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Tanzania Comprehensive Health Commodities Financial Needs Assessment

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Presentation Outline

I. Overview of Comprehensive Health Commodities Financial Needs Assessment

II. Assessment Results

III. Strengths & Limitations

IV. Recommendations

Introduction

- Despite significant improvement in the supply chain over the decades, unavailability of medicines has continued to be a major block into realizing the intended population health of Tanzanians

- **Adequate financing** and **operational efficiency** are the major factors attributing to availability of health commodities

- **Lack of a total/ holistic approach** in estimating the total health commodities financial needs, makes it unclear whether:
  1. the current funding envelope from all sources is sufficient to cover total needs, or
  2. better management of direct funds to health facilities will realize efficiency gains and hence minimizing any financial gap that may exist

Assessment Overview

The comprehensive health commodities financial needs assessment provides insights into facility level needs.

Purpose: Assess the range of funding sources available at a facility and compare to the total commodity needs for each facility

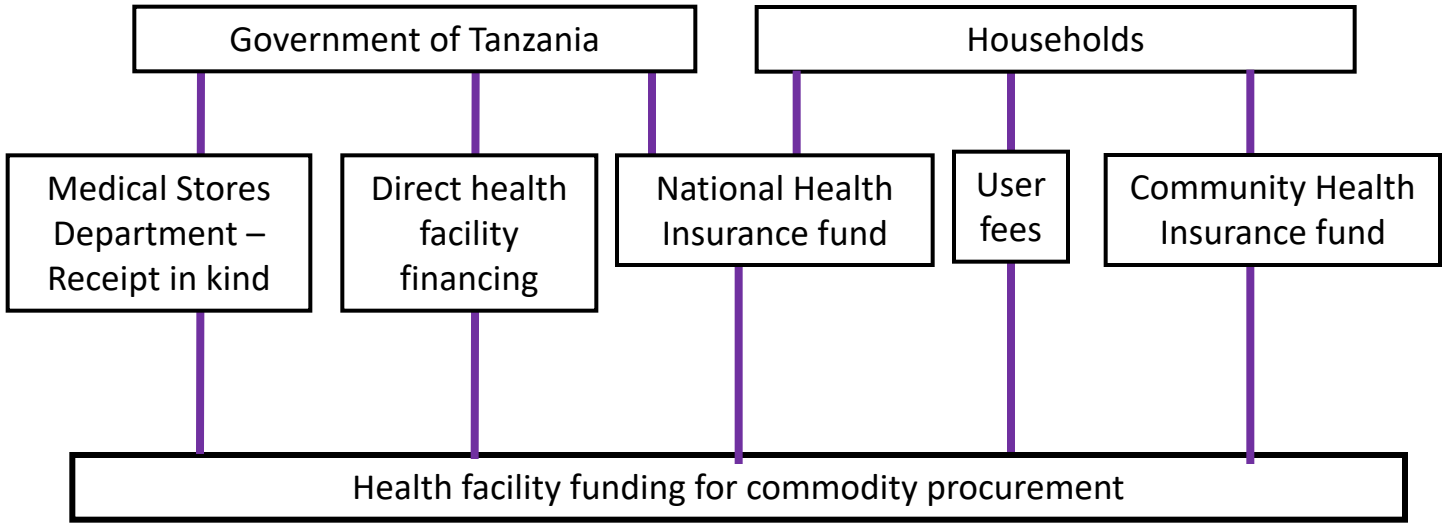
Assessment Objectives:

- Assess representative total health commodities financial needs for a health facility
- Identify available funds to cover the financial needs estimated for health facility
- Define any financial gaps
- Determine Medical Stores Department (MSD) market share

Overview of domestic health commodity financing in Tanzania

- Domestic financing for health commodities flows through several channels

Vertical program commodities largely covered by donors



- Medical Stores Department (MSD) is a semi-autonomous department under the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) responsible for procurement, storage, and distribution to all public sector facilities in the country. MSD is the supplier of first resort for health commodities.
- Facilities can use any funding source to procure products from MSD. In case of a stockout at MSD, facilities must be notified by MSD and then can procure from other sources

Methodology

Data was collected from 152 facilities covering on average 133 unique commodities per facility for fiscal year 2016 – 2017

152

Health Facilities

Public health facilities and faith based organizations across 14 regions including:

- 80 Dispensaries
- 48 Health Centers
- 24 District Hospitals

86% of the facilities are located in the rural areas

6% of the facilities in 1 region (Shinyanga) participating in the prime vendor model

47% of the facilities across 6 regions participating in Results Based Financing

133

Average Unique Commodities Ordered per Facility

The assessment covered the following systems and commodity types:

- ILS System
- ARV System
- TB and Leprosy System
- Vaccines
- Medical Equipment and Supplies

The number of commodities managed on average were:

- Dispensary – 100 commodities
- Health Center – 143 commodities
- District Hospital – 219 commodities

14

Average Data Collection Days

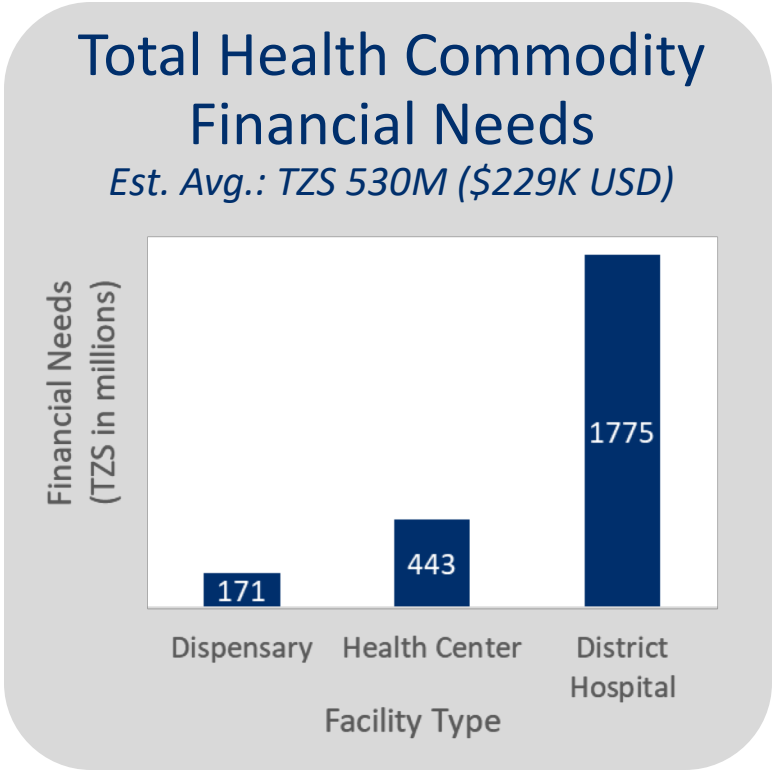
Data collection was performed by 50 data collectors from MOHCDGEC, PORALG, and GHSC

Data collection was performed from February 14 – March 2, 2018 with the following average data collection time:

- Dispensary – 1.4 day
- Health Center – 2.0 days
- District Hospital – 3.6 days

ASSESSMENT FINDINGS

Average health commodities financial needs by facility type

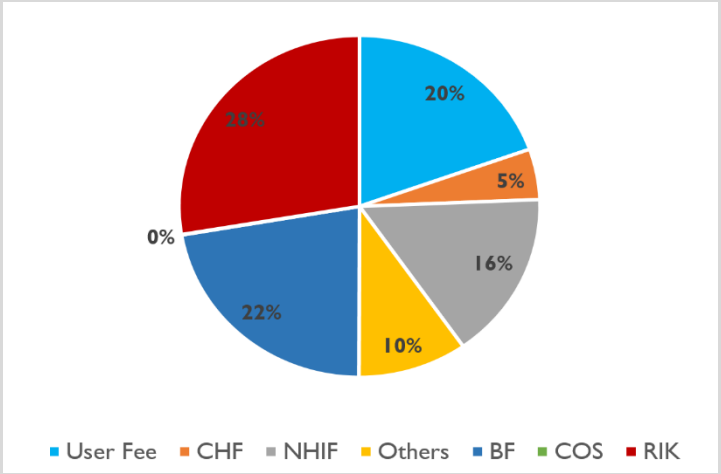


Key Takeaways	District Hospitals had the greatest financial needs across facility types Based on the estimated average total health commodity financial needs, TZS 2,055B allocated for the health sector in fiscal year 2016 – 2017 would only cover the needs of district and lower level health facilities
Contributing Factors	Number of patients served Facility location - rural vs. urban Skilled staff Results based financing

Average funds available across all facility types

2016/2017 Average Funds Available

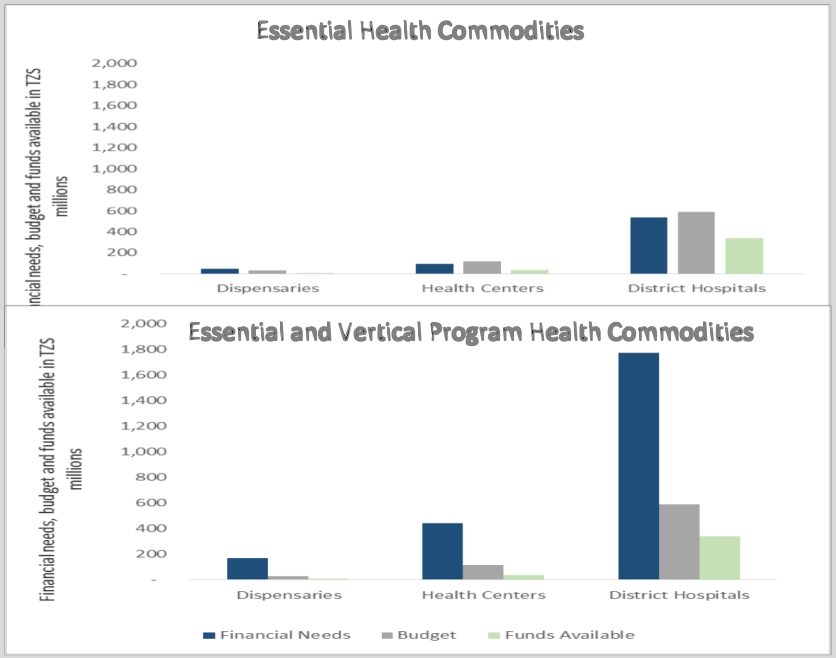
Est. Avg.: TZS 126.5M ($55K USD)



Key Takeaways	Receipt in kind funds made up the highest contribution at 28%. The significance of receipt in kind as a percentage of estimated funds available differed decreasing in higher facility levels. It was challenging to disaggregate sources as all funds were lumped together upon collection/disbursement and expended as a whole. The introduction of Facility Financial Accounting and Reporting System (FFARS) since 2017/18 will likely address this challenge.
Contributing Factors	Facility location - rural vs. urban Results based financing Funds used for health commodities

Average financial needs vs. budget and funds available by facility type

Average financial needs, budget & funds available

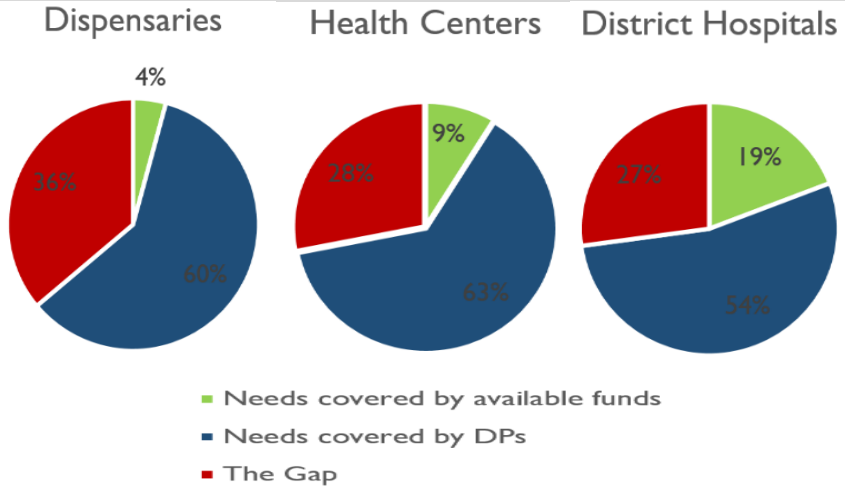


Key Takeaways	Available funds run short of the essential commodity needs. For sustainability reasons, the comparison between health commodity needs in totality against budget and funds available is important.
Contributing Factors	Facility location - rural vs. urban Results based financing Funds used for health commodities

Average financial gap for all health commodities

Average Financial Gap across facility types

Est. Avg.: TZS 142M ($62K USD)

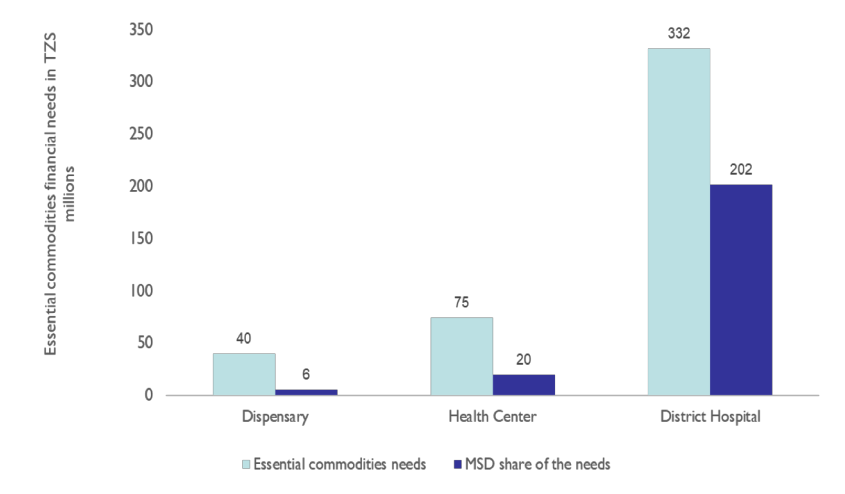


Key Takeaways	Most of the financial needs for health commodities are covered by vertical program commodities. The financial gap is highest for dispensaries.
Contributing Factors	Patients served Facility location (urban vs. rural) Skilled staff Results based financing

MSD share of the essential health commodities financial needs

Average MSD market share across facility types

Est. Avg.: 59% All Sources, 36% Only Complimentary Funds



Key Takeaways	An average of 59% of all health commodities expenditure from all sources was made within MSD which mirrors the high reliance on receipt in kind funds especially for dispensaries (79%). Such expenditures include complimentary funds deposited to MSD for additional health commodities procurement together with the quarterly deliveries of commodities from the RIK funds. However, when considering only complimentary funds used for health commodities expenditure, the share dropped to an average of 36%.
Contributing Factors	Prime vendor model Funds used for health commodities

Strengths and Limitations

Strengths

- Active collaboration, input, and investment from the Government of Tanzania MOHCDGEC and PO-RALG
- Establishment of benchmark given large scope covered
- Use of scientific methods which can be replicated for future analysis

Limitations

- Data accuracy and data quality
- All information collected from ledgers which may differ from the dispensing registers providing increased values for specific data fields (ex: stock-out days)
- Price data obtained from multiple sources when not available in the MSD price catalogue

Recommendations

- Increase social insurance base as a model towards attainment of universal health coverage
- Increase MSD's visibility in two way tracking between MSD and health facilities as recommended in the system redesign
- Increase MSD scope by tapping into available complimentary funds and improve the implementation of the Drug Revolving Fund
- Use the 2016/17 MSD market share data as a baseline to track MSD performance through various systems
- Change health system financing model from input to output financing e.g. results based financing as it has been shown to increase efficiency
- Use innovative funding sources to increase domestic funds e.g. raise new taxes in tobacco/alcohol earmarked to health care

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