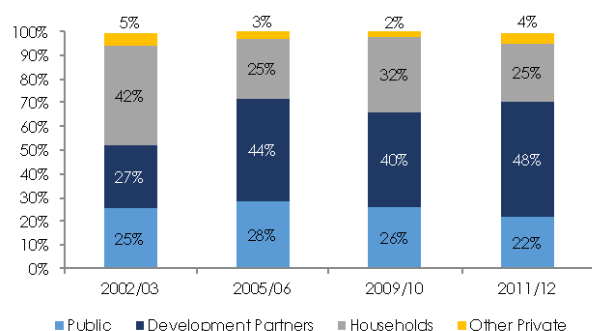




Key Indicators	
Population (2014)	51.8 million
GDP per capita (current USD, 2014)	\$955
Income classification	Low
Health Financing (FY 2011/12)	
THE per capita (USD)	\$49
THE as % of GDP	7.3%
GHE as % of THE	36.3%
GHE as % of GGE	11.3%
OOP as % of THE	33.2%
DAH as % of THE	48%
Pooled private as % of THE	29%
HIV Financing (2011)	
HIV/AIDS prevalence adults 15+ (2015)	5.1%
DAH for HIV as % of TAE	93%
TAE per PLHIV (USD)	\$179
GAE as % of GGE	1.7%
GAE as % of TAE	5%

Source: WHO, 2015; TACAIDS, 2012; URT, 2012; World Bank, 2015. THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket payment, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure. Note: Estimates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity.

Figure 1: Health Financing, by Source



Source: URT, 2012.

Overview

Between 2002 and 2013, in real terms, the Government of Tanzania's (GOT's) health expenditure as a percentage of total health expenditure (THE) decreased from 45% to 36%. Per capita, government expenditure on health has increased slowly, up to US\$49 in 2013, which compares favorably to other countries in the region. High proportions of Tanzania's THE (Figure 1) are financed by foreign donors (48% in fiscal year (FY) 2011/12) and household/out-of-pocket (OOP) spending (33% in FY 2011/12) (Figure 2), rather than from sustainable or prepaid sources such as general government revenue or health insurance. As a share of the total GOT budget for FY 2015/16, the total health budget grew modestly from the previous year (9.1% to 11.3%, excluding consolidated fund services), but this growth was driven largely by a significant on-budget foreign component. At 7.3%, Tanzania's spending as a percentage of gross domestic product (GDP) on health is higher than the average of 5.3% in other low-income countries (LICs). The 11.3% of discretionary general government expenditure spent on health (inclusive of on-budget donor support) is more than the LIC average (9.2%) but still short of the Abuja target of 15%. With decentralization, the role of local government authorities and nongovernmental organizations in managing funds for health has increased.

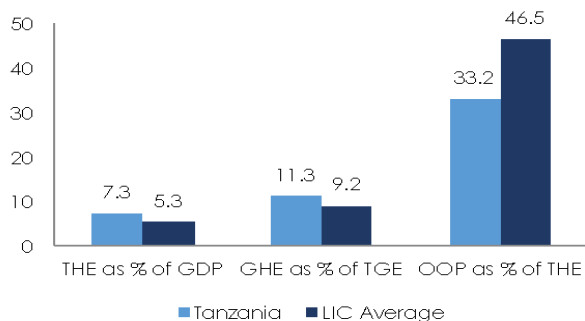
Beginning with the *Third Health Sector Strategic Plan 2009–2015*, the GOT made a commitment to universal healthcare via social health insurance. Tanzania's health financing system is dominated by tax- and donor-funded health delivery, with a modest proportion of the population enrolled in social, community, or private health insurance. The remaining population, reflecting the still-large proportion of people working in the informal sector or the very poor, is dependent on the public sector; they neither have insurance nor are served by any other risk-pooling or sustainable mechanism. As laid out in the draft national health financing strategy (HFS), the government is now considering several changes to how healthcare is financed and has strongly committed to raising revenue. The mission of the HFS is to establish a comprehensive social health protection system for all Tanzanians. Components of the HFS include pooling the current risk pools into a single national health insurer (SNHI) and developing a minimum benefits package that will be available to all, while increasing efficiency through improved public financial management and choosing the most appropriate provider payment mechanisms.

Health Financing Functions

Revenue contribution and collection

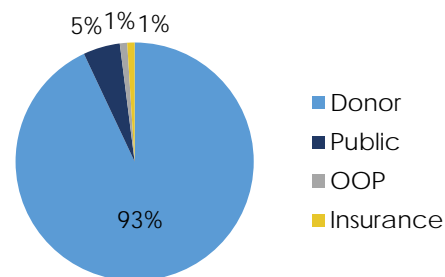
Financing for the health sector from the GOT (22% of THE) is heavily subsidized by donors (48%). The rest is financed by

Figure 2: Comparative Health Expenditure (2013)



Source: WHO, 2015.

Figure 3: Share of AIDS Expenditure (FY 2011/12)



Source: URT, 2012.

households (15%) and other private sources (5%), such as private health insurance. GOT financing for the health sector is provided by general tax and budget support, with no designated revenue stream. The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) has plans to request an earmark of 30% from value-added tax and excise tax collected from alcohol and tobacco sales to be set aside for the SNHI.

Pooling

As a major component of its HFS, the GOT is planning to introduce a SNHI scheme. Current insurance coverage is modest, at 25.8% of the population. The National Health Insurance Fund (NHIF) is the largest scheme as defined by premiums collected (US\$148.6 million in 2014), and the Community Health Fund (CHF) has the most beneficiaries (8.2 million people by January 2016). The private health insurance sector covers only 1.4% of the population. If this legislation passes, SNHI will eventually be mandatory, resulting in increased revenue and risk sharing. This type of mechanism can reduce the burden on the government’s health budget and allow the GOT to concentrate its resources on provisions for vulnerable, low-income groups that cannot afford to pay. Prepayments are a way to pool risk and cross-subsidize coverage for those who are sick—including people living with HIV (PLHIV)—through premium payments from healthy people.

Purchasing

Government spending on health is dominated by the central level. Centrally, the MOHCDGEC is responsible for national referral hospitals and procurement of the majority of drugs and commodities. Local government authorities are responsible for primary healthcare and district, but not regional, hospitals. Most government spending on health (60–68%) is on recurrent items, such as salaries, commodities, and other charges, indicating less funding for capital improvements and additions. The NHIF uses fee-for-service and capitation models to pay for health services. The poor and those working in the informal sector do not pay for services; facilities tend to use CHF revenue to support service delivery.

HIV Financing

In 2015, HIV prevalence for adults (age 15 and older) was 5.6%; there were 1.6 million PLHIV. HIV is estimated to account for 17% of all deaths in Tanzania. According to the Tanzania Commission for AIDS’ (2012) *Public Expenditure Review 2011: HIV and AIDS*, total expenditure for HIV was US\$270.4 million, or roughly US\$179 per person.

PEPFAR resources accounted for an estimated 80% of all specified HIV resources in FY 2012/13 (US\$295 million). The FY 2011/12 National Health Accounts (Figure 3) showed the government financed only 5% of HIV programming (URT, 2012). An AIDS Trust Fund has been proposed with the aim of financing 30% of the national response by 2018, thus decreasing donor dependency.

The multisectoral HIV and AIDS response in Tanzania is estimated to require US\$600–617 million per year, with the largest portion of money going to antiretrovirals. According to an audit of Global Fund to Fight AIDS, Tuberculosis, and Malaria grants to Tanzania, the funding gap is US\$232 million for medicines and laboratory reagents only until December 2017 if the country uses an eligibility threshold of CD4 count ≤ 350 (Global Fund, 2016). The gap will increase to US\$328 million if the National AIDS Control Program’s new treatments guidelines for eligibility—CD4 count ≤ 500—are applied.

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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).

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