Complimentary Funds for Health Commodities

Sikika

2015

EXECUTIVE SUMMARY

The government of Tanzania has been trying to find ways of increasing budgets for improving health services and reducing health sector budgetary gap. One of the strategies introduced is the use of complementaryfunding arrangements, that is, other sources of funds apart from what is centrally allocated by the government and includes; Out of Pocket (OOP), health insurance funds (National health insurance Fund (NHIF), Community Health Fund (CHF), Tiba kwa Kadi (TIKA) and health basket funds.

In 2015, Sikika assessed the management of complementary funds from selected public health facilities in ten Local Government Authorities (LGA) in order to get a better understanding as to why facilities still experienced shortages of health commodities despite the availability of complementary funds.

The analysis covered two consecutive financial years of 2012/13 and 2013/14. The study looked at the collection and expenditures of complementary funds in relation to central budget allocation on health commodities and also the existing guidelines on the use of complementary funds in sampled LGAs and health facilities. It was envisaged that findings from this study would help Sikika to design advocacy campaigns that would enhance effective and efficient use of complementary funds for improved availability of health commodities in the country.

This was a retrospective study that was conducted in two phases. Phase one was conducted in 2015 where financial information on three types of complementary funds (user fees, NHIF/CHF/TIKA and basket funds) for procuring health commodities was collected using a structured questionnaire. The comparative analysis for two consecutive years (2012/13 and 2013/14 FYs) was done to find out to what extent money from complementary funds do the sampled LGAs raised from the cost-sharing channels and what is their proportion on health commodities' budgets as compared to the government budgets.

Findings showed that the overall central government budget allocation is not sufficient to cater for the health commodities' demand at the LGAs surveyed with the exception of Kibaha, Temeke (2013/14) and Ilala (2013/14). Despite the fact that demand for health commodities is almost the same for the LGAs of Temeke, Iramba and Mpwapwa, the government allocation is not proportionally the same. Findings also showed a huge contribution of complementary funds in purchasing health commodities in the LGAs and health facilities surveyed, but the management of these funds remains questionable.

The study recommends that central government should make sure that either the existing guidelines are streamlined or develop and disseminate new guidelines to enhance easy management of complementary funds especially at health facility level where now in addition to the collection, planning and budgeting, direct financing is also done. Health facilities should be encouraged to use the guidelines for the management of complementary funds in order to improve availability of health commodities. Councils to oversee the management of the complementary funds in terms of planning and allocation as according to the guidelines.

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1. INTRODUCTION

Essential health commodities (medicines and medical supplies) is one of the core elements of a primary health care system that is necessary to accelerate the intention to achieve "health for all" (Declaration of Alma Ata, 1978). However, access to medicines in terms of availability and affordability, remains a major global health concern towards achieving Universal Health Coverage., limiting the move towards Sustainable development goal no 3.(8).

Estimates in developing countries show that only one third of medicines are available in the public sector whereas the remaining two thirds are provided by private facilities in higher prices (Raniah A, 2017)..
In Tanzania, public health facilities are required to purchase essential health commodities from Medical Stores Department (MSD), however due to poor availability at MSD, health facilities have to purchase health commodities from private facilities in order to complement what is missing from MSD, using complementary funds. MSD ability to fulfill health facilities' order stood at 73% in 2015. (Strategic review of MSD, 2015).

Insufficient funds for purchase of heath commodities is the main contributing factor for poor availability, accessibility and affordability of health commodities; others include weak management system of funds on the utilization of cost sharing revenues and so on (IHI, 2013). In Tanzania for example, for years; budget for health commodities has been below 50% of the quantified needs (Sikika, 2015). The government allocations (block grants) are far less than need estimates of about 577+Bilion Tsh (Strategic review of MSD, 2015).

Potentially this means that shortages and frequent stock out of essential health commodities are unavoidable. The government of Tanzania has been trying to find ways of increasing budgets for improving health services and bridging the budgetary gap, one of the strategies introduced was the use of other sources of funds to complement the government budgetary allocations here termed as complementary funds, which includes Out Of Pocket payments (OOPs), health insurance funds (National health insurance Fund (NHIF), Community Health Fund (CHF), and Tiba kwa Kadi (TIKA)).

Despite availability of different sources of funds, that could be utilized to reduce or narrow the budgetary gap, availability of health commodities in most of the public health facilities in Tanzania has been low for a trend of time. Globally, statistics indicate that the median availability of tracer medicines in public and private outlets is 23.4% and 47.9% respectively (World Health Statistics, 2014). Specifically, in Tanzania the average availability of the tracer items according to NIMR, 2011 was 21% in the year 2008 - 2009 and 37% in the year 2012 (MOHSW, 2013). As we go for publishing of this report, availability of health commodities at public health facilities according to RMO and DMO annual conference in 2018 was around 94%. Despite this increased availability MSD ability to fulfill health facilities continued to decline, average order fulfillment rate stands at 54% in 2018(MSD) as opposed to 73% mentioned earlier. This indicates that complementary funds play a big role in covering availability of health commodities.

Sikika, in 2015, assessed the management of complementary funds from selected public health facilities in ten LGAs. The analysis covered two consecutive financial years of 2012/13 and 2013/14.

Specifically, the study looked at the collection and expenditures of complementary funds in relation to central budget allocation on health commodities and also the existing guidelines on the use of complementary funds in sampled LGAs and health facilities.

2. STUDY OBJECTIVES

Generally, this study was conducted to assess the collection of cost-sharing funds at the health facilities and expenditures of these funds on health medicines and other commodities in sampled LGAs and their health facilities.

Further, the study assessed any existing guidelines that provide instructions on the use of the complementary funds on the purchase of health commodities. It was envisaged that findings from this study would help Sikika to design advocacy campaigns that would enhance effective and efficient use of cost sharing funds for improved availability of health commodities in the country. Specifically, this study aimed to;

1. Identify demand and budget allocation for health commodities in ten LGAs,

2. Find out proportions of complementary funds on health commodities' expenditures in ten LGAs, and

3. Compare central budget allocation to complementary funds on health commodities to in ten LGAs

4. Assess health providers' awareness on existing guidelines for the management of complementry funds in selected health facilities.

3. STUDY METHODOLOGY

This study was conducted in two phases. Phase one was conducted in 2015 where financial information on three types of complementary funds (user fees, NHIF/CHF/TIKA and basket funds) for procuring health commodities was collected using a structured questionnaire.

The comparative analysis for two consecutive years (2012/13 and 2013/14 FYs) was done to assess the trend of collection and allocations of complementary funds on health commodities. The response rate was 8 LGAs of Temeke, Ilala, Kinondoni, Mpwapwa, Singida rural, Simanjiro, Kibaha and Iramba) although initially, the plan was to cover all the ten LGAs that Sikika was operating, but due to missing of some of important data, some of the LGAs were dropped during analysis.

Interview was done with the districts' pharmacists to provide information on total demand estimates for health commodities for the district as well as budget allocation from both central government and available complementary funds.

Phase two was conducted in 2016 to assess awareness of health providers on existing guidelines for the management of complementary funds. 46 health facilities (31 dispensaries, 12 health centers and 3 hospitals) from 10 LGAs were involved. A structured questionnaire was used to collect information from facilities' incharges. Moreover, to triangulate the information given by in-charges, interviewers asked in-charges to provide copies of the guidelines mentioned during the interviews.

4. STUDY FINDINGS

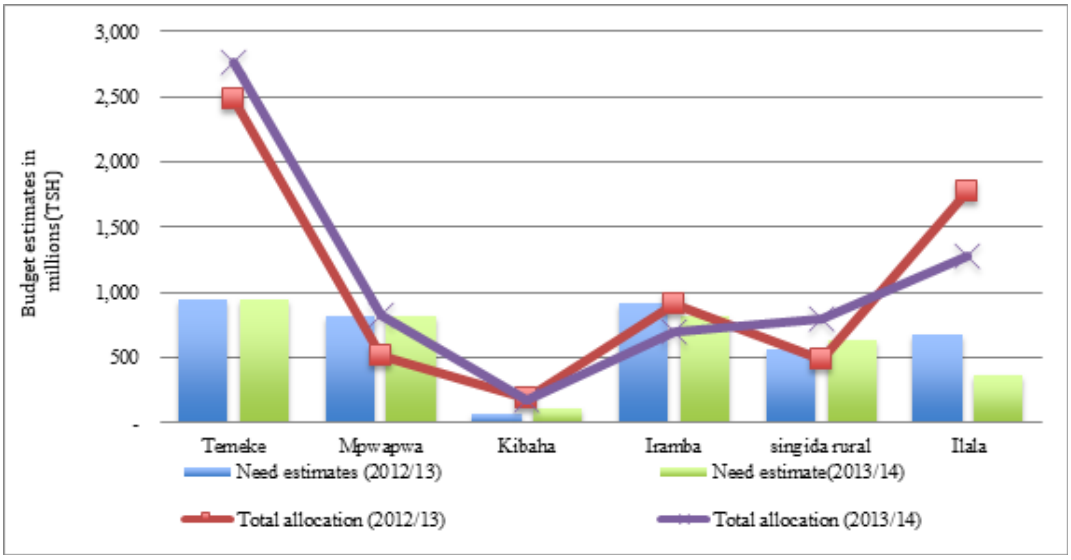
4.1 Budgetary estimates vs. allocations of budget for health commodities

This objective was designed to get a snapshot of budgetary estimates for health commodities against their allocations in the interviewed LGAs. The following are the summary results.

4.1.1 Budgetary estimate vs. total budget allocation for essential health commodities

Overall funds allocation is a combination of all sources of funds used on health commodities' expenditures. Analysis shows an equal relationship between budgetary estimates of health commodities and their allocations in almost all the LGAs, except for Temeke and Ilala where, the allocations exceeded demand by more than 100%. Figure 1 shows a relationship between need estimates and their overall allocations in 2012/13 and 2013/14 financial years.

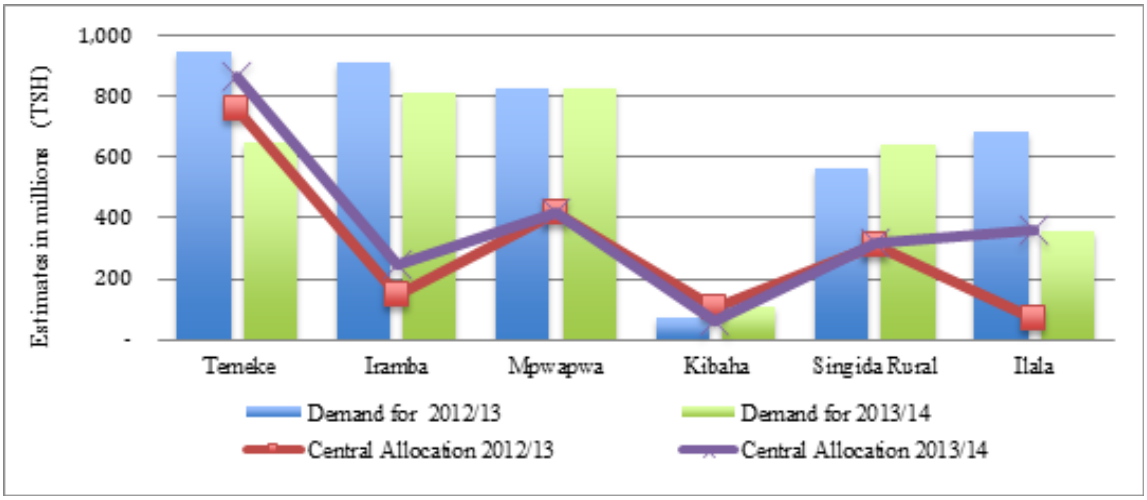
Figure 1: The relationship between demand estimates and total fund allocation for health commodities



4.1.2 Demand estimate for essential health commodities vs. central government budget allocations

In all the LGAs reviewed except for Kibaha, Temeke (2013/14) and Ilala (2013/14), demand estimates for essential health commodities were higher than funds allocated from the central government. The biggest gap are observed in Iramba (for both years) and Ilala (2012/13) where the average demand estimate were more than 3 times higher the allocated funds from central government (Figure 2)

Figure 2: Demand estimates VS Central budget allocation for essential health commodities



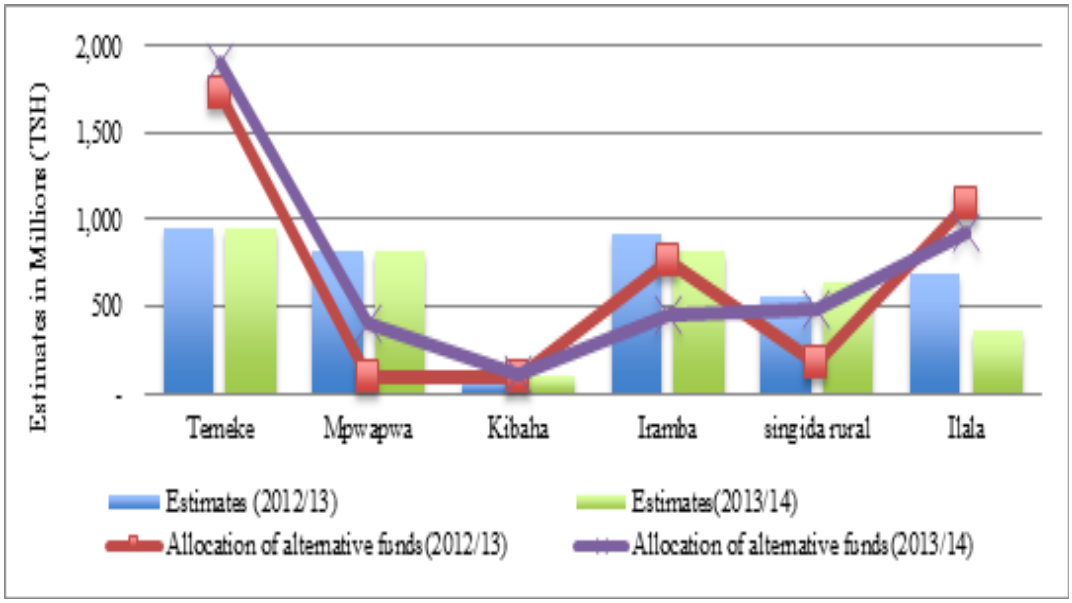
4.2 Proportions of complementary funds on health commodities' expenditures

The analysis shows the overall contribution of complementary funds on health commodities expenditures in the LGAs interviewed. It further shows proportion of individual source of fund on health commodities' expenditures for the financial years 2012/13 and 2013/14. The percentage was computed from the total available fund from the specific source allocated to health commodities.

4.2.1 Overall contribution of complementary funds on health commodities' expenditures

The findings show that, allocation from complementary funds alone was two times higher the demand estimates for Temeke and Ilala LGAs, and was almost enough to cater for the demand estimates in Kibaha, Iramba and Singida rural. (Figure 3).

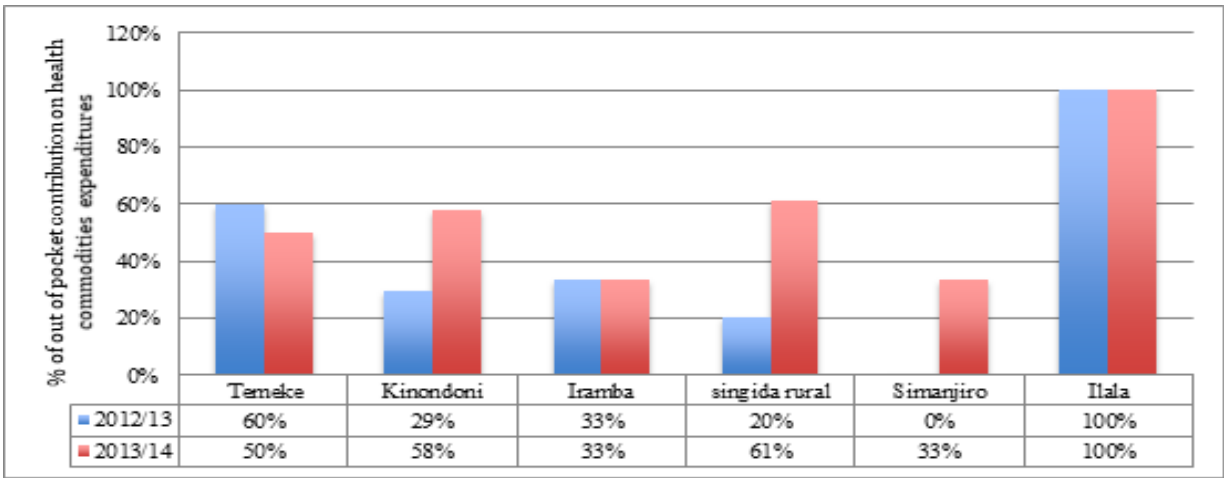
Figure 3: Allocation of complementary fund on health commodities expenditures



4.2.2 Contribution of out of pocket (OOP) on health commodities' expenditures

Figure four shows contribution from out of pocket expenditures on health commodities for the two consecutive years. The contribution varies across LGAs whereas almost all the LGAs were found to use less than 50% of the collection for health commodities, with exception to Temeke district which used 60% of OOP collected in the year 2012/13, Singida used 61% of the collection in the years 2013/14 and Ilala, which used all the collection (100%) in both years. Simanjiro had the missing information for the year 2012/13 hence zero value is indicated.

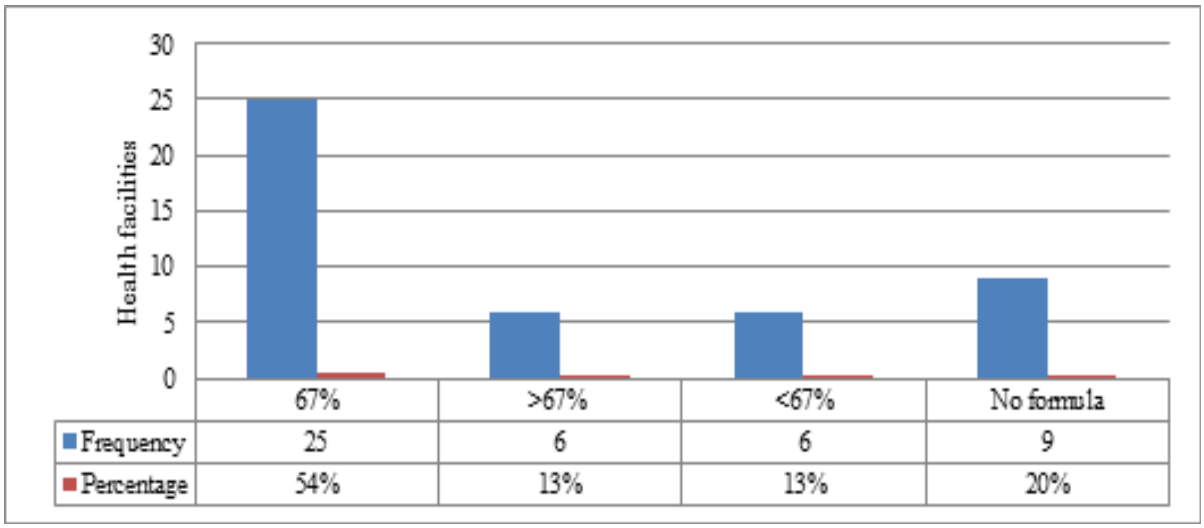
Figure 4: Percentage contribution of out of pocket collections on health commodities' expenditures



	Temeke	Kinondoni	Iramba	singida rural	Simanjiro	Ilala
2012/13	60%	29%	33%	20%	0%	100%
2013/14	50%	58%	33%	61%	33%	100%

Analysis from the selected health facilities shows that, majority of health facilities 25(54%) use 67% of the fund collected from out of pocket on health commodities, this is aligned with the information obtained from the LGAs. Figure (5) five shows responses from the health facilities on percent of OOP that is used on purchasing health commodities.

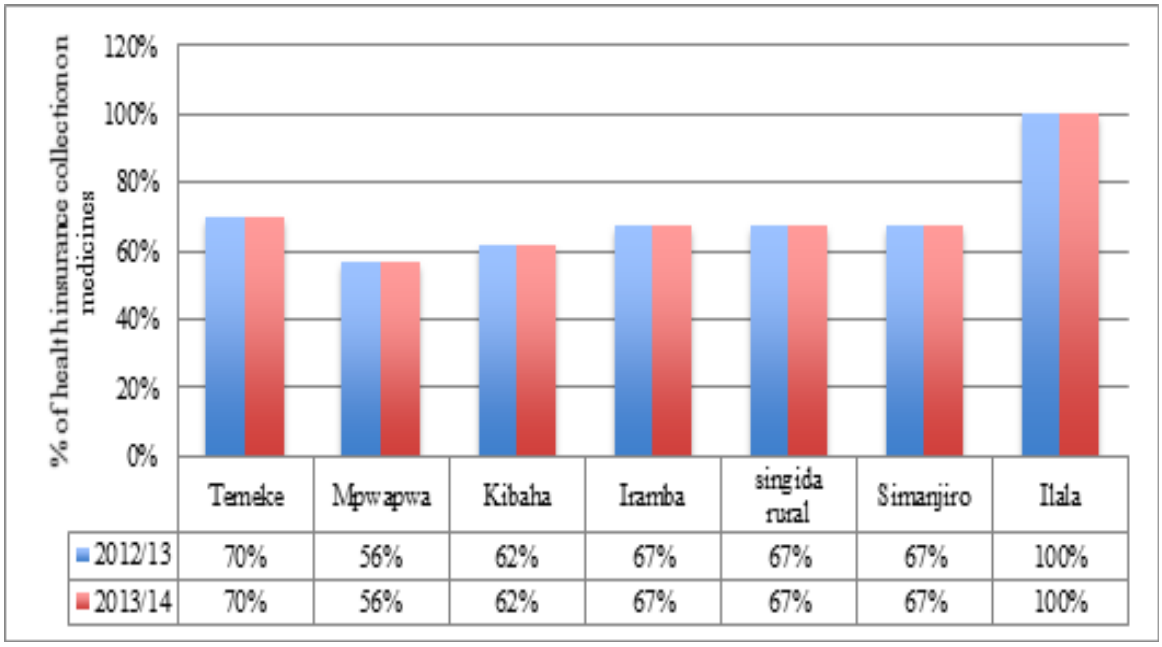
Figure 5: Responses from health providers on the percent use of user fees on health commodities (N=46)



4.2.3 Contribution of insurance (NHIF, CHF/TIKA) on health commodities' expenditures

For the health insurance fund (NHIF, CHF/TIKA), Percent allocation was found almost constant in all the LGAs. The analysis shows, all the LGAs with exception to Mpwapwa, allocated more than 60% of the collection on health commodities. Figure (6) six shows allocation of health insurance fund on health commodities' expenditures for 2012/13 and 2013/14.

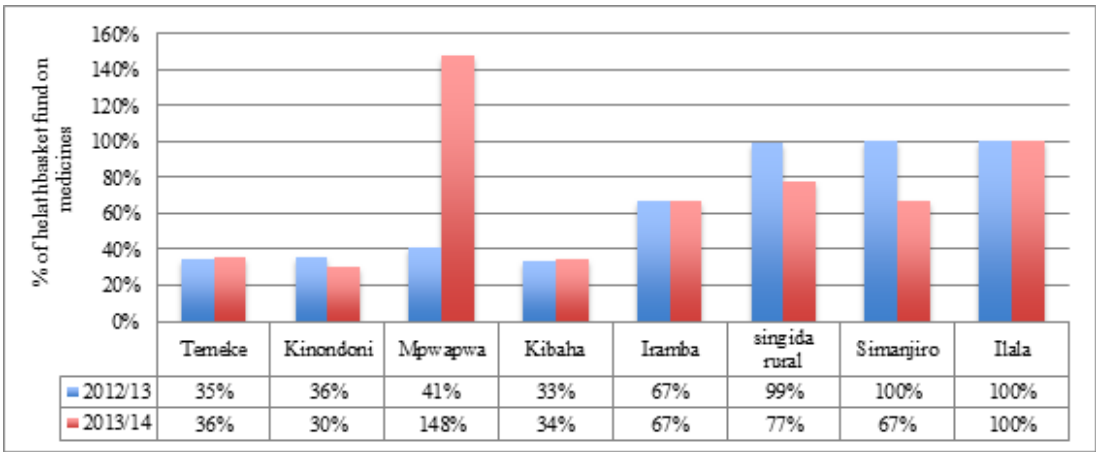
Figure 6: Percentage contribution of health insurance on health commodities' expenditures



4.2.4 Contribution of the basket funds on health commodities' expenditures

For the case of basket funds, the analysis shows mismatch of allocations within and across the LGAs. There are LGAs, which used the entire available funds while others used a quarter of it on health commodities. Findings also show huge differences of allocated proportions in different years for the same LGAs. For instance, Mpwapwa allocated 41% and 148% of the funds on health commodities in 2012/13 and 2013/14 respectively. On the other hand; Ilala used all funds on health commodities while Temeke, Kinondoni and Kibaha used only a quarter of the funds (figure 7).

Figure 7: Percent contribution of basket fund on health commodities' expenditures

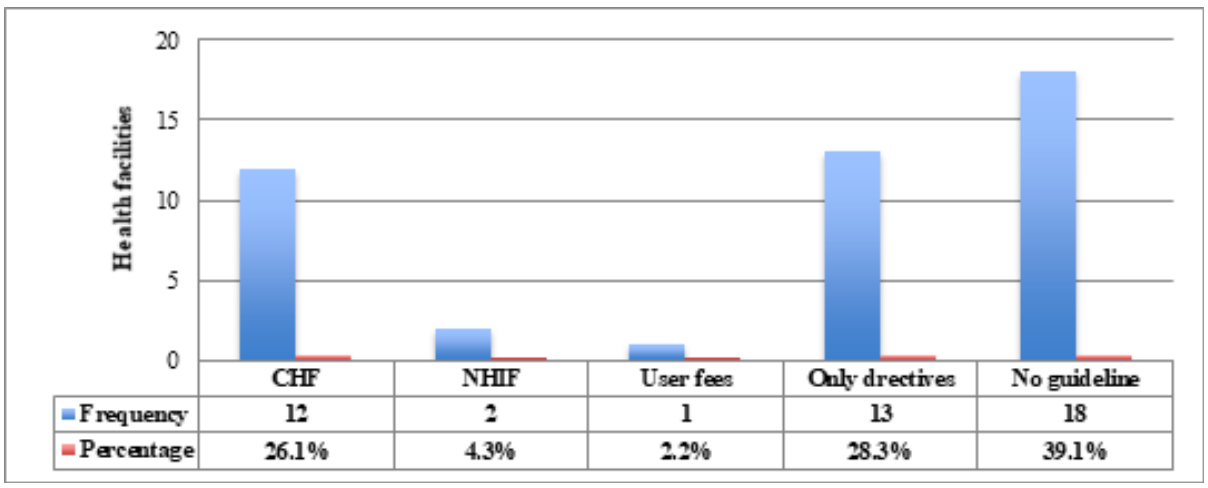


	Temeke	Kinondoni	Mpwapwa	Kibaha	Iramba	singida rural	Simanjiro	Ilala
2012/13	35%	36%	41%	33%	67%	99%	100%	100%
2013/14	36%	30%	148%	34%	67%	77%	67%	100%

4.3 Health providers' awareness on existing guidelines for the management of complementary funds at health care facilities

Findings show that, 60% of the respondents (28) were aware of the existing guidelines for the management of complementary funds in their facilities. Out of that number, 26% (12) mentioned the existence of the CHF guidelines, 4% (2) mentioned the NHIF guidelines, 2% (1) mentioned user fees guidelines and majority 39% (18) mentioned the existence of directives such as letters and circulars from PORALG (then PMORALG) and MOHCDGEC (then MOH) for the management of complementary funds (figure 8). While others referred to guidelines for the establishment of council health boards and health facility governing committees as the one for complementary funds, the study was not able to obtain a physical copy of any of the mentioned guidelines .

Figure 8: Health providers' awareness on existing guidelines for complementary funds (N=46)



	CHF	NHIF	User fees	Only drectives	No guideline
Frequency	12	2	1	13	18
Percentage	26.1%	4.3%	2.2%	28.3%	39.1%

5. DISCUSSION

Overall, the government budget allocation was not sufficient to cater for the health commodities' demand at the LGAs surveyed with the exception of Kibaha, Temeke (2013/14) and Ilala (2013/14). Despite the fact that demand for health commodities was almost the same for the LGAs of Temeke, Iramba and Mpwapwa, the central allocation is not proportionally the same. Further research is needed to find out the reason for this disproportionality; possible reasons could be the quality of data used in computing the allocation using the "allocation formula ".[1]

The overall contribution from complementary funds seem more than what needed to bridge the budgetary gap (surpasses the estimated needs). At the time of publishing this study, complementary funds have played a big role to positively affect availability at health facilities up to an average of 94%. (RMO meeting 2018). OOP has been cited as the next most important financing source after donor funds (Mtei, G et all 2014). However, the burden of OOP payments is significantly large among the poorest segment of the population who remains unprotected against financial risks and sometimes denied access, limiting the move towards universal coverage (ibid).

Since availability of total funds available appeared to be much higher than the estimated budgetary demand, is possible that demand estimation is done basing on inaccurate or incomplete data. Sikika has observed duplication of important data used for planning and budgeting in CCHPs from one year to the other during social accountability exercises. (Sikika 2013), leading to incorrect estimation.

On the issue of the guideline used on how much from the complementary funds should go to purchasing health commodities, none of the interviewed was able to name or physically provide any guideline used for the management of complementary funds. However they were able to tell the percentages required to apportion these complementary funds. The absence of the formal guidelines for the management of complementary funds, especially at facility level can as well contribute to low availability of essential health commodities as the funds available may be used to other expenditures than to health commodities.

[1]It is the main principles that the Pharmaceutical Service Section at the MOHCDGEC uses to allocate block grants for health commodities. The criteria used for allocation are: firstly, allocation according to the type of health facility, whereby hospitals get 40% of the total allocation, primary health facilities get 50%, and other services get 10%; secondly, allocation according to serviced population, whereby district population receives 70%, poverty count 15%, and under-five mortality 15 %

6. CONCLUSION AND RECOMMENDATION

This study aimed to assess the management of complementary funds and their existing guidelines in sampled LGAs and facilities. Findings show a huge contribution of complementary funds on health commodities in the LGAs and health facilities surveyed although its management remains a questionable. It was also found that there is either lack of awareness on existing guidelines among the participants or no existence of such guidelines at the facilities, which direct the usage of the complementary funds on health commodities.

However at the time of publishing this report in 2018, Direct facility Financing (DFF) had been introduced for management of health basket funds at health facility level. Although its implementation has started, health facilities are facing challenges in managing other complementary funds in a sense that they have to follow different guidelines in managing one facility account.

The following are recommendations derived from these findings;

1. The central government should streamline the existing guidelines for the management of complementary funds and disseminate to the facilities for ease management of these funds.

2. LGAs should ensure the service providers understand and use the guidelines for the management of complementary funds in order to improve availability of health commodities at the facilities.

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