



PROSPECTS FOR SUSTAINABLE HEALTH FINANCING IN TANZANIA

Brief

Katie West-Slevin and Arin Dutta
Health Policy Project, Futures Group

Overview

While Tanzania has made significant progress on priority health indicators, the limited effectiveness of health financing constrains its ability to achieve more. Under current circumstances, Tanzania will not meet several of the 2015 targets set by the Health Sector Strategic Plan (HSSP) III, including maternal mortality. Similarly, new facility standards (soon to be adopted) cannot be met without committing additional resources. Overall, there is inadequate funding for medical commodities, and disparities between regions suggest the need to reprioritize and to allocate health funds more rationally. Further, a high dependency on external funding, a decline in donor support, and a fragmented health financing structure create serious challenges for Tanzania's health sector.

Despite these challenges Tanzania is making progress toward sustainable financing. The government of Tanzania (GOT) is exploring a range of innovative financing solutions, including establishing an AIDS Trust Fund (ATF), and the country has a favorable macroeconomic situation with chances of growth in public revenue. In addition, the GOT has made a commitment to universal

healthcare and is working toward a comprehensive health financing strategy.

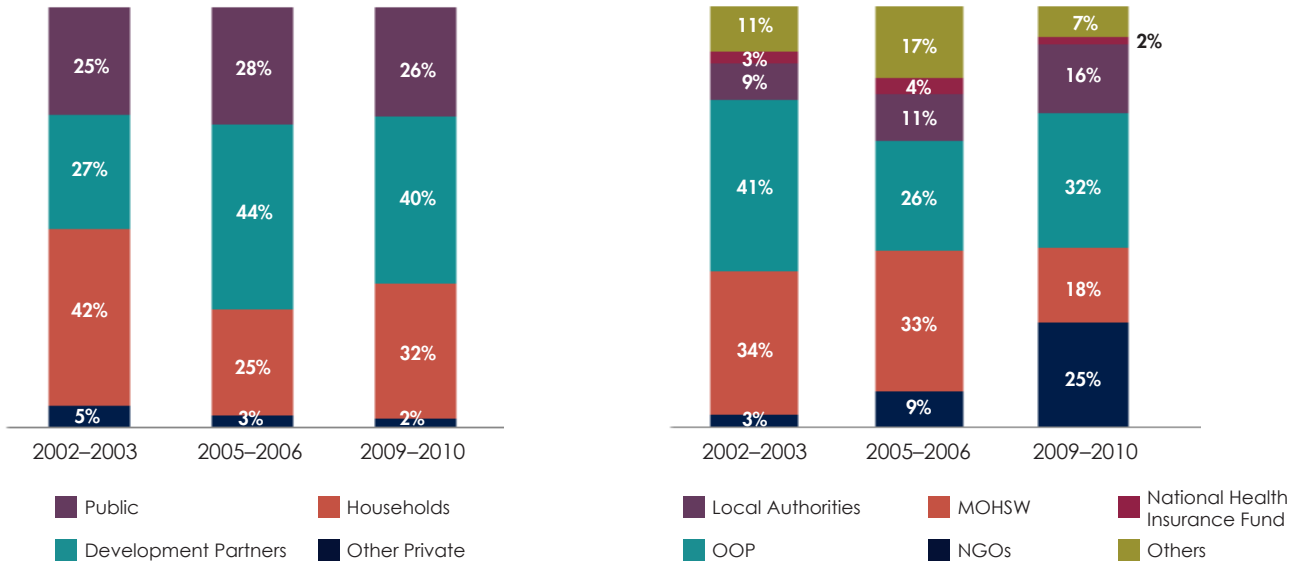
Levels and Sources of Financing for Health

Composition of total health expenditure

Tanzania's total health expenditure (THE) was 8.2 percent of nominal gross domestic product (GDP) in 2009–2010. Its composition has shifted over the past several years.

- **Sources:** Overall since 2002–2003, external donor resources increased as public sector resources and households' out-of-pocket expenditure (OOP) declined (Figure 1). OOP still contributes significantly to THE.
- **Financing agents:** The Ministry of Health and Social Welfare (MOHSW) reduced its management of THE (18%) and local government authorities (LGAs: 16%) and nongovernmental organizations (NGOs: 25%) took on increased managerial roles. OOP is the largest financing agent (Figure 1).

Figure 1: Composition of total health expenditure by financing source (left) and financing agent (right)



"Others" (right) includes regional authorities, parastatal organizations, private firms, and the Tanzania Commission for AIDS (TACAIDS). Percentages may not add up to 100 due to rounding.

Source: MOHSW, 2014a

Trends in public allocation to and expenditure on health

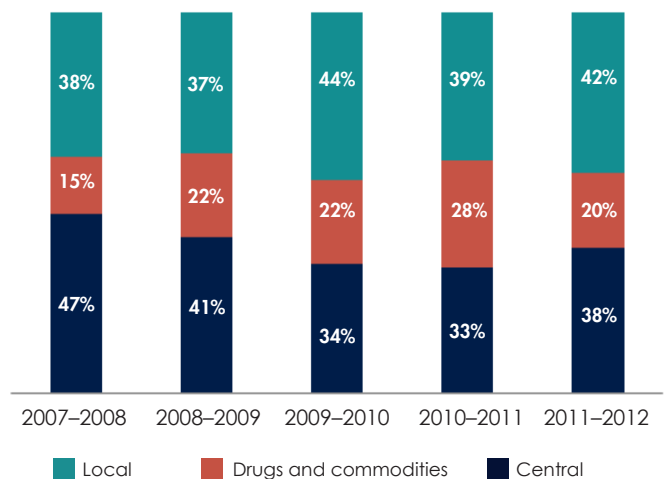
In both nominal and real terms, the GOT's allocation to health has increased over time, but has stagnated as a proportion of the total budget (9%–11%).

- In FY 2013–2014, the GOT allocated 8.9 percent of the discretionary budget (8.7 percent of actual spending) to health (MOHSW, 2014b). Tanzania's allocation compares well with other African countries but international and cross-country comparisons are problematic as data often do not reflect in-country realities and/or are unavailable.
- On-budget foreign funding as a share of actual GOT health spending increased from 32 percent in FY 2011–2012 to 38 percent in FY 2013–2014.
- The central level of Tanzania's health system procures the majority of drugs and commodities which are then transferred to LGAs and higher-level hospitals. LGAs are expected to buy some commodities using their own resources and a fixed percentage of basket fund allocations, but the stipulation has been difficult to enforce. The Prime Minister's Office, Regional Administration and Local Government (PMORALG) is responsible for the payment of salaries. Figure 2 shows the disaggregation of the GOT health budget with LGAs and regions combined as "local" and commodity procurements separated at the central level.

Trends in external financing for health in Tanzania

- Due to Global Fund contributions, non-basket resources for vertical programs have overshadowed the general health basket fund (HBF). The HBF expenditures decreased in nominal terms from US\$97 million in FY 2009–2010 to US\$90 million in FY 2012–2013 (Figure 3). The main funders of the HBF in FY 2012–2013 to FY 2013–2014 were the Canadian, Danish, and Irish governments.

Figure 2: Composition of GOT health sector budget, by level, separating drugs



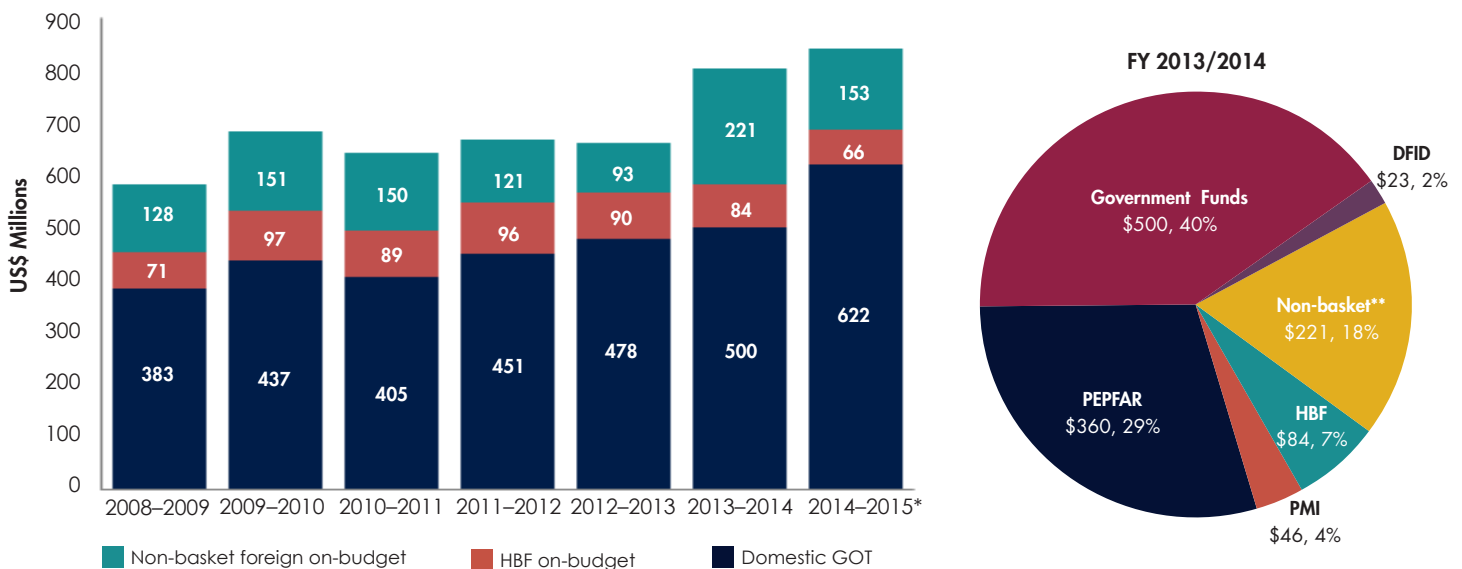
- U.S. government (USG) support for HIV and malaria is very large compared to all other external resources. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) contributed US\$295 million in FY 2012–2013 (October–September) and the President’s Malaria Initiative (PMI) committed US\$49 million, averaging about one-third of the overall total. Within the HIV response, PEPFAR resources accounted for an estimated 80 percent of all specified HIV resources in FY 2012–2013, even given mismatch in fiscal years, and an estimated 92 percent in FY 2013–2014.
- All other formal external donor support on-budget represented 18–21 percent of the overall total. Some bilateral donors such as the United Kingdom Department for International Development (DFID) provide general budget support and project support to NGOs and other organizations (Figure 3).
- Trends in external funding to the health sector suggest a reduction in the number of active donors and in total volume.
- Three HBF donors have exited the mechanism since FY 2013–2014 and there is a planned decline in the number of active external funders in the HIV response from nine to five. The agreement between GOT and HBF donors will also come to an end in 2015 and it is unclear whether existing partners will recommit at past levels.
- The stability of funding for vertical programs will depend on the continued USG and Global Fund support. With a move to the Global Fund’s New Funding Model, Tanzania has been issued an overall funding envelope of US\$633 million, which includes both new and existing money for AIDS, tuberculosis, and malaria for fiscal years 2014–2016. About 61 percent of this amount is allocated for HIV. Tanzania has applied, like many other countries, for additional incentive funding. Funding for these vertical diseases is not likely to meet known requirements.

Trends in local funding for health

Each region’s share of Tanzania’s local health funding appears to be aligned with its share of the total population. However, there were large shifts in shares of funding after FY 2012–2013 when administrative reforms altered LGAs and formed new regions. Further realignment of funds may be needed to suit current epidemiological and service delivery realities.

- In response to a long-standing perception of regional inequity in the availability of key health resources, the Big Results Now (BRN) initiative emphasizes fair health worker distribution.

Figure 3: Health basket fund in GOT actual health expenditure (left), and donor spending, alongside GOT actual health expenditure, US\$ millions (right)



*Data for FY based on approved estimates. **Includes on-budget Global Fund expenditures. Values do not include other small bilateral donors’ support off-budget. PEPFAR values are inclusive of overhead.

Sources: Various, including PEPFAR, DFID operational plans, Mid-term Review of the HSSP III.

- Under PEPFAR, there is a plan to refocus resources on regions with higher HIV prevalence. These will be saturated with investments in key services. In other regions these services where services will be funded at lower levels.

Road Map to Universal Health Coverage

The GOT has made a commitment to universal health coverage under the Third Health Sector Strategic Plan (HSSP III) for 2009–2015 via social health insurance. In addition, the government is working on a comprehensive health financing strategy (HFS), for which it still faces several crucial decisions.

- Like many other countries in the low-income group, Tanzania’s health financing system is dominated by a tax- and donor-funded health delivery system, with a modest proportion of the population enrolled in social, community, or private health insurance. The remaining population, reflecting the still large proportion working in the informal sector or the very poor, are dependent on the public sector and do not have insurance or are not served by any other risk pooling or sustainable mechanism.
- Current discussion around the HFS acknowledges the highly fragmented nature of the health financing system, with multiple risk pools and funding sources and a high dependency on external funds, especially in certain programs. For this region, a recent consensus has emerged that the HFS should focus on a single national health insurer (SNHI). However, given the many stages of achieving the HFS, the realization of SNHI is likely many years off (Figure 4). In the interim, sustainable financing reforms for the health sector require

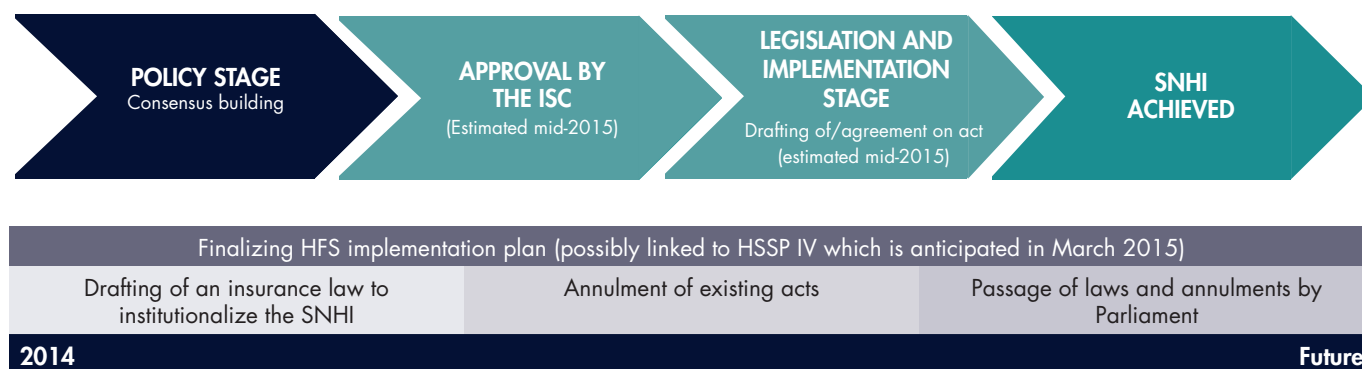
mobilization of domestic resources, and further growth in health insurance coverage using existing schemes.

Prospects for Sustainable Health Financing

Existing tax-funded sources for health

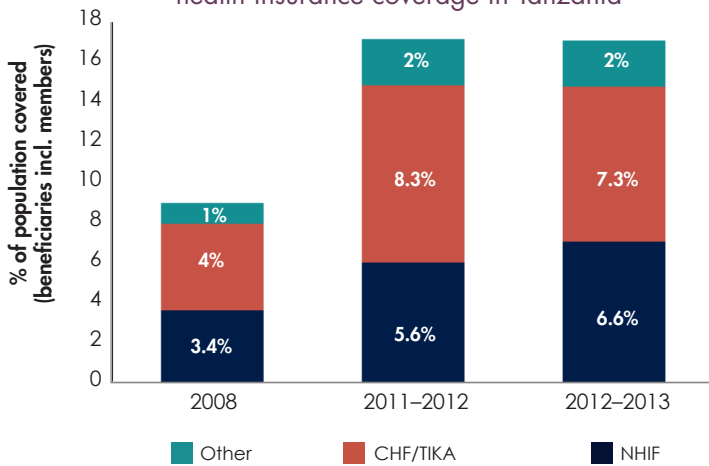
- Tanzania has a favorable macroeconomic situation with chances of growth in public revenues. Growth is expected to be 7 percent in FY 2014–2015, public debt and inflation are stable, and the GOT has a fiscal deficit target of 5 percent.
- Government revenue collections for FY 2013–2014 fell short of the target proposed in the budget because of delays in making tax policy changes, prompting restrictions on discretionary spending.
- Future prospects for government revenue growth look positive, with the number of registered income tax payers growing, even though total revenue as a share of GDP has remained stable. Mobilizing additional revenue will depend on raising collections of value-added tax (VAT), which has been reformed. The International Monetary Fund predicts a revenue-to-GDP ratio of 20 percent by FY 2015–2016.
- Local own-source revenue (LOSR), raised from sources of taxation open to LGAs, amounted to TZS 268 billion (US\$167.5 million) in FY 2013–2014 (estimate), which can be compared with TZS 10,100 billion (US\$6.3 billion) in central government non-grant revenue. LGA LOSR sources amount to only 3 percent of domestic revenues excluding loans and grants, and less than 2 percent of all national revenue, although recent reviews have suggested that LGA LOSR is an insignificant source (less than 1%) of all health spending at the local level.

Figure 4. Stages of enacting a single national health insurer



Source: HPP analysis

Figure 5: Recent trends in population-level health insurance coverage in Tanzania



Key: CHF: Community Health Fund. TIKA: Tiba kwa Kadi. NHIF: National Health Insurance Fund

- There has been a long-standing effort to support LGA revenue generation, but significant obstacles remain: a small local tax base for the areas open for LGA taxation, low collection rates as a function of lack of data and incentives, low awareness and willingness to pay among LGA taxpayers, revenue collection outsourcing challenges, and low administrative ability by LGAs to raise and manage LOSR. It is expected that LGAs will remain dependent in the short term on resources transferred from the central level and donor support.

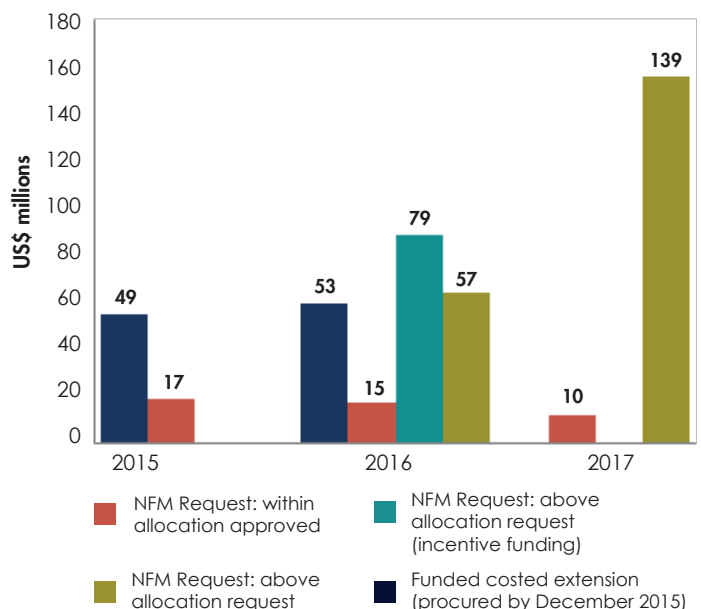
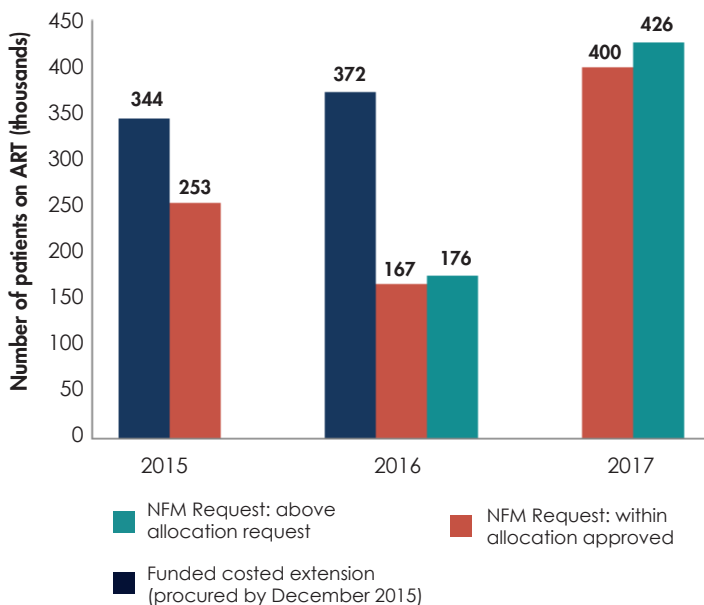
Health insurance schemes

- Health insurance coverage, across all schemes, has stagnated at about 15–16 percent in Tanzania in recent years (Figure 5). This translated to 7.2 million people covered in FY 2012–2013 (16% coverage rate), compared to about 12.3 million in Kenya (28% coverage rate).
- The National Health Insurance Fund (NHIF)—the scheme with the largest number of primary policyholders (536,829 as of FY 2012–2013)—has significant challenges with efficiency, paying out approximately 41 percent of contributions as benefits, compared to an improved 55 percent for the National Hospital Insurance Fund in Kenya (FY 2011). NHIF members in urban areas were more likely to use outpatient care from private facilities.

Innovative financing solutions

- Tanzania is likely to see large financial gaps for the HIV response, especially for critical commodities such as antiretroviral drugs, which are predominantly financed by the Global Fund (Figure 6).
- Due its substantial dependence on the Global Fund and PEPFAR, the GOT is considering establishing an ATF. If successful, the ATF will reduce Tanzania’s dependency on external funders by 36 percent in the short term (not defined), and by 2028 will meet half of the country’s total need.

Figure 6. Global Fund NFM support to antiretroviral therapy (ART) in Tanzania, 2015–2017



Key: UNDP: United Nations Development Programme. GF: Global Fund. GF NFM: Global Fund New Funding Model. USG: United States Government. NHIF: National Health Insurance Fund

- It is unclear if the request by the Tanzania Commission for AIDS' (TACAIDS) for TZS 170 billion (US\$106.3 million) for the ATF from the FY 2015/16 GOT budget will be approved. Some observers believe a lower range of TZS 50–60 billion (US\$31.3–37.5 million) is feasible. This will still leave a funding gap in certain areas, which grows over time (Figure 6). Thus the ATF may need to seek additional sources of financing—more easily done if the ATF is not a line holding account but instead has legal status as a trust.

Unless otherwise indicated, all figures come from Dutta, A. 2015. *Prospects for Sustainable Health Financing in Tanzania: Baseline Report*. Washington, DC: Health Policy Project, Futures Group.

Note

1. The exchange rate for Tanzanian shillings (TZS) to U.S. dollars was calculated as the average of values from the series from World Development Indicators (annual averages) and the calculated average of UN Effective Rates.

References

A full list of references can be found in: Dutta, A. 2015. *Prospects for Sustainable Health Financing in Tanzania: Baseline Report*. Washington, DC: Health Policy Project, Futures Group.

Ministry of Health and Social Welfare (MOHSW). 2012. *Health Sector Public Expenditure Review, 2010/11*. Dar es Salaam: Directorate of Policy and Planning, MOHSW, United Republic of Tanzania, and Health Systems 20/20 Project, Abt Associates Inc.

MOHSW. 2014a. *National Health Accounts 2011/12: Presentation at Joint Technical Review Meeting*. Dar es Salaam: MOHSW, United Republic of Tanzania.

MOHSW. 2014b. *Public Expenditure Review PER 2013–14 Update: Presentation at Joint Technical Review Meeting*. Dar es Salaam: MOHSW, United Republic of Tanzania.

Contact Us

Health Policy Project
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004

www.healthpolicyproject.com
policyinfo@futuresgroup.com

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HPP is implemented by Futures Group, in collaboration with Plan International USA, Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

The information provided in this document is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.