



HEALTH BUDGET BRIEF 2018

TANZANIA

Key Messages and Recommendations

- » The health sector was allocated Tanzanian Shillings (TSh) 2.22 trillion in Fiscal Year (FY) 2017/2018. This represents a 34 per cent nominal increase on FY 2016/2017 or a 28 per cent increase once adjusting for inflation. The health budget accounts for 7 per cent of the national budget and 1.8 per cent of gross domestic product (GDP). While accounting for nearly 10 per cent of the total budget in FY 2013/2014 it decreased to 7 per cent in FY 2017/2018.
- » The largest increase to the health sector in FY 2017/2018 has been foreign-funded development spending which is estimated to increase by 127 per cent on the previous year. However, recurrent spending within the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) has reduced from 44 per cent in FY 2013/2014 to 30 per cent in FY 2017/2018.
- » Budget Execution by Local Government Authorities (LGAs) and Regional Administrations has been quite good, averaging 89 per cent and 91 per cent respectively over the past four fiscal years.
- » Actual development spending was 38 per cent of approved estimates in FY 2015/2016 and 71 per cent in FY 2016/2017. In FY 2015/2016 the MoHCDGEC was funded 4 per cent of its total development budget and executed 3 per cent.
- » The bulk of the difference came from a massive reduction in donor-financed development spending. TSh338 billion was slated to be provided to the MoHCDGEC while only TSh12 billion was released.
- » Improvements to national revenue forecasting and health donor coordination are required to improve national level health budget execution.
- » Over the past five years, donor contributions to the sector have fluctuated significantly. For instance, the share of donors in the development budget has declined from 92 per cent to 57 per cent between FY 2013/2014 and FY2017/2018.
- » Health outcomes for the poor in Tanzania have been improving. However, child mortality, nutrition status, vaccination coverage and likelihood of attending a health facility to deliver a baby are still heavily determined by: location, wealth and mother's education. The Health Sector Strategic Plan IV (HSSP IV) equity focus is critical to ensure continued improvements in the health of vulnerable Tanzanians, including children.
- » High population increase relatively to Government contributions to the health sector puts additional pressure on households to cover medical expenses. In 2014, out-



of-pocket expenditures accounted for an estimated 23 per cent of total health expenditure. Both poor households and women have high out-of-pocket health costs, exacerbating inequality. With that understanding the Government through Health Policy of 2007 has introduced free health services to women and children.

» The Health Funding Strategy (HFS) holds scale-up and funding targets. Focusing on addressing emerging issues such as electronic payments, improvements in health contracting and merging the National Health Insurance Fund (NHIF) and the Community Health Funds (CHFs) could lay the groundwork for the scale up of the health interventions coverage.

1. INTRODUCTION

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEG) is the leading Ministry, Department and Agency (MDA) for most health sector policies. This Ministry also administers the majority of health funds (49 per cent). As decentralisation gathers pace, the President's Office, Regional Administration and Local Government (PORALG) is taking a greater role coordinating the delivery of health services by local and regional authorities. Regional and local authorities were responsible for delivering 41 per cent of the total health budget.

The Tanzania AIDS Commission (TACAIDS) is an independent Department under the Prime Minister's Office. It represents less than 1 per cent of the national health sector budget and is responsible for coordination, advocacy and communication regarding the national response to HIV and AIDS.

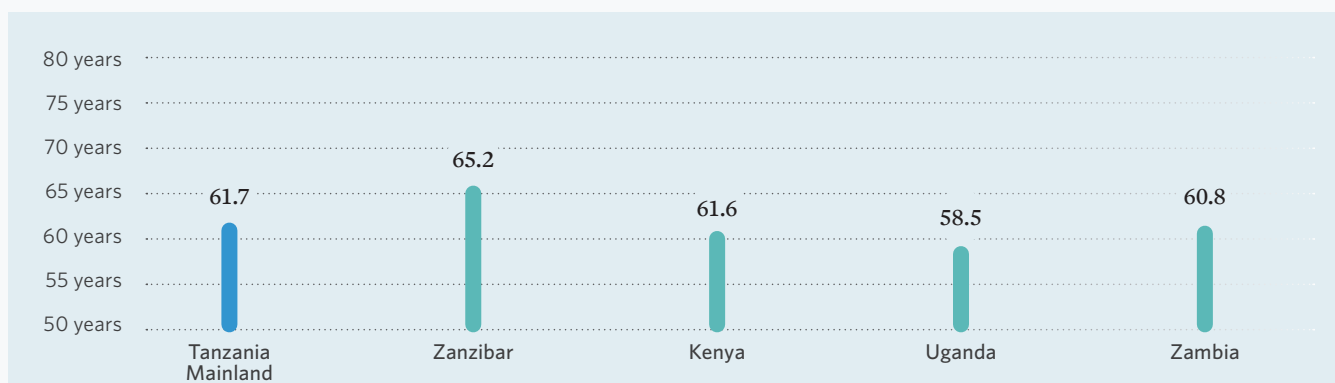
The National Health Insurance Fund (NHIF) was originally established to provide compulsory health insurance for central government employees. Recently, private companies and individuals have been able to opt in to the NHIF. As of March 2018, the NHIF covered 7 per cent of the population¹. Direct transfers to the NHIF from the Government of Tanzania (GoT) are estimated to account for 10 per cent of the health sector budget in FY 2017/2018.

The Community Health Fund (CHF) is a voluntary pre-payment insurance fund for health care. It has been rolled out to 167 out of 184 councils operating under Local Government Authority through NHIF coordinators. Participants pay for an annual membership which entitles them to access basic medical care and medicine without paying additional co-payments. The National Government subsidises these funds through a matching subsidy. The CHF subscription costs and the services covered are defined by District governments. As of March 2018, coverage under the CHF was 13,325,718 representing 25 per cent of the population. This is an impressive increase from 2011, when only 7.9 per cent of the population were covered.²

Health outcomes in Tanzania are impacted by the burden of HIV and AIDS, malaria and tuberculosis, which account for 11 per cent, 4 per cent and 4 per cent respectively of total deaths³. Disability Adjusted Life Year (DALY) is a measure used to compare the disease burden of a population and to make comparisons between countries. A DALY is a sum total of life years and productive life years lost due to premature mortality and disability⁴. The burden of disease impacting children differs from the general population. Neonatal Disorders cause 30 per cent of total DALYs of the population under-5. Extending access to basic and emergency obstetric and newborn care is vital for improving the health of children. Malaria is especially dangerous for children under the age

FIGURE 1: Life Expectancy international comparisons

Source: National Bureau of Statistics (NBS) 2015, World Development Indicators (WDI) 2016



1. <http://www.nhif.or.tz/pages/profile#gsc.tab=0>

2. <http://www.hpss.or.tz/index.php/what-we-do/health-financing/community-health-funds>

3. Global Burden of Disease (GBD) 2016

4. http://www.who.int/gho/mortality_burden_disease/daly_rates/text/en/



of five. Malaria in Tanzania is responsible for 10 per cent of all DALYs lost under-5.

The overarching health policy is the National Health Policy of 2007. The policy outlines the Government's aim to reduce morbidity and mortality; improve access to health services; prevent and control communicable diseases; promote awareness of non-communicable disease; promote self reliance; build partnerships between health providers; increase the quality and quantity of health staff and maintain and procure health infrastructure and medical equipment. The policy also provides for the revision and production of health policy guidelines, laws and standards. This policy is currently being reviewed.

The Health Sector Strategic Plan IV guides health interventions in Tanzania from the national level to the council level. The plan is slated to run from 2015 to 2020. The HSSP IV set financing targets of TSh793 billion in transfers from the GoT to the health sector. TSh1,401 billion was expected to come from external sources and TSh637 billion from the Single National Health Insurer (SNHI). The estimated resource for full implementation of HSSP IV was 4.6 per cent of GDP.

Health outcomes in Tanzania are better than might be expected given the low expenditure on health, endemic diseases and a large rural population. Life expectancy in mainland Tanzania is on par with Kenya and is higher than Uganda and Zambia. One explanation points to previous Government investments in training and recruiting physicians.

TABLE 1: Key health statistics

Source: Demographic and Health Survey (DHS) 2015

| | |
|---|-------------------------|
| Life expectancy (years, 2015) | 61.7 years |
| Urban | 59.9 |
| Rural | 62.6 |
| Male | 59.7 |
| Female | 63.7 |
| Infant mortality rate | 54/1,000 live births |
| Stunting | 34% |
| Wasting | 4.4% |
| Vaccine coverage for children aged 12-23 months | 75% |
| Maternal Mortality ratio | 566/100,000 live births |
| Coverage of insecticide-treated bed nets (%) (Household with at least 1 ITN) | 65% |
| HIV/AIDS prevalence (adult and children) | 5.3%* |
| Births attended by skilled health personnel (%) | 64% |
| Proportion of health facilities with electricity, clean water and improved sanitation | 19% |
| Rural | 5% |
| Urban | 60% |

* 2016/2017 Tanzania HIV Impact Survey indicates that adult HIV/AIDS prevalence is 4.8% for Tanzania Mainland.

TABLE 2: Human resources for health, international comparisons

Source: World Bank, World Development Indicators (WDI) 2016 *

| | MAINLAND | KENYA | UGANDA | ZAMBIA |
|--|----------|-------|--------|--------|
| Physicians (per 1,000 people), 2012 | 0.25 | 0.198 | 0.117 | 0.173 |
| Hospital beds (per 1,000 people), 2010 | 0.7 | 1.4 | 0.5 | 2 |
| Nurses and midwives (per 1,000 people), 2013 | 0.436 | 0.863 | 1.306 | 0.784 |

TABLE 3: Child mortality and other indicators, international comparisons, 2015 (unless otherwise indicated)

Source: DHS 2015; DHS 2010 and World Bank's WDI for comparable countries

| | TZ MAINLAND | ZANZIBAR | KENYA | UGANDA | ZAMBIA | RWANDA |
|---|-------------|----------|-----------|-------------|------------|-------------|
| Neonatal mortality (per 1,000 live births) | 29 | 28 | 22 | 19 | 21 | 19 |
| Post-neonatal mortality (per 1,000 live births) | 23 | 17 | NA | NA | NA | NA |
| Infant mortality (per 1,000 live births) | 52 | 45 | 36 | 38 | 43 | 31 |
| Child mortality (per 1,000 live births) | 29 | 11 | NA | NA | NA | NA |
| Under-5 mortality (per 1,000 live births) | 79 | 56 | 49 | 54 | 64 | 42 |
| Stunting (%) | 35 | 24 | 26 (2014) | 33.7 (2011) | 40 (2013) | 44.3 (2010) |
| Wasting (%) | 4.4 | 7 | 4 (2014) | 4.8 (2011) | 6.3 (2013) | 3.0 (2013) |

2. HEALTH SPENDING TRENDS

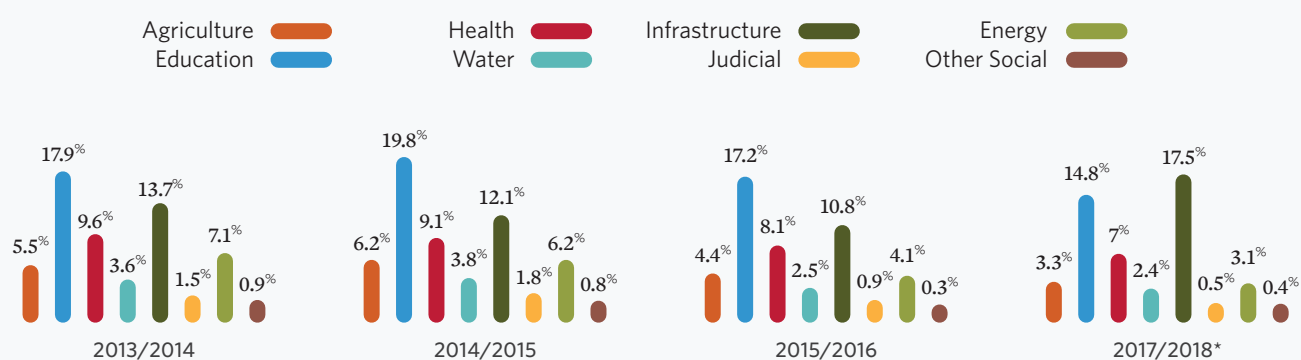
Health sector share from FY 2013/2014 to the approved budget for FY 2017/2018, has gone from consuming 9.6 per cent of the national budget to just 7 per cent. The FY 2017/2018 approved budget has allocated TSh2.22 trillion to the health sector, a 34 per cent nominal increase on the previous fiscal year or a 28 per cent increase accounting for inflation.

The MoHCDGEC and LGAs and Regional Administrations received an additional TSh254 billion and TSh218 billion respectively. TACAIDS and PORALG received significant cuts,

equivalent to 44 per cent and 47 per cent respectively from the previous approved budget in FY 2017/2018. This is likely due to low execution in FY 2016/2017 where TACAIDS only executed 37 per cent of its health spending while PORALG only executed 9 per cent. Due to the very low execution rates the FY 2017/2018 approved budget represents an increase on the previous fiscal year outturn. Of total health sector funding in the FY 2017/2018 budget estimates: MoHCDGEC is expected to receive 48.5 per cent, LGAs 35 per cent, Regional Administrations 5.8 per cent, the NHIF 9.6 per cent, PORALG 0.8 per cent and TACAIDS 0.3 per cent (Figure 3). This is a similar funding breakdown to FY 2016/2017 with major changes being driven by a reduction in development spending by LGA and Regional Administration and an increase in donor-funded development spending under MoHCDGEC.

FIGURE 2: Spending priorities by sector, percentage of the total budget approved Including Consolidated Funds Service (CFS)

Source: Integrated Financial Management Information System (IFMIS)



In comparison to neighbouring countries, Tanzania's total expenditure on health is low (Table 4). Tanzania's health spending as a percentage of GDP is lower than that of Kenya, Uganda and Rwanda. This is moderated when differences in prices and population are considered with Tanzania's total (public and private) spending is slightly more than that of Uganda and Rwanda (Health expenditure per capita Purchasing Power Parity, PPP). Public contribution to health spending is also lower than in Kenya and Rwanda as a percentage of GDP (health expenditure, public per cent GDP).

The total investments fall short of the estimated minimum financial requirements to provide basic health services to the population. The HSSP IV estimated total health financing needs to be US\$42 per person per year, while the WHO high level task force estimated health financing requirements to be US\$44 per capita. This equates to US\$2 billion in FY 2017/2018 or TSh4.7 trillion. The current budget allocation to the health sector is TSh2.22 trillion. This equates to less than half (47 per cent) of the finances required to realise the HSSP IV goals. This shifts an unreasonable burden to the private provision of health and out-of-pocket payments.

FIGURE 3: Health sector composition
FY 2017/2018 budget estimates

Source: Ministry of Finance and Planning (MoFP)
Priority Spending Analysis

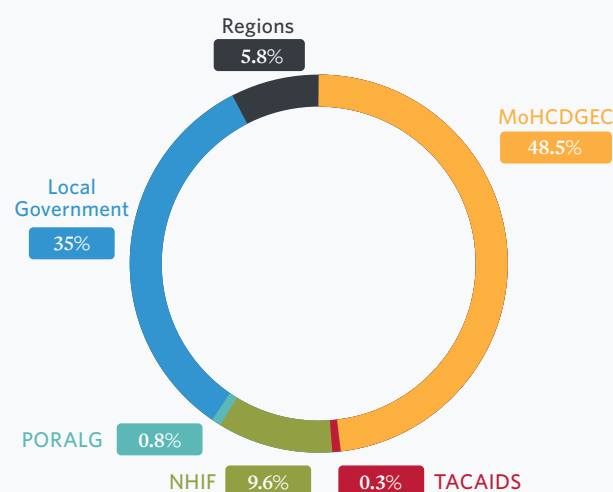


TABLE 4: Comparative health expenditure statistics

Source: World Development Indicators 2016

| | TANZANIA | KENYA | UGANDA | RWANDA |
|--|----------|--------|--------|--------|
| Health expenditure per capita (current US\$) | 51.72 | 77.70 | 52.29 | 52.48 |
| Health expenditure per capita, PPP (constant 2011 international US\$) ⁵ | 137.49 | 168.98 | 132.59 | 125.07 |
| Health expenditure, private (% of GDP) | 2.99 | 2.22 | 5.42 | 4.66 |
| Health expenditure, public (% of GDP) | 2.59 | 3.50 | 1.80 | 2.87 |
| Health expenditure, public (% of total health expenditure) | 46.41 | 61.25 | 24.94 | 38.10 |
| Health expenditure, total (% of GDP) | 5.58 | 5.72 | 7.22 | 7.53 |

Takeaways

- Over the last five years, share of public spending on health in terms of total public spending and GDP has been declining.
- The Global Fund and the Health Basket Fund are responsible for major increases to the MoHCDGEC development budget in FY 2017/2018. Development spending administered by LGAs and Regional Administrations has decreased.
- Health spending per capita is lower in Tanzania than neighbouring countries. Health spending from FY 2013/2014 to FY 2017/2018 is well below the Abuja target of 15 per cent.

5. Note: This figure as well as health expenditure per capita includes total health spending, public, private and donor Per capita spending, as calculated in the paragraphs below, refers to on-budget health spending.

3. COMPOSITION OF HEALTH SPENDING

Figure 4 shows recent budget increases to the health sector have been for development rather than recurrent spending in line with the government priorities. Recurrent spending within MoHCDGEC has reduced from 44 per cent in FY 2013/2014 to 30 per cent in FY 2017/2018. The recurrent budget for MoHCDGEC has stalled, growing only 5 per cent in nominal terms since FY 2013/2014. Over the same period the allocations for a number of major items in the MoHCDGEC recurrent budget have been increasing. The wage bill has increased by 23 per cent over the past five years and between FY 2016/2017 and FY 2017/2018 there were large increases in allowances, and domestic and international travel. This has reduced the resources available for operations with items such as general supplies and services only increasing by 3 per cent from FY 2016/2017 to FY 2017/2018.

The FY 2017/2018 approved budget for MoHCDGEC shows large planned increases to development budget, increasing by a total of 52 per cent compared to FY 2016/2017 budget estimates. Domestically sourced development spending is expected to increase by 5 per cent while foreign sourced development spending is expected to increase by 127 per cent. The increases in foreign-funded development spending are due to large on-budget transfers from the Global Fund and the Health Sector Basket Fund.

The creation of the nurses and midwives and pharmaceuticals sub-votes in FY 2016/2017 has assisted in ensuring these vital enablers of health services are prioritised. HSSP IV underlined the need for investing in these key enablers. The creation of these sub-votes assists in prioritising and monitoring spending to priority areas. These two areas had struggled to attract funding in the past, with financing for pharmaceuticals specifically addressed by the Health Financing Strategy. In the FY 2017/2018 approved budget the Nurses and Midwives sub-vote increased by 328 per cent on FY 2016/2017 outturns or 9 per cent on the FY 2016/2017 approved budget while the pharmaceuticals sub-vote increased by 66 per cent on FY 2016/2017 outturns.

FIGURE 4: Actual spending by economic classification

Source: IFMIS *2017/2018 approved budget, no data available for 2015/2016

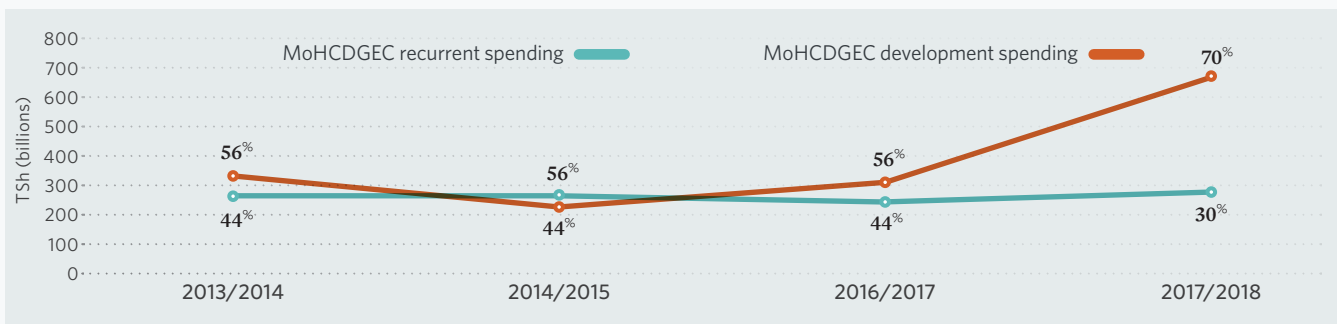
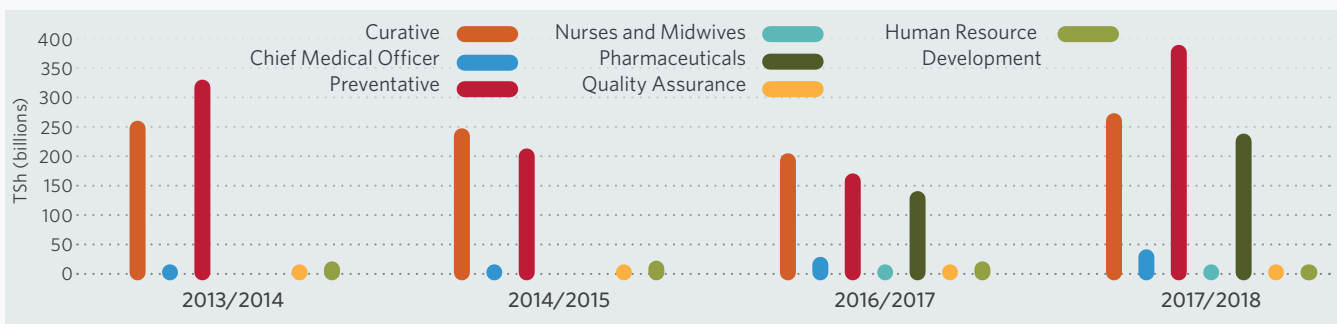


FIGURE 5: Programme health spending by MoHCDGEC

Source: IFMIS, MoFP



Takeaways

- Recent budget increases to MoHCDGEC have mainly accrued to the development budget. The creation of additional sub-votes in the MoHCDGEC budget has successfully attracted and allowed for monitoring of funding to vital enablers of health service delivery. A good example of effective Public Financial Management reform.

4. BUDGET CREDIBILITY AND EXECUTION

Budget execution by LGAs and Regional Administrations has been quite good, averaging 89 per cent and 91 per cent respectively over the past four fiscal years. Budget execution by national level MDAs flagged in FY 2015/2016 and had not recovered to previous levels in 2014/2015. Actual execution rates averaged 51 per cent in 2015/2016 across all national level MDAs. At 28 per cent national MDAs underperformed compared to the average (Figure 6).

The performance of the development budget is the biggest determinant of health sector execution performance. Actual development spending was 38 per cent of approved estimates in FY 2015/2016 and 71 per cent in FY 2016/2017. In FY 2015/2016 the MoHCDGEC was only funded 4 per cent of its total development budget and executed 3 per cent. The bulk of the difference came from a massive reduction in donor-financed development spending. TSh338 billion was slated to be provided to the MoHCDGEC while only TSh12 billion was released. In FY 2016/2017, 96 per cent of MoHCDGEC foreign funded development spending was executed while only 50 per cent of locally approved funding was executed.



Photography: © UNICEF Tanzania

FIGURE 6: Budget execution by level

Source: IFMIS, MoFP

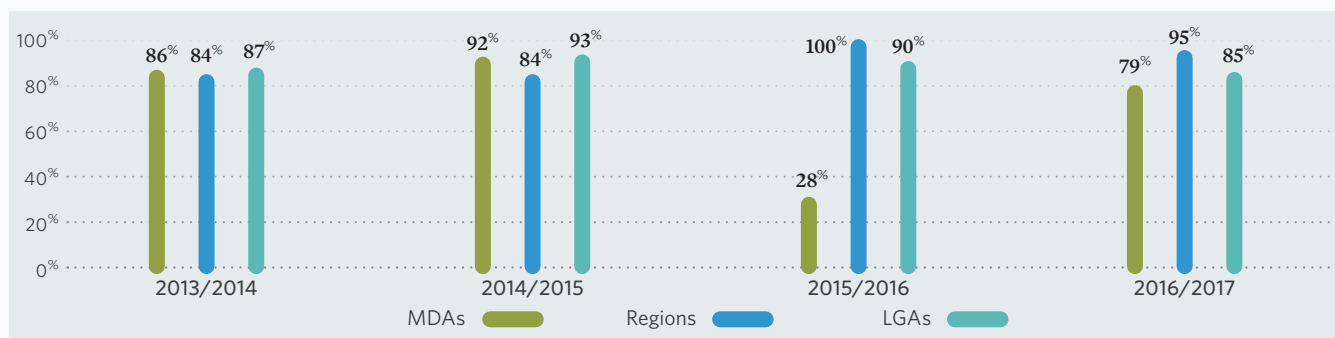
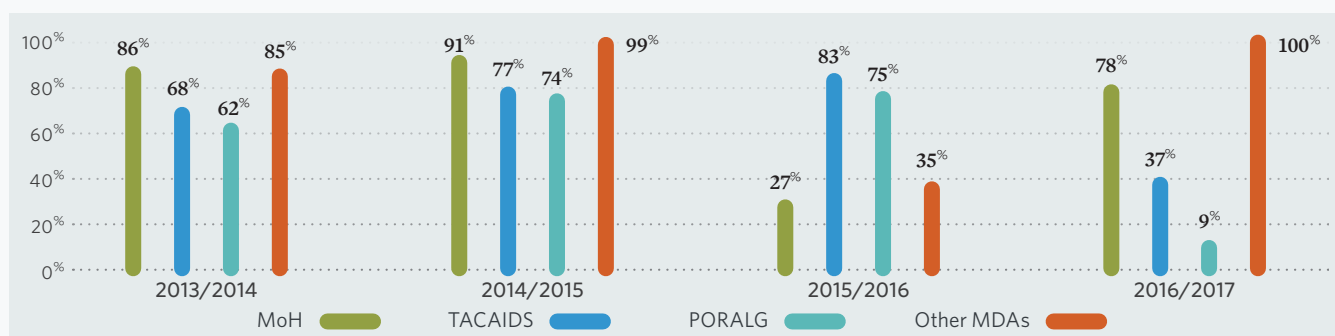


FIGURE 7: Budget execution for national level health spending against approved budget estimates

Source: IFMIS, MoFP



5. DECENTRALISATION AND HEALTH SPENDING

Health and social welfare services are provided from community care through to national levels of care, beginning with community health care, dispensaries and health centres, and proceeding through first level hospitals, regional referral hospitals and zonal and national hospitals, all providing increasingly sophisticated services.⁶

The health sector in Tanzania is highly decentralised. Recently a majority of health sector resources came to be controlled by decentralised entities. The health sector operates at both national and subnational levels based on a decentralised approach introduced in 2001. Core responsibilities lie with MoHCDGEC and PORALG. The former coordinates overall planning, financing and monitoring, whereas local level planning and service delivery are the responsibility of local governments under PORALG. At the subnational level, there are regional and council health services, with the latter consisting of public, private or faith-based organisation-owned dispensaries, health centres, district hospitals and other hospitals. Regional

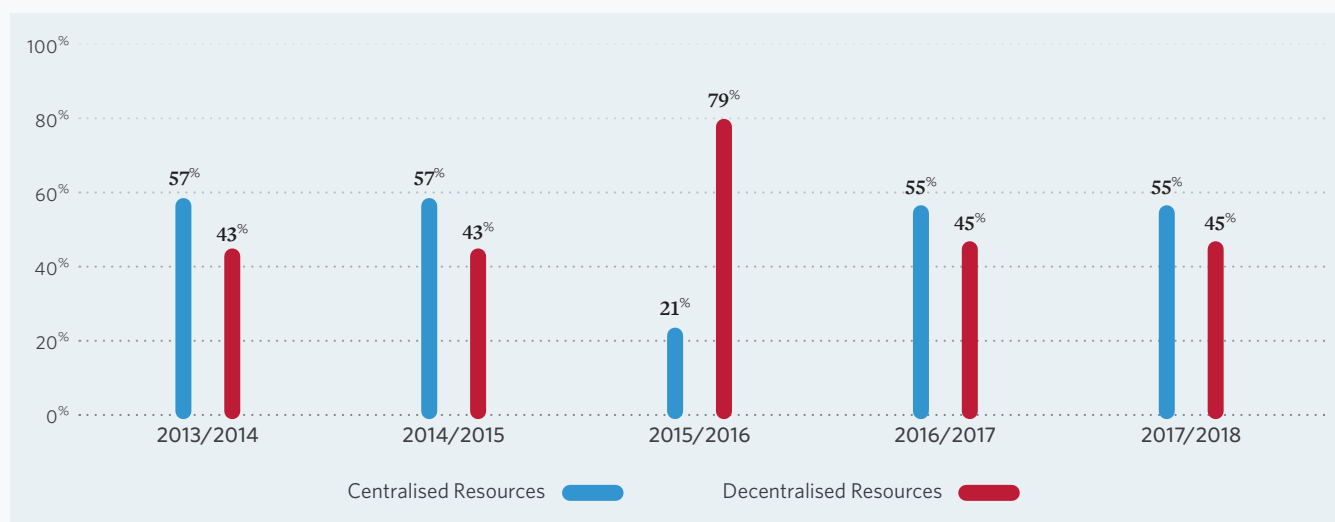
health services comprise of regional referral hospitals while national-level services consist of specialised and consultant hospitals.

The Government has been making some progresses to decentralise resources against Decentralisation by Devolution goals. Figure 8 shows that the share of resources controlled by decentralised authorities has been increasing since FY 2013/2014. The massive spike in the percentage of decentralised resources in FY 2015/2016 was due to the low execution of donor-funded development spending at the national level.

The best measure of progress against Decentralisation by Devolution goals has been the percentage of recurrent health sector resources controlled by LGAs and Regional Administrations. In FY 2014/2015, 50 per cent of recurrent resources were controlled by central authorities and 50 per cent controlled by LGAs and Regional Administration. The FY 2017/2018 budget shows 28 per cent of the recurrent budget will be controlled centrally while 72 per cent of recurrent resources will be managed by decentralised authorities.

FIGURE 8: Percentage of health resources centralised and decentralised

Source: IFMIS, MoFP



Takeaways

- The health sector is already highly devolved; progress toward greater devolution is continuing.
- In FY 2014/2015 recurrent spending was equally divided between national and local authorities. In the FY 2017/2018 budget 72 per cent of recurrent resources will be controlled by local authorities.

6. Health Sector Strategic Plan IV (HSSP IV)

6. EQUITY AND HEALTH SPENDING

In Tanzania, a child's health is likely to depend on where he/she lives and the income of the household with a complementary exemption from the government. A child of a family from the poorest quintile is more than twice as likely to die than a child born to the highest quintile. The good news is that health outcomes amongst the poorest improved from 2010 to 2015 to the point where health outcomes amongst the poor in 2015, exceed average health outcomes in 2010.

Overall, the greatest determinants of health outcomes and access to health services for children and mothers are the region they live in, followed by household income with a complementary exemption from the government. The 2015/2016 Demographic Health Survey shows basic vaccination coverage of children between the age of 12 to 23 months positively correlated with the level of the mother's education, the income of the household and region. The greatest disparities in vaccination rates were between regions. Basic vaccination coverage ranges from a low of 54 per cent in Katavi, 56 per cent in Shinyanga and 59

per cent in Tabora to a high of 93 per cent in Kilimanjaro, 88 per cent in Kagera and 87 per cent in Dodoma.

In rural areas 44.2 per cent of births are at home, while only 12.8 per cent of births in urban areas are at home. A skilled birth attendant is present at 95.2 per cent of births of households from the highest quintile. This percentage drops to 42.1 per cent for the lowest quintile.

Children of mothers with no education and incomplete primary education had a 67 per cent and 63 per cent chance of being vaccinated respectively. Children of mothers with complete primary or secondary schooling and above had an 80 per cent and 81 per cent chance of having complete vaccinations. Only 65 per cent of children from the poorest quintile of households, while 83 per cent of children of the wealthiest quintile households, were vaccinated.

HSSP IV has a strong focus on improving health outcomes for all Tanzanians. The plan outlines the intention to focus on the most under-served regions and councils, where health outcomes are below average, and to redistribute qualified staff to improve the quality and accessibility of health services.⁷

TABLE 5: Mortality indicators (per 1,000 live births) by quintile

Source: DHS 2015, 2010.

| | 2010 | 2015 |
|--------------------------|------|------|
| Neonatal mortality | 28 | 29 |
| Post-neonatal mortality | 33 | 23 |
| Lowest wealth quintile* | - | 25 |
| Highest wealth quintile* | - | 21 |
| Infant mortality | 60 | 52 |
| Child mortality | 35 | 29 |
| Lowest wealth quintile* | - | 34 |
| Highest wealth quintile* | - | 15 |
| Under-5 mortality | 93 | 79 |
| Lowest wealth quintile* | - | 78 |
| Highest wealth quintile* | - | 73 |

*Data for URT

Takeaways

- Child mortality, vaccination coverage and the likelihood of attending a health facility to deliver a baby are heavily determined by; location, household income and the education of a mother.
- Improvements in health outcomes are reaching poor Tanzanians. By 2015 health outcomes of the poorest improved beyond average Tanzanians in 2010.
- The current strategic plan HSSP IV has a strong equity focus with plans to redistribute human resources for health to the most under-served regions and councils.

7. HSSP IV 2015-2020

7. FINANCING THE HEALTH SECTOR

7.1 Financing the development budget

In recent years, the Government of Tanzania has assumed greater responsibility for funding health related development. This follows a trend of increased locally funded development spending since FY 2015/2016. The FY 2017/2018 locally-funded budget for development spending is 244 per cent greater than the budget in FY 2015/2016.

Donor support to the sector has been highly volatile. Year on year changes in donor contributions to the approved budget have averaged 65 per cent with a large increase expected in FY 2017/2018. Donors are expected to contribute 57 per cent to the health sector development budget in FY 2017/2018.

7.2 Out-of-pocket health spending

Tanzania has made significant progress in reducing reliance on out-of-pocket payments for health. In 2000, out-of-pocket payments accounted for 47 per cent of total health expenditure. By 2014 out-of-pocket expenditures account for an estimated 23 per cent of total health expenditure. Reducing out-of-pocket payments is important for improving health seeking behaviour and reducing income and gender inequality. Figure 10 shows the women in the lowest wealth quintile have higher out-of-pocket health expenditures than the second lowest wealth quintile. Women of all wealth quintiles have higher out-of-pocket health expenditures than men.

7.3 National Health Insurance

The NHIF, originally established by an Act of Parliament in 1999, provides health care services to all Central Government

FIGURE 9: Domestic and foreign development funds for MoHCDGEC

Source: IFMIS, MoFP

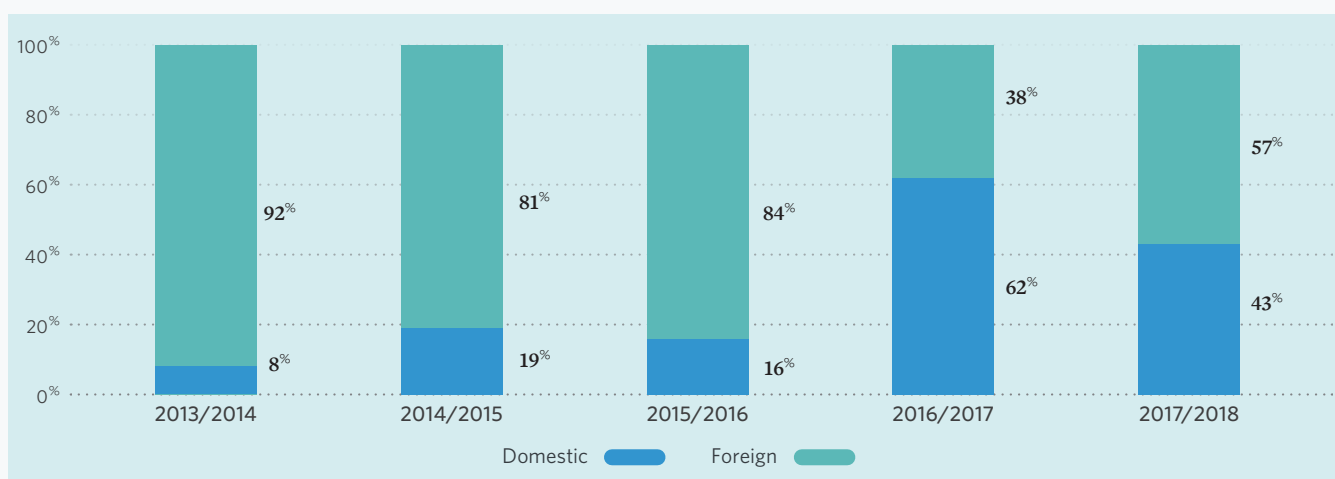
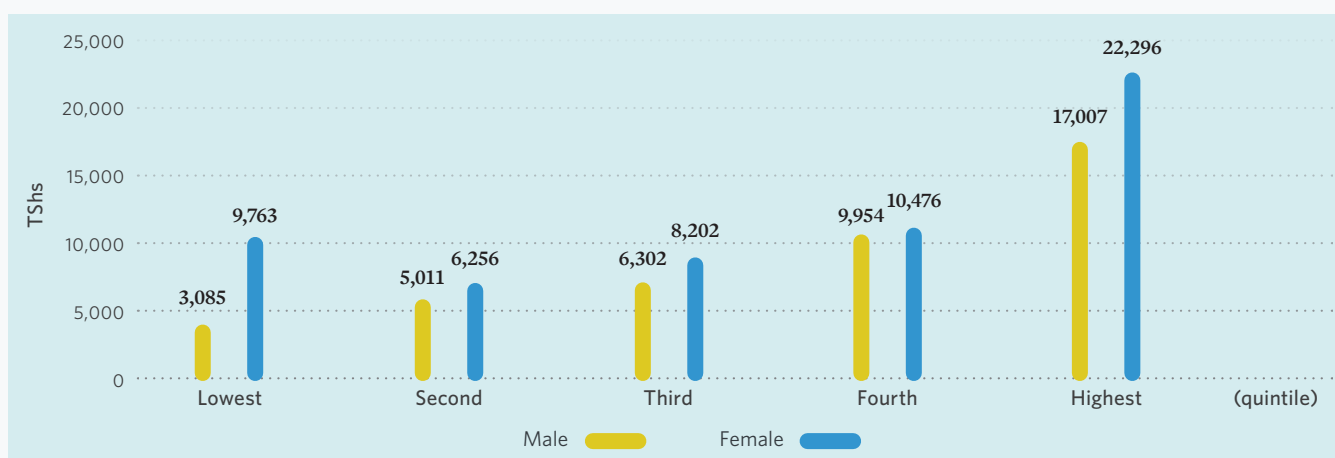


FIGURE 10: Annual out-of-pocket health spending per capita by gender and wealth quintile (TShs)

Source: DHS 2015



employees. The Act establishing the fund was further amended to include private sector institutions, individual members and their respective legal dependants that joined the fund on a voluntary basis.

The Community Health Funds (CHFs) were established by the Government of Tanzania with the support of the World Bank with the first pilot district in 1996. CHFs are now mandatory in all districts. CHFs are voluntary community-based financing schemes in which households pay contributions to finance part of their basic health care services to complement the government health financing efforts.

Health insurance coverage has grown in recent years although coverage of special groups (those requiring a government subsidy to access care) dropped in FY 2016/2017. Health insurance holds the hope of increasing the resources available for health and providing basic universal health coverage. The number of people covered

by the NHIF increased by 13 per cent from FY 2016/2017 to March 2018. The number of registered health providers has expanded rapidly. Membership of CHFs expanded by 9 per cent from FY 2016/2017 to March 2018. (Table 6).

Improving basic administration of current health insurance providers will allow a scale up of NHIF enrolment. Improving health contracting, rolling out electronic payments, linking payments to health services and quality of care, as well as generating the necessary political involvement, are all steps required before increasing enrolment in NHIF and considering mandatory enrolment. Merging NHIF and CHF, and establishing new funding agreements between the national and local governments, has the potential to delay the adoption of a single national health insurance fund, and delay scale-up.

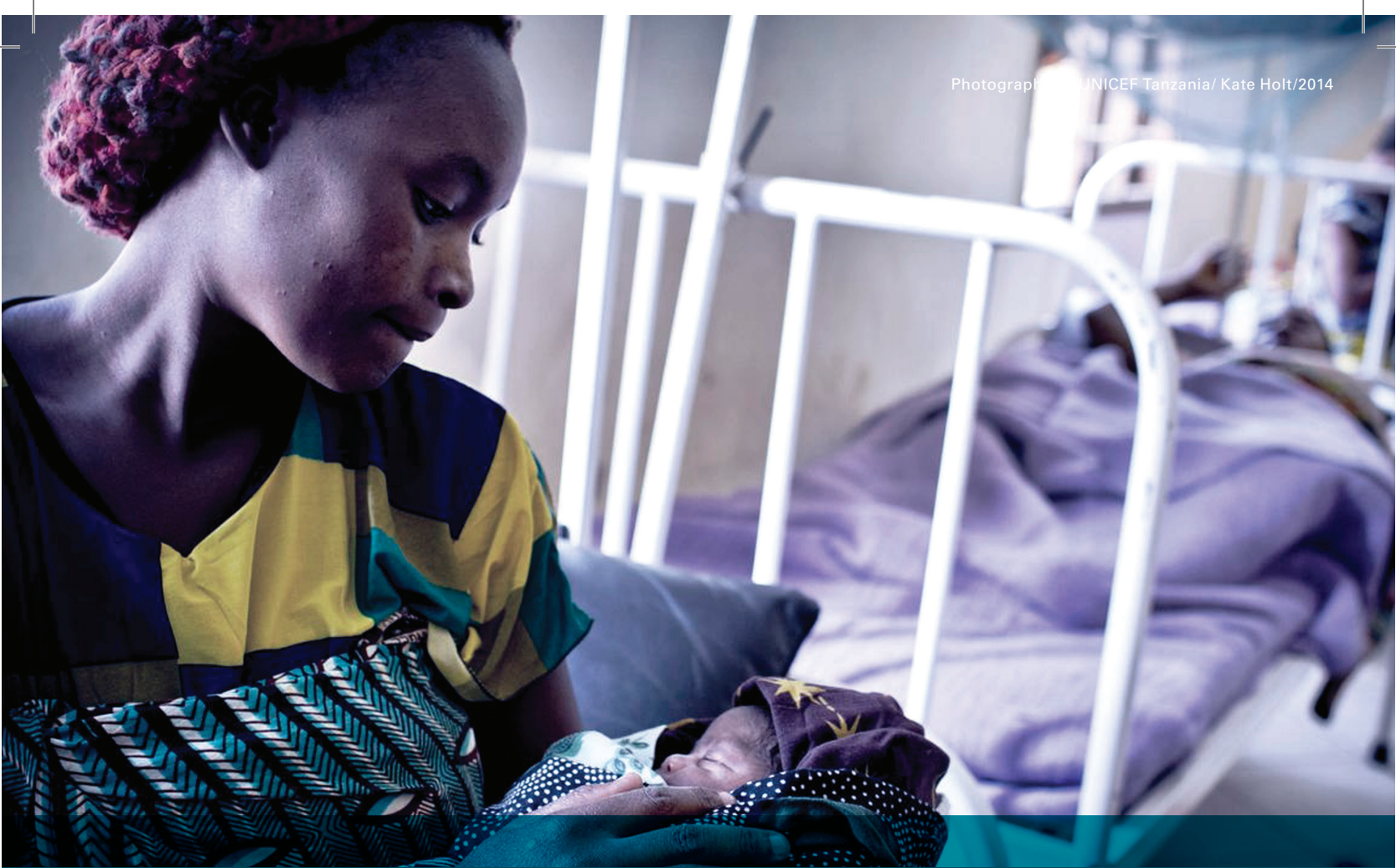
TABLE 6: Changes in the number of people covered by health insurance

Source: MOHCDGEC Implementation report 2016/17

| | NHIF | CHF | SPECIAL GROUPS |
|-----------------|------------|-----------|----------------|
| 2015/16 | 702,598 | 1,452,855 | 99,543 |
| 2016/17 | 753,892 | 2,030,666 | 58,015 |
| March 2018 | 850,268 | 2,220,953 | |
| % Change | 13% | 9% | -42% |

Takeaways

- Since FY 2015/2016 the Government has assumed a greater responsibility for funding health development spending. Donor support to the sector has been highly volatile, highlighting the need for improved donor co-ordination.
- Out-of-pocket health spending as a percentage of total health spending has dropped from 47 per cent in 2000 to 23 per cent in 2014. This has a direct impact on minimising wealth and gender inequalities.
- A single national health insurance holds the hope of increasing the resources available for health and providing basic universal health coverage.
- Health insurance coverage has been growing steadily.



Acronyms

| | |
|----------|---|
| CHFs | Community Health Funds |
| CFS | Consolidated Funds Service |
| DALYs | Disability Adjusted Life Years |
| DHS | Demographic and Health Survey |
| FY | Fiscal Year |
| GBD | Global Burden of Disease |
| GDP | Gross domestic product |
| GoT | Government of Tanzania |
| HFS | Health Financing Strategy |
| HSSP IV | Health Sector Strategic Plan IV |
| IFIMS | Integrated Financial Management System |
| ITN | Insecticide-Treated Bed Net |
| LGAs | Local Government Authorities |
| MDA | Ministry, Department and Agency |
| MoFP | Ministry of Finance and Planning |
| MoHCDGEC | Ministry of Health, Community Development, Gender, Elderly and Children |
| NBS | National Bureau of Statistics |
| NHIF | National Health Insurance Fund |
| PORALG | President's Office Regional Administration and Local Government |
| PPP | Purchasing Power Parity |
| RA | Regional Administration |
| SNHI | Single National Health Insurer |
| TACAIDS | Tanzania Commission for AIDS |
| TShs | Tanzanian Shillings |
| WDI | World Development Indicators |

