "the government of Tanzania prefer to improve insurance schemes rather than increasing out pocket expenditure by patients which account about half of the total spending" (Haazen, 2012:2).

Apart from the model of financing, the level of funding is still very low, "with most funds earmarked either for salaries or for specific donor programs such as activities financed by the Global fund" (Haazen, 2012:).

Consider the framework of health financing reforms in Tanzania

Figure 8 : Framework for Health Financing Reform Options



Source: Adapted from Kutzin 2000. ((Haazen, 2012:2)

“From the diagram above, all source of financing for Tanzania healthcare system are presented. The demonstration shows how the healthcare system in Tanzania is fragmented with multiple source of financing. The diagram also presents all possible features that are found into two models that explain the healthcare system of Tanzania- The out-pocket model and private model.

The Out-pocket model includes out-pocket payments and user fee for purchasing healthcare services. The private model is presented by pooling of funds which is all about health insurance that protect individuals against financial cost of ill health.

The mentioned two model that best describe the key features of Tanzania healthcare system can also be observed in figure.8 which indicates the financing options where by external funds, public funds, pooling funds, out pocket payment and user fee are well described. The framework of health financing reforms in Tanzania demonstrate the notion of multiple or pluralist or mixed type of financing that characterise Tanzania and majority of developing countries in the world.

CHAPTER 4.0 DISCUSSION

Study Objectives

This study aimed to look at key characteristics and challenges of Tanzania's healthcare system and identify models that could best describe the features of Tanzania healthcare system. The main focus was to look at how the Tanzania healthcare system can learn from one of the OECD countries in which Germany was chosen. The data for this descriptive comparative analysis were collected from the Public documents and literatures such as case studies, research papers, and international organizations.

I presented the background of both healthcare systems as the starting point, by looking at how and where they came from, particularly the Tanzania healthcare system, which is the main area of focus within this paper. I also presented the systematic comparison that dwells on the two healthcare systems by focusing on three main aspects; health financing, health policy objectives and delivery and regulation system. Through this comparison, the key characteristics of two healthcare system were presented.

Four models were presented to identify and describe how different healthcare systems in the world are financed. The purpose of this presentation was to find out what model could describe the Tanzania healthcare system. Through, the presentation of the models, I looked at the main financing mechanism, the coverage, and how people participate within the healthcare system.

The observed facts on two healthcare system were evaluated, particularly the models of health financing against the healthcare systems. The main purpose of this evaluation was to find out, in which model does Tanzania and Germany healthcare system lies in and what model could precisely describe or characterise the Tanzania healthcare system.

All source of information were checked to avoid information based on bias and relevance of its sources. Some other information such as statistical data were omitted due to lack of connection to the study and to avoid huge amount of information.

Tanzania healthcare system was compared with the Germany healthcare system due to the fact that Tanzania is one of the poor country that is struggling to improve its economy and other areas such as healthcare system to ensure equal distribution and quality of services while as Germany as rich and well developed country was used to contrast and identify key

challenges of Tanzania healthcare system due to the fact that its healthcare system is well renowned for its advanced technology.

Main Findings

Based on the descriptive comparative analysis- results, the key characteristics and challenges of Tanzania healthcare system were identified and the model of healthcare financing were presented and evaluated.

4.1 Key Challenges And Characteristic Of Tanzania Healthcare System

According to the study on Tanzania's health system and work force crisis, the Tanzania healthcare system is facing work force crisis, which typically characterise the Tanzania healthcare system. The study revealed that there is high level of shortage of staffs, low motivation of staffs and shortage of drugs and medical equipment (Kwesigabo, et al., 2012), poor allocation of fund (WHO, 2011). Limited resource and technology is another feature that characterise the Tanzania healthcare system (URT, 2003).

The shortage of medical officers, especially doctors is very high in rural areas compare to urban areas, however, even the number of doctors working in urban areas is not sufficient enough to service the population. A survey that was conducted in 2006 found that 52 per cent of all doctors work in the Dar es Salaam region, 25 doctors were treating every 100 000 people compared with the national average of 3.5 doctors per 100 000 people and there was only one doctor or fewer per 100 000 people in 14 out of 26 regions (Kwesigabo, et al., 2012:40).

The study also found that Lack of supervision and low motivation among healthcare officers was not satisfying enough, lack of capacity to adequately complete diagnostic examinations at dispensaries and district hospitals is high among physicians in Tanzania. There is not enough supervision to carry out tasks at professional level especially among primary healthcare officers, such challenges have motivated high level of absenteeism at the rate of 40 per cent (including absences for training) (Kwesigabo, et al., 2012).

However, while the world average density per 1000 population for health worker such as clinical staff, nurses and all types of health workers is 9.3, Africa has average density of 2.3 per 1000 population compare to 18.9 health workers per 1000 population in Europe (Manzi, et al., 2012). This challenge is caused by low motivation and lack of enough incentives for

health workers in African, especially subsaharan Africa in which Tanzania has 0.39 nurses and 0.25 clinical staff per 1000 population (Manzi, et al., 2012:)

A survey of 143 health facilities in five district (Nachingwea, Lindi Rural, Ruangwa, Tandahimba and Newala Districts in Southern Tanzania, with a total population of about 900,000 in 2002) was conducted in Tanzania, aimed at looking the number of health workers available in accordance to Ministry of health (MOHSW) staff guidelines. The study found out that the MOHSW staff guideline recommends 441 clinical staff and 854 nurses for the facilities visited. However, only 20% (90/441) of the recommended number of clinical staff and 14% (122/854) of the recommended number of nurses had been employed in those visited facilities, this indicate how the country is still having a challenge on human resource within the healthcare sector (Manzi, et al., 2012).

Situational analysis on human resources for health indicated that there is a decline of human resources from 67,000 in 1994 to 49,000 in 2001/02 and thus such decline has affected the health service delivery system in the country (URT, 2007). Such shortage of health officers has also increased the burden of diseases across the country in which poor people are the main victims.

Due to shortage of health workers in most of health facilities, the number of people depending on traditional medicine and alternative has increased. The scarcity of resources and shoratage of health workers in most of medical facilities pushed the government to recorgise the traditional healers who servers most of rural population.

The Tanzania national health policy, indicated that more than 60% of the population use tradtional medicines for their day to day life (URT, 2003). In 2000, it was estimated that there were about 75,000 traditional practitioners(TP) in which the ratio of TP against the popouation was 1:400 while that of doctors to patient was 1:20,000 (Shemdoe & Mhando, 2012).

In additional to that, "over 80% of Tanzanians depends on traditional phytomecine to treat various diseases" (Shemdoe & Mhando, 2012:15). According to 'a review on some potential traditional phytomedicine with antidiabetic properties' indicates that Phytomedicine are popular for the treatment of diabetes, and many conventional drugs have been derived from prototypic molecules in medicina plants (Gunjan, et al., 2011)

An ethnographic study on the paradox of cost and affordability of tradtional and government health service in Tanzania, indicated that the increasing recognition and use of trational

medicine in Tanzania has been due to increasing cost of health services in government health facilities and thus most of poor people can not afford despite of their willingness to pay (Muela, et al., 2000). It was argued that "paying the fee is the matter of necessity rather than of willingness"(Muela, et al., 2000:298).

Moreover, the study revealed that people are more concerned with the modalities of payment to get health services whether it is a traditional clinic or government health facility. The study reported that when patients attend the government health facility were required to pay before the treatment while attending the traditional clinic the patient could decide when to pay, before or after. How payment is made at the government health facilities is through fixed cash payment while at the traditional clinic could depend on negotiations, kind, labor work or credit basis according to wealth status of the patient (Muela, et al., 2000).

However, according to The Traditional and Alternative Medicine Control Act No. 23 of 2002 (Shemdoe & Mhando, 2012) the government through the village community government appraise, assess and recommend who to be registered by an approved authority (URT, 2003).

A report on a survey conducted by the Ministry of health (MOHSW) in Tanzania on medicine and insurance coverage, reports that inaccessibility to medicine as a big challenge in Tanzania. The survey indicated that medicines are accessible to only members of schemes who counts to be 20% of those covered by different schemes (URT, 2008). The problem with medicine accessibility is even among those ensured as the study indicated. "Availability can be measured in terms of the opportunity to access the health care as and when needed" the opportunity to access medicine to both insured and not insured is still a challenge within the Tanzania healthcare system(Peter, et al., 2008, p. 165).

Regarding the distribution of health services and insurance coverage in general, the study found out that 80% of health insurance programs are only working in urban area and 80% of responses indicated that medicine benefits are accessible only to members of schemes (URT, 2008). According to the Tanzania national health policy, about 80% of the population live in rural places, majority being engaged in agricultural activities and thus these people in rural areas are victimised by unequal distribution of health services in the country and more plans are required to be done (URT, 2003).

The country health care sector still rely on foreign aid for drugs, and is widely characterized by low funding, lack of quality services, medical supplies, drugs and equipment, absence of

more specialized stuffs and inadequate reimbursement for health care providers and lack of functioning information system (Smith and Rawal, 1992 & Dominic Haazen, 2012).

A review on Tanzania health insurance regulatory framework; indicated that, there is varying degree of inefficiencies in the allocation of public funds, especially for drugs, delays in the approval and delivery of budgeted government funds, distribution of drugs that do not reflect the needs across different geographical location. All these according to the review contributes to the poor provision of health services across the country (Bultman, et al., 2012)

Literatures have pointed the reasons for poor coverage that has been a challenge for universal coverage in Tanzania and other places in Africa.

A study that examined the factors influencing low enrolment in Tanzania's health prepayment schemes (Community Health Fund) by Kamuzora & Gilson(2007:98); mentioned "inability to pay membership" contributions is identified as an important barrier. Analysis of documentary data shows that inability to pay annual contributions preventing poor households from joining the Community health fund(CHF)"

The study also identified lack of accountability as a problem as re-quoted from the findings "With regard to financial matters, we do not know what is happening. No financial report has ever been given to us.' 'They haven't told us how the money has been used. We don't understand." (Kamuzora & Gilson, 2007: 100)

In addition to that people are unwilling to pay more than minimal for health insurance coverage and people need to be made aware to be able to pay that minimal amount especially proper understand on risk pooling concept (Haazen, 2012).

Other challenges within Tanzania healthcare system includes increasing over reliance on direct payment at the time people need care; continuation of payment or fees for consultation, procedures, and over counter payment for medicines and inefficiency and inequitable use of resources (WHO, 2010). poor technology, uncontrolled price of goods and services delivered by healthcare system (Mtui & Osoro, 2011), Low absorption capacity of spending units, non release of funds, delay in the release of funds, and lengthy and cumbersome procurement process (URT, 2012)

Even though, the Ministry of health (MOHSW) recognises challenges related to healthcare services. In its report on primary healthcare service development program (PHSDP)

acknowledges that the biggest problem is inadequate coverage of the health system to deal with the health service needs of all people in the country due to the fact that there is uneven distribution of health services to different communities which is the outcome of poor infrastructure (some areas are too remote to be accessed) especially in rural areas. Such uneven distribution of health services has highly contributed to poor quality of services as some of communities are left out of health services participation (URT, 2007).

4.2 Tanzania's Challenges based on comparison between Tanzania and Germany healthcare system

The Germany healthcare system is highly advanced and well organised compare to that of Tanzania especially due to the fact that the Tanzania healthcare is more centralised under the ministry of health while the Germany is more decentralised giving the Länders and corporatist more authority.

There is a significant differences between the two healthcare systems due to the fact that the two countries differ at economic level. The difference in health policy objectives indicates how the two healthcare systems have different mission and plans which reflects the real situation and the level of healthcare system development of the country.

The Germany healthcare system is highly advanced and well organised (Jakubowski, 1998) compare to that of Tanzania especially due to the fact that the Tanzania healthcare is more centralised under the ministry of health (Mtui & Osoro, 2011) while the Germany is more decentralised giving the Länders and corporatist more authority (Busse & Riesberg, 2004).

The major source of financing are quite different, even though, some of other complimentary source are similar but different in character. As the Germany healthcare sector depend on social health insurance as the major source of financing (Busse & Riesberg, 2004), the Tanzania healthcare system depend on public financing which includes taxation and donor funding as the major financing source. It also depends on out-pocket payment, health insurance as complimentary source to fund its healthcare system (Bultman, et al., 2012) while Germany compliment its healthcare system through taxation and out-pocket payment (Busse & Riesberg, 2004).

However, we can easily understand these two healthcare system by examining the features, scope and usability of health insurance, taxation and out-pocket payment models of health financing between the two healthcare systems. Talking of the features imply the prominent attribute, scope- a situation in which these forms of payment operates and Usability- the quality of being able to provide good healthcare services.

i) Health Insurance

Health insurance system; the tradition of insuring people in Germany is for about 100 years (Olsen, 2009), and it is considered as one of the oldest healthcare system in the world (Brin, et al., 2007) compare to that of Tanzania in which is a new idea (Bultman, et al., 2012) that came into effect about 15 years ago (NHIF, 2012).

Health Insurance is the major source of financing, in which the healthcare system is dominated by compulsory contribution to statutory health insurance (Busse & Riesberg, 2004), this is different with the Tanzania insurance system in which it is considered as the complimentary source of financing, where only public servants contribution to National Health Insurance Fund(NHIF) are made compulsory (NHIF, 2012), and other people are voluntarily contributing to community and private health insurance schemes (URT, 2003).

ii) Coverage

However, only statutory health insurance cover nearly 88% of the population, while the private health insurance cover 10% of the population (Busse & Riesberg, 2004). Statistically, 98% of Germany population is covered by health insurance schemes while all health insurance schemes that exist in Tanzania are currently estimated to cover about 15% of the all population (Bultman, et al., 2012). It is clear that Tanzania healthcare system has a long way to go to ensure universal coverage to its population.

The coverage of health insurance between Tanzania and Germany is unlike, with the consideration of universal coverage, no single person is out of health insurance coverage, be it a statutory or private health insurance (Busse & Riesberg, 2004) All groups of people are covered regardless of their level of income such working individual, then spouse and their children, retired persons, unemployed and all student not above 25 years (Altenstetter, 2003). On the other hand, in Tanzania healthcare system, there is no universal coverage, and both public and formal-private health insurance schemes tend to cover high income categories and

provide comprehensive package to their members compare to informal sector schemes (Bultman, et al., 2012).

There is a wide range of choice of sickness fund, but SHI is made mandatory only for those who earn up to €47,700 (Brin, et al., 2007), and those who can not afford such as unemployed and students, for those who earn above €47,700 can either voluntarily join the SHI or choose to join private health insurance for specific coverage (Busse & Riesberg, 2004). Meanwhile, in Tanzania, the choice of sickness fund is limited, for instance, it is compulsory regardless of public servant's income to join the NHIF, but it is upon to individual people to join other schemes voluntarily (Bultman, et al., 2012).

iii) Insurance Companies/ Programs

There are about 50 health insurance companies in Germany, but private health insurance institutions are very restricted (Altenstetter, 2003) while as in Tanzania, the number of insurance companies is not known and not documented, only popular health insurance companies/ Program such as NHIF, NSSF-SHIB(public), Community health Insurance Fund(CHIF) (Kuwawenaruwa & Borghi, 2012), Tanzania private Hospital consortium, Strategis, African Air rescue (AAR), Prosperity Africa, Momentum (URT, 2008), Small Scale micro insurance Such as Chawana (Kuwawenaruwa & Borghi, 2012), VIBINDO (the umbrella organization of informal sector operators in Dar es salaam region), UMASITA(Tanzania informal sector community health fund) and UMASIDA are known (Haazen, 2011),

Furthermore, in order to promote better quality of health services the Germany health insurance market has been liberalised, and thus this new approach has increased competition among health insurance companies with high level of cross subsidization between the poor and the rich (Busse & Riesberg, 2004) while in Tanzania, the competition is limited, there is limited cross subsidization among public health insurance schemes, and no cross subsidization among informal sector schemes between the poor and the rich (Bultman, et al., 2012).

In additional to that, the question of equal access is of concern, the Germany healthcare system through its social insurance scheme and private insurance companies offers equal access to services regardless the percentage of their contribution (Brin, et al., 2007) but not in Tanzania. The review on health insurance indicates that, there is no equal access of services,

be it mandatory or private or for non insured people, this has given rise to OOP, no equity in payment into the health system, CHIF and private health insurance charges different flat fees while the public schemes charge based on contribution (Bultman, et al., 2012).

iv) Taxation

Apart from health insurance as the source of healthcare financing, another source is taxation. General taxation is one of the most equitable financing source, it pools funds from all individuals (Bultman, et al., 2012). Literatures have described how the two healthcare systems use tax to fund for their healthcare system. However, there are differences on how effective taxes are collected, and how taxes are used to fund healthcare system.

In Tanzania, VAT is the major source of tax revenue but taxation as the source of funding in Tanzania has no specific use, it is generally collected to support the health sector through general budget support or basket funding (Bultman, et al., 2012). In 2010/11 the funding through tax was about 53.9% of the of total expenditure (Haazen, 2012). While in Germany according to Hospital Financial Act, tax is used for investments cost and to fund research and training in the hospital Universities, and education in the Universities (Busse & Riesberg, 2004). Although literature indicate that the collection of tax in most low income countries tax system is not effective as high income countries due to the lack of a robust tax base and low institutional capacity to effectively collect taxes (Carrin, et al., 2005).

v) Out-pocket Payment

The out-pocket payment is found everywhere, but there are differences on how and when the out-pocket payment is made (Hurst, 1991). Tanzania and Germany healthcare system, both uses out-pocket payment mechanism as complimentary source of financing in purchasing the health services, however, the nature of OOP is different in each country. In Tanzania, Out-pocket payment are direct payments incurred by households and individuals when accessing healthcare services (Bultman, et al., 2012). Within the Tanzania communities, OOP is not for some specific health needs and it is unavoidable due to fact that the government is unable to deliver better healthcare services (Bultman, et al., 2012). Meanwhile in Germany OOP is an option to reduce expenditure when purchasing services that are not included in public health service such as dental care, physiotherapy, transportation liable to pharmaceutical cost (Busse & Riesberg, 2004). However, high level of OOP is mostly observed in low income than high

income countries and it is considered as one of the of the hindrance to accessing healthcare (Musango, et al., 2013)

vi) Donor Funding

Due to its level of development, Tanzania relay on donor support to finance its healthcare system (Mtui & Osoro, 2011). Donors such as Global Fund contribute huge amount of money to assist healthcare in Tanzania. Germany does not depend on donor but rather is one among of the donors that contribute to fund the Tanzania healthcare system. According to public expenditure review; "the foreign funding still accounts for a dominant (88.8%) share of the development budget in health intervention" (URT, 2012:13). Tanzania is one of two countries in Sub Saharan African that have registered a significant increase in the relative importance of donor funding between 2005 and 2010.

vii) Service Delivery System

The organization of service delivery system between Tanzania and Germany is different. In Tanzania health services are delivered different according to the level of administration and service. Through seven administrative levels, health services delivery ranges from family level to referral level or abroad (Kwesigabo, et al., 2012). While the Germany healthcare is delivered at three levels; the Federal or national level, the Länder or state level and the Corporatist level (Busse & Riesberg, 2004). The services are delivered by Organizations and associations that involve various services by well regulated and qualified physicians. These organizations and associations includes: 16 regional hospital organizations, Germany hospital organization, 17 regional physicians Associations, and Federal association of SHI physicians (Busse & Riesberg, 2004),

According to the Ministry of Health and Social Welfare, health services in Tanzania are delivered by different agent such as The Government (through community health post, dispensary, health centres, district hospital, national and regional hospital), Parastatal Organization (such as NSSF and NHIF) , voluntary organization , Religions Organization(KCMC and Bugando hospital), Private Practitioners and Traditional Medicine (URT, 2014).

There are differences in some areas of service delivery. Apart from the similar existence of Public healthcare service (primary and secondary care) in both of two countries there are

difference in some services. For instance, the Germany healthcare service delivery system includes ambulatory care provided by private for profit, acute care and long term care provided by non profit, family physicians and specialist physicians care, rescue and emergence care (Busse & Riesberg, 2004), all these services are not included in the national health policy as the part of delivery system in Tanzania.

viii) Regulation

The System on how to regulate the healthcare system depend on administration level. There is a difference on how different administration level carry out their daily responsibilities. The regulations are mainly influenced by how the healthcare system is either centralised or decentralised. In Tanzania, the government or central level is the controller and regulator of the healthcare activities. The central level, monitor and evaluate health services across the country while supervision and inspection are carried out by regional and district level. (URT, 2003).

Regulation for Health Insurance Schemes: "The NHIF Act does not allow for flexible contribution rate setting to enable adjustments according to need. NSSF, on the other hand, does not charge health insurance-specific contributions. The NHIF Act (Section 36 (2)) does not allow for the maximizing of financial reserves. It is therefore recommended that the GOT consider operationalization to protect NHIF members from being either overcharged or having unnecessarily limited benefits" (Bultman, et al., 2012:).

However, in Germany, the federal level regulate all issues related to equity, comprehensiveness and rules that stand for social financing activities, while the Länder level maintain and regulate the hospital infrastructure and public health services. The cooperatist level through payers make decision and negotiate prices, and quality assurance on behalf of sickness funds and through providers, the cooperatist level are responsible to regulate and provide all personal acute healthcare services (Busse & Riesberg, 2004).

4.3 DEVELOPING TANZANIA'S HEALTHCARE SYSTEM:

OPPORTUNITIES & CONSTRAINS

The opportunities and constrains that Tanzania could experience from the Germany healthcare system is crucial for the development of Tanzania healthcare system . The comparison of the two healthcare system aimed at looking in which area can Tanzania learn or experience from Germany healthcare system.

However, it is only for viable aspects that Tanzania can learn from Germany. This is due to the fact that Germany has largely invisted on healthcare compare to Tanzania. The healthcare spending in Germany is higher compare to that of Tanzania. The Germany healthcare spending accounted for 11.3% of GDP in 2012, two percentage points higher than the OECD average of 9.3% (OECD, 2014). while Tanzania spend around 6% of its GDP for healthcare (Musango, et al., 2013). The following are viable aspect to learn from Germany

a) Adequacy and equity in access to healthcare services

The major problem that face Tanzania healthcare system is unequal distribution health resouces. There is a gap among the people from rich to poor families and rural to unurban areas. The Germany healthcare system. Despite of poor economy, Tanzania can still manage a minima access to health care by ensuring all health centres receives equal number physicians, and medical packgaes while the rural areas been given priority.

In Germany the notion of " equal distribution" is stipulated in the constitution as a Basic Law that requires " All living conditions shall be of an equal distribution" although health protection and promotion is not mentioned (Busse & Riesberg, 2004:30)

b) Income Protection for patients

The Germany healthcare has successfully protected its population from payment fpr heathlcare which threaten income sufficiency and instead people pay for protection on the basis of ability to pay, this involve insurance, savings and income redistribution. However, the health insurance scheme have been made mandatory almost to all population following the regulation on income. Those who earn up to 47,000 euro need to be member of the scheme (Brin, et al., 2007). Through exemption policy, specific population, sub groups, and people with substantial healthcare needs such as children adolescence up tp age of 18 are exempted (Busse & Riesberg, 2004).

c) Clear autonomy for providers

The Germany healthcare system has put more emphasis on free choice, ready access and high numbers of providers (Busse & Riesberg, 2004). The doctors and other providers within the healthcare system have maximum freedom in matters of medical and organization innovations (Hurst, 1991). In Tanzania, providers are too limited, doctors are only employed within hospitals, lowly paid in salary form with no maximum autonomy.

d) Solidarity, Subsidiarity and Corporatism Principles

Healthcare system in Germany has been more progressive and advanced due to three principles of Solidarity, subsidiarity and corporatism.

i) Solidarity

Through solidarity principle, the government needs to take responsibility for ensuring universal access by helping those unable to participate in the private health insurance sector and let people contribute according to their (Bidgood & Clerk, 2013). This principle is well applied in Germany and since 2009 no one is left out of the coverage.

ii) Subsidiarity

In health care system, "subsidiarity means that the government is only responsible for setting the legislative framework and establishing the corporatist bargaining process" (Bidgood & Clerk, 2013:1). With subsidiarity, the Germany healthcare system has been decentralised under which policy is implemented by the smallest feasible political and administrative units in society in which the doctrine is endorsed by political parties and is embedded in the German constitution—the Basic Law of 1949 (Bidgood & Clerk, 2013).

iii) Corporatism

This involves organisations or bodies in which its governing bodies with power to make decisions are democratically elected and represent employees and employers on the governing boards of sickness funds. These bodies negotiate the terms of medical care and reflect the interests of groups such as doctors, dentists, pharmacists, the pharmaceutical industry and insurers. The important of these bodies is that it is difficult for any group to change the rules, or to raise fees or contribution rates without the consent of the other parties (Bidgood & Clerk, 2013).

The Germany healthcare has a "highly decentralised decision making and effective negotiation system between providers, parties and third third part payers at central, state and local level" (Jakubowski, 1998:61)

Apart from the aspects mentioned, there are many aspect that can be a lesson to Tanzania but unfortunately they are not viable with the Tanzania healthcare system as far its economy is concerned.

How Can Tanzania adapt or reform its healthcare system ?

The most challenging area within the healthcare sector in Tanzania is health financing system. This is not only in Tanzania, but almost all sub saharan African countries face same challenge. In Sub Saharan African health financing system are almost all pluralist, with fund collected and flowing through several sources and mechanism (Musango, et al., 2013). In most cases it includes, government, donors, households, employers and non government organization (Musango, et al., 2013). Universal coverage is mentioned as one the challenge in which only 5-10% of the population in Sub Saharan African are covered (WHO, 2010)

However, there are mechanisms or better ways in which Tanzania can improve its healthcare system based on the experience from Germany. The viable aspects such as the application of income protection, solidarity, subsidiarity, and cooperatism principles have successful been applied in other countries in Asia and Africa.

What to Avoid within the healthcare financing system

The country need to avoid over reliance on direct payment at the time people need care; The Tanzania government need to avoid fees for consultation, procedures, and over counter payment for medicines and inefficiency and inequitable use of resources (WHO, 2010), technological improvement, control price of goods and services delivered by healthcare system (Mtui & Osoro, 2011), increase absorption capacity of spending units, fast release of funds, and easy and effective procurement process (URT, 2012).

SOLUTION TO HEALTH FINANCING CHALLENGES IN TANZANIA

For Voluntary Health Insurance Schemes

a) Trust In The Integrity And Competence Of The Managers- To Win Population's Trust

There has been problems with most of health insurance in Tanzania, a study to examine factors for low enrolment of CHF in Tanzania mentioned poor management and lack of accountability as one of the challenge facing health insurance schemes in Tanzania (Kamuzora & Gilson, 2007). However, the solution to this is " trust in the integrity and competence of the managers- to win population's trust" (Carrin, et al., 2005:803).

b) Affordability Of Premiums Or Contribution

Another solution to ensure high rate of enrolment and universal coverage is 'affordability of premiums or contribution' this can be done screening which amount of premium can be affordable regarding people's ability to pay policy(unit of enrolment), avoid adverse selection, and keeping flat contribution regardless of household size up to seven members. Such techniques have been used in Rwanda to help people joint schemes that are voluntary in character (Carrin, et al., 2005).

c) Time To Collect Contribution

Due to poverty, majority of Tanzania live under 1\$, and therefore payment for health insurance on time have been challenging. The simple technique that could ensure their enrolment is "time to collect contribution". There should be specific time in which majority of household could afford to pay. For instance during specific community event or seasonal such during harvesting or contribution could be collected quarterly, yearly or seasonally (Carrin, et al., 2005).

d) The Quality of Care

Most of services delivered by health insurance in Tanzania are not of quality, Kamuzora & Gilson, (2007), have identified poor quality of services as one of the reason for low enrolment, thus people are satisfied enough and not attracted join. However, quality of care need to be taken into consideration if the country wants to ensure universal coverage to its population. This can be done through increasing quality of services such as rapid recovery,

employ good health personnel, supply good and enough drugs and nice welcome. All these features have made Maliando Scheme in Guinea- Conaky successful scheme among other scheme (Carrin, et al., 2005:804).

e) Exemption and Pro-Poor Policy

Despite of the fact that the Tanzania National Health Policy, mentioned exemption policy but in reality the practical part of it has been questioned. More strategies are needed to ensure poor people are included in the health insurance schemes. Carrin, et al., (2005) suggest that the poor house hold should be allowed to join but this should be done after intensive screening to identify the poor household, not only that but also, the churches and other charity organization should collect money and pay for identified groups of poo households. The good example of this strategy has been applied in Rwanda in which a church paid for about 300 orphans.

The schemes need to differentiate contributions according to one of four socio-economic groups such as poor, middle, upper middle and rich. Such pro-poor policy has been success - full in Bangladesh under Gonosathya Kendra (GK) scheme (Carrin, et al., 2005).

For Compulsory Health Insurance for All

Compulsory health insurance is one of the most sustainable and effective way to finance healthcare system. Such mechanism has been very successful in Germany since the introduction of Statutory health Insurace(SHI). However, some developing countries can offer a lesson to Tanzania on how to manage compulsory health insurance for all.

i) Thailand: It is one of the Asian country that have moved further cover its population. It is achievement is the result of 2001 general election campaign promise. After election, it introduced a special scheme known as "30 baht" scheme (this represent amoung of co-payment equivalent to US \$ 0.75) This schem covers all people particularly poor people who are not covered through Civil Servants's Benefit Medica Scheme (CSMBS) and Social Security Scheme (SSS) for formal private sector (Haazen, 2011:36).

Techniques: Door- to door approach, in which 44.5 Million people were signed up from April 2001 up to April 2002 (within one year), get covered as quick as possible, ensured cost control, and minima payment toward each patient 30 baht and additional government financing to protect the poor(Haazen, 2012:36)

ii) Rwanda: It has been successful in healthcare compare to its neighbour Tanzania. Fragmentation of health insurance scheme is an hindrance factor in Tanzania but in Rwanda there has been a solution to this challenge. There is one Scheme since 1998 that provide service to all people except military people who are covered by the second and only existing scheme. Rwanda Health Insurance Scheme Company (RAMA) and Military Medical Insurance. All people are obliged to join the RAMA (Haazen, 2012:44).

iii) China: Most premimu in China begun with small premiums as a condition that quickly demonstrated the value of schemes. Through this strategy many were attracted.

Other Mechanism To Raise Fund For Healthcare

Apart from heealth insurance as the mechanism for funding healthcare, there are other suggested ways in which Tanzania healthcare system could rise its fund. According to Musango, et al.,(2013:13) "Sustainable and effective health financing system that relies argerly on prepayment and pooling is firmly interlinked with a government's overall revenue raising capacity"

a) Raise Public Financing Resources

The country need to "take advantage of enomic growth by raising public financial resources through taxation and revenue generation mechanism" (Musango, et al., 2013:13). Currently Tanzania is one among of 16 countries that its total health expenditure per capital ranges between US \$ 20 to US \$ 44 (Musango, et al., 2013).

Introduction of Innovative ways to raise funds for health should also be considered. The government need to design more ways that will increase the domestic fund for healthcare, for instance increasing taxation mobile phones, foreign exchange and on product harmful to health such as tobacco, sugar and salt or transfats. This innovative ways has been successful in different countries as follows

i) Gabon :It introduced introduced a levy on mobile phones (WHO, 2010) this tax was increased up to 10% on mobile phone operators, it also introduced tax on money transfer "whereby a 1.5% levy on the post-tax of profit was imposed on the companies that handle remittances, both taxes raised an equivalent of US \$ 30 Million for health in 2009". (Musango, et al., 2013:15).

ii) Cambodia: Introduced a Health Equity Fund to cover the cost of the poor people in the country (WHO, 2010).

iii) Indonesia: it totally renovated its system by increasing the efficiency of revenue collection by avoiding "tax avoidance" which is considered to be a serious problem in many low income countries (WHO, 2010).

iv) India: it increased a significant foreign exchange market with daily turnover of US \$ 34 Billion although it is still facing challenges on distribution of healthcare services (WHO, 2010).

b) Avoid/ Reduce Out-pocket payment and Reliance on donor support

There is a need to reduce reliance on out-pocket payments through establishing new ways to increase funds that comes from prepaid sources and subsequently pooled (Musango, et al., 2013). To avoid dependence on donor (donor support); this can be achieved through increasing priority to health by increasing own investment in health by reallocating budget or by making larger claim on its funds from debt relief, transparent on spending donor fund and avoidance of wastage of resources (WHO, 2010).

According to a review of 22 low income countries, showed that through 50% increase in tobacco taxes, they could collectively raise US \$1.42 billion (Musango, et al., 2013). However, some low income countries can provide a lesson on how to effectively raise sufficient fund.

c) Political Commitment

Political will and commitment is very important not only for healthcare but also for all development interventions. Most of successful countries in health care sector, political commitment has played a major role. Development of healthcare needs dedicated and accountable people. Rwanda (with strong government leadership), China (high level of political commitment), Vietnam, and Indonesia have demonstrated how important it is for leaders to be committed to ensure availability of healthcare service (Haazen, 2012).

CHAPATER 5.0 Limitations, Further Studies & Conclusion

5.1 Limitations

Like any other study, this study should be considered with lack of some information that have not been presented. Different reforms have been taking place in Germany and Tanzania that are not included in this study. For instance in Germany, currently there is a new card system in which people will be using to access healthcare system whenever possible, but such information have not been included in this study (Obermann, et al., 2013)

In Tanzania, new development initiative has been established recently to boost speed of development in all sectors known as "Big Results Now" that has been adopted from Malaysia. However, caution should also be taken to understand that the study focused much on health financing compare to other two aspects (delivery and health policy objectives), this is because through understanding on health financing other aspect can easily be understood. The two aspects, much of its information have not been written.

The study largely used secondary data, in which most of documents could have biases, and therefore, primary methods of data collection could possibly bring different results that can be important for this study.

The study also did not involve mechanisms for healthcare providers payment despite of the fact that health financing systems were discussed in details. There are different payment mechanisms for healthcare providers. If taken into consideration could have added additional findings on this study.

Not all information about Tanzania healthcare system were presented. This is due to the fact that most of its information are not documented and some are not scientifically researched to be used for academic papers. Public documents are not easily accessed, a lot of information are missing in this study. For instance data on regulation for healthcare are not available enough to be used.

The Tanzania National Health policy that has been presented is of 2003(english version) but there is another edition of 2007 that has not been included in this study because it was hard to translate it from Swahili to English language (official translation) despite of the fact that it has no huge difference with that of 2003. The Germany health Policy objectives were from

1991 report on OECD healthcare system, as common objective for seven countries in Europe although not much have been changed compare to the current objectives

5.2 Further Studies/ Research

In accordance to the presented findings and limitations of this study, it is important for other studies to focus on single aspects rather than looking at all three aspect at a time. This will give a clear situation of each aspect. Additional studies should also look at different mechanism for providers payment that have not presented in this study. Understanding on payment mechanism for healthcare providers is very important in healthcare delivery system.

The review of heathcare policies is also important to be included into further studies, policies are important tools to understand the healthcare system of the country. Both Tanzania and Germany health policy objectives should be reviewed.

Further studies should also try to use other source of data collection and if possible they should use quantitative instead of qualitative approach. Case studies could also be interesting for further studies instead of comparing the two systems.

The comparison of healthcare system matches in significant ways if both countries compared have the same or equivalent economic levels, for instance Germany and UK, US and Canada, Tanzania and Rwanda, or Kenya and Uganda. It is challenging to compare countries are that too far different in economic levels.

Another important aspect for further studies is an assessment of resources available in Tanzania in relation to the health needs of the population. This assessment is very important in understanding the position and ability of the country to adopt and adapt new mechanism and strategies for its healthcare system.

Contribution of private sector in health should also be considered into further studies, not much about of it have been included in this study despite of its renowned contribution in Tanzania healthcare system

Resource allocation within healthcare need to be studied, this is because there is an increasing gap between the rich and the poor. Issues of equity principles and solidarity principle need to be considered.

Lastly, more studies are need on the role of community based health insurance due to its importance. CBHI are schemes that most of poor people if organised could be financially protected against illness and burden of diseases. CBHI are also important for the healthcare financing system.

5.3 Conclusion

This study is one of the rarely studies to be conducted, on the basis of comparison involving the developed and developing country which are economically and politically different.

The study has exposed different challenges and characteristics of the Tanzania healthcare system. Different financing options were also discussed in details. However, there still other challenges that were not mentioned due to the fact that the study focused on three key aspects; health policy objectives, financing and delivery and regulation.

Much emphasis need to be put in financing mechanisms which are vital and significant for the development of healthcare system. There are some progress such as health insurance coverage. Health insurance coverage is progressively raising among the Tanzanian population, this is since its introduction despite some challenges such as the cost of healthcare service, and its affordability to majority of rural and poor one people still exist.

However, rich people or wealthiest people working in the formal sector continue enjoying the benefit of healthcare provision compare to the poor and vulnerable groups. According to Kuwawenaruwa & Borghi, (2012:4); "the diversity of schemes, in terms of contribution rates and benefits offered, means that the effect of insurance is inconsistent, both in terms of the amount and nature of services received by members".

The government in associations with other stake holders in the healthcare sector need to availability of affordable insurance options for poorer groups and ensuring greater uniformity in the benefits offered across schemes in order to improve health system equity through setting affordable premiums for schemes. (Kuwawenaruwa & Borghi, 2012)

Apart from affordability of services, geographic accessibility, availability, financial accessibility, acceptability, or quality of care (Peter, et al., 2008) are also important to ensure equity, equality, quality of care and reduction of disease burdens. Due to that more strategies are need to be put into place to increase number of health facilities close to the rural population, improve the quality of healthcare, avoid all possible barriers to avoid financial hardship.

Further studies should focus on how the government can avoid or reduce the dependence on donor support, out-pocket payment and user fees that increases financial burden to the population and gap among the people.

Once and for all, the presented model best described the Tanzania healthcare system, and the comparison with Germany contrasted well and identified key differences that are crucial and vital for development of Tanzania healthcare system . However, any further study that could re-evaluate the research question and look at it deeper, could be of interest. Based on presentation of different models of healthcare financing system, different payment mechanism, recent technologies and development could be identified to describe any developed or developing country.

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