# BUDGET ISSUE PAPER FOR HEALTH

MAINLAND

JULY 2022

## Key messages

- Between FY 2017/18 and FY 2021/22, there was a 0.2 per cent increase in the nominal allocation to the health sector budget. Nonetheless, the proportion of government budget excluding debt servicing costs allocated to the health sector decreased from 9 per cent to 7.3 per cent. This was reflected in a domestic per capita allocation, as low as TSh 33,873 (approx. USD 15), which is lower than the recommended benchmark of US$86[1] (approx. TSh 199,094) required to achieve universal health coverage.
- Curative care services received the largest proportion of the health sector budget for FY 2021/2022, accounting for 26 per cent, followed by district hospitals (22 per cent), preventive services (13 per cent) and dispensaries (10 per cent).
- In FY 2021/22 LGAs accounted for 15% of the overall health budget. However, there was a challenge in obtaining complete LGA-related data for analysis.
- In FY 2021/22, there were significant variations in intra-LGA (Local Government Authority) per capita budget allocations. Njombe received the highest per capita allocation (TSh 35,292) while Simiyu region had the lowest per capita allocation (TSh 8,874).
- Execution rates were consistently high for domestic recurrent funds, low for local development funds and fluctuating for on budget foreign development funds. However, a fluctuation in the recurrent budget execution rates were observed between FY 2017/18 and FY 2019/20. These are attributable to changes in the number of health-care staff whose salaries form a significant part of the recurrent budget.

[1] Tanzania Health Sector Public Expenditure Review 2020.

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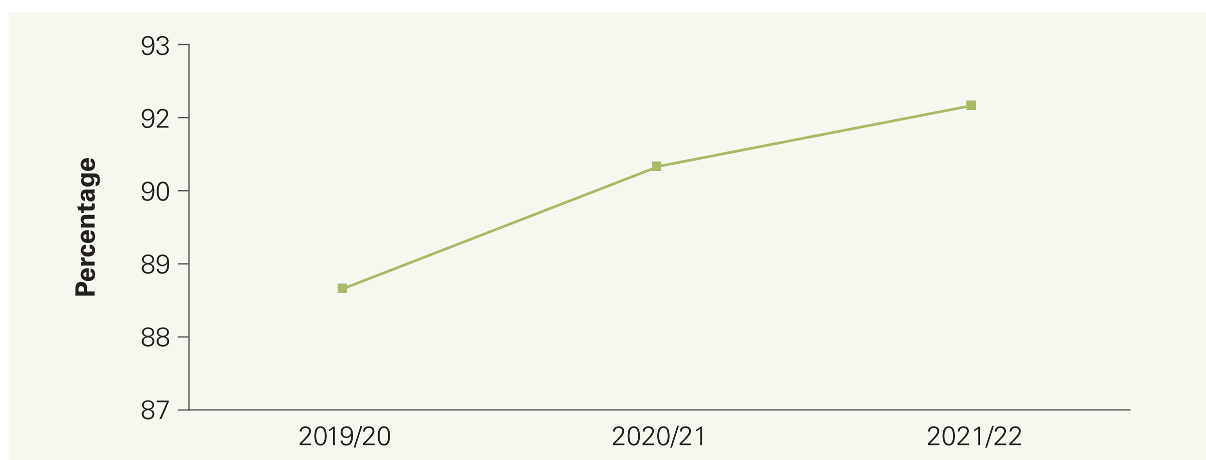
# Introduction

Tanzania's Development Vision 2025 provides the direction and philosophy for long-term development strategy for the country. The vision mentions health as one of the priority sectors contributing to a higher quality of life for all Tanzanians. The National Health Policy 2007 and the Health Sector Strategic Plan (HSSP V) 2021–2026 guide health policy in Tanzania Mainland. The main objective of the health policy is to improve the health and well-being of all Tanzanians, with a focus on those most at risk, and to engender a health system that is responsive to the needs of the people.

Since FY 2019/2020, the health sector has recorded several improvements. For example, the number of health facilities increased steadily from 7,113 to 8,458 between 2015 and 2020. The life expectancy improved from 64.9 years in 2018 to 66 years in 2020.[2]

In 2014, Tanzania introduced the combined measles–rubella vaccine in the routine immunization schedule. Two doses of measles–rubella vaccine (MR1 and MR2) are recommended at 9 and 18 months, respectively. In 2015, MR2 coverage among eligible 18-month-old children in Tanzania was only 57 per cent, lower than the WHO-recommended coverage of 95 per cent.[3] Between FY 2019/20 and FY 2021/22, the proportion of children that have received the second dose of measles–rubella increased from 89 per cent to 92 per cent (Figure 1). Nonetheless, the number of measles–rubella under-vaccinated (who have not received the second dose) children increasing by 53 per cent between 2019 and 2020.

**Figure 1:** Proportion of children who received the second dose of MR between FY 2019/20 and FY 2021/22



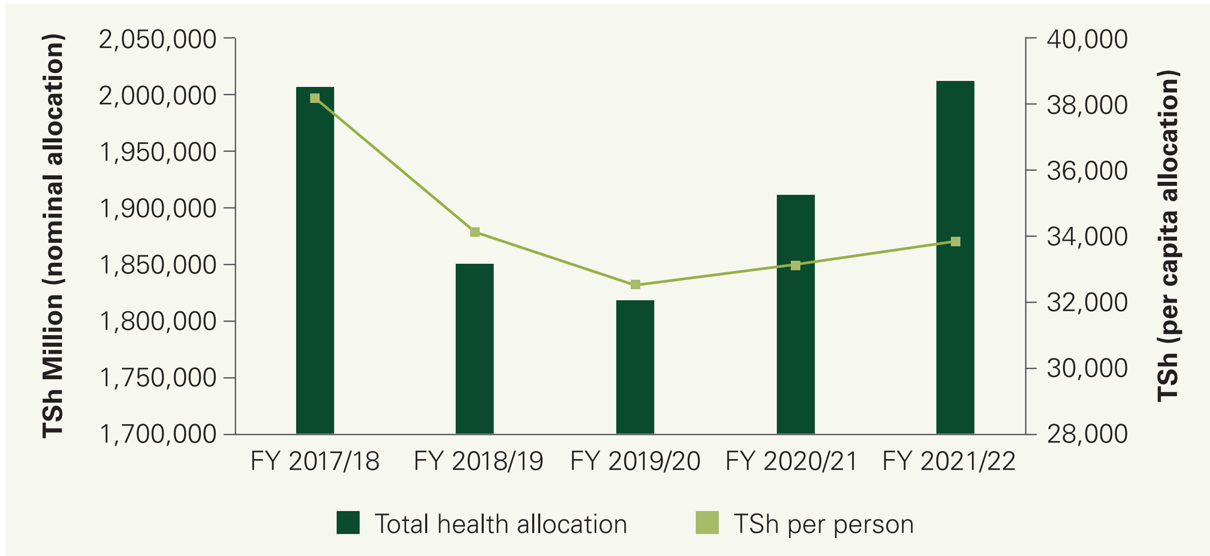

*Source: HMIS.*[4]

# Budget trends

Between FY 2017/18 and FY 2021/22, the nominal health budget allocation, excluding National Health Insurance Fund (NHIF), decreased from 9 per cent to 7.3 per cent of the total government budget, which is lower than the 15 per cent required by the Abuja Declaration. Such a reduction resulted in a decrease of 11 per cent in per capita allocation, from TSh 38,211 (approx. USD 17) to 33,873 (USD 15) and remains below the recommended benchmark of US$86.27[5] (approximately TSh 199,094), required to achieve universal health coverage. Figure 2 illustrates nominal and per capita health budget allocations for FY 2017/18 to FY 2021/22.

[2] Annual Health Sector Performance profile 2020.
[3] Factors associated with non-uptake of measles–rubella vaccine second dose among children under five years. *Pan African Medical Journal,* May 2019.
[4] Data from Head of Heath Management Information System (HMIS) Policy and Planning Department- MoHCDGEC
[5] Source: International Health Partnership (2009) and McIntyre et al. (2017) – Universal Health Coverage per capita spending.

**Figure 2:** Health budget nominal allocation and per capita allocation between FY 2017/18 and FY 2021/22




*Source: Analysis of MoFP budget data.*

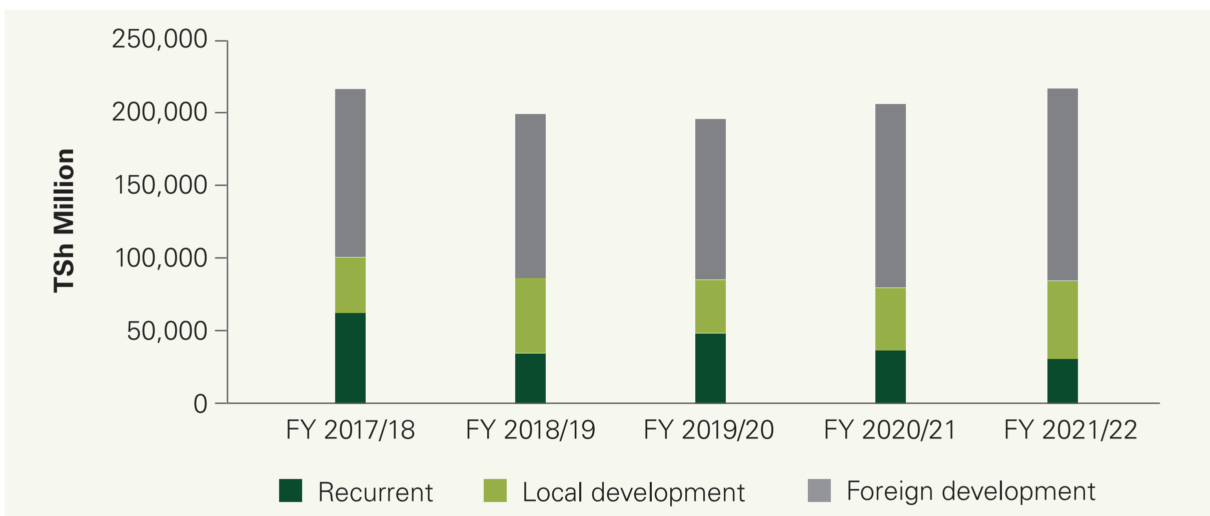
In FY 2021/22, important inequities in the intra-LGA budget allocations were reported. The average per capita allocation for all regions was TSh 18,376. Njombe region had the highest per capita allocation of TSh 35,292, which was three times higher than Simiyu, which had the lowest per capita allocation of TSh 8,874. The disparities in budget allocation by region could result in unequal access to health-care services among regions.

# Budget analysis

## Analysis by funding category

Between FY 2017/18 and FY 2021/22, there was a 14 per cent increase in allocation of recurrent health budget, following an increase in the number of health-care workers from 55,300 to 98,987 between FY 2017/18 and FY 2021/2022 (Figure 3).

**Figure 3:** Health sector nominal allocations by fund category between FY 2017/18 and FY 2021/22

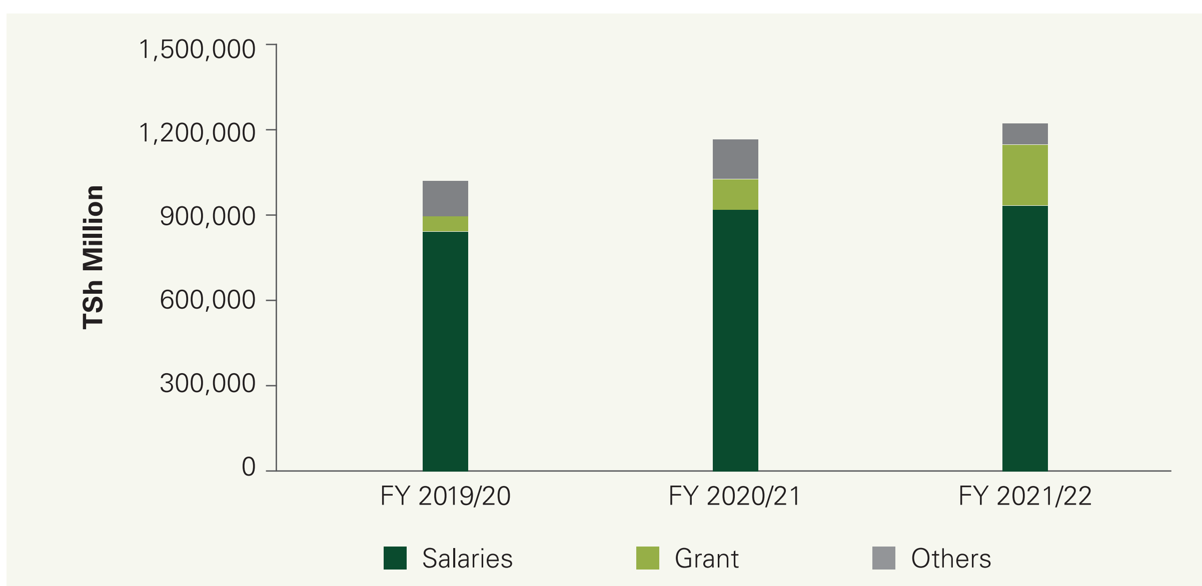



*Source: Analysis of MOFP budget data.*

## Recurrent budget

Between FY 2019/20 and FY 2021/22, salaries accounted for 79 per cent of the recurrent budget for health, on average (Figure 4). In 2019/2020, the total human resources requirement for health was 212,193, yet the actual number was 98,987, indicative of a 53 per cent staff shortage, and the doctor-to-population ratio was 1 to 20,396. Over the same period, the 'other charges' budget category dropped by 40 per cent (TSh 50 billion).

**Figure 4:** Analysis of the nominal recurrent budget allocations




*Source: Analysis of MOFP budget data.*

## Local development budget

During the period of analysis, the domestic local development budget increased by 40 per cent (TSh 43 billion). Most of the funding between FY 2019/20 and 2021/22 was allocated towards strengthening of referral hospitals, an activity which accounted for 52 per cent of the local development budget (TSh 262 billion), followed by the construction of district hospitals at 15 per cent (TSh 75.75 billion), the Primary Health Development Programme which stood at 9 per cent of the budget (TSh 49 billion), and strengthening of immunization services at 4 per cent of the budget (TSh 20 billion).

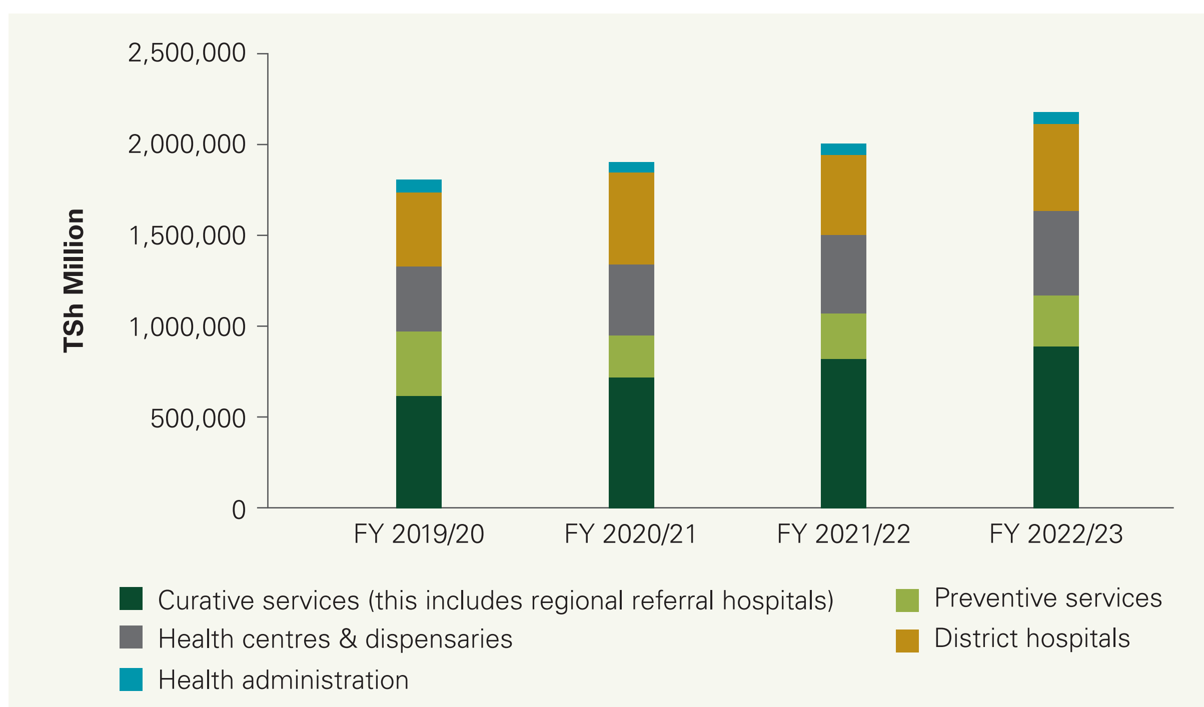
## Foreign development budget

Between FY 2017/18 and 2021/22, there was a 51 per cent drop in the foreign development budget. The decrease in foreign development funds was mainly due to the reduction in the budgets of several donor-funded programmes between FY 2019/20 and FY 2021/22. As a result, the budget for communicable diseases/vaccines decreased by 74 per cent (TSh 71 billion), Strengthening Primary Health Care Results by 86 per cent (TSh 44 billion), HIV and AIDS Control Programme by 75 per cent (TSh 85 billion) and support to TB/ Leprosy Control Programme by 42 per cent (TSh 6 billion).

## Analysis by subprogrammes

The budget allocation by subprogrammes reveals that most of the resources were allocated to the curative care services subprogramme. In FY 2021/22, curative services accounted for 26 per cent (TSh 529 billion) of the nominal health budget, followed by district hospitals at 22 per cent (TSh 443 billion), regional referral hospitals at 15 per cent (TSh 297 billion) and preventive services at 13 per cent (TSh 252 billion). Figure 5 shows the analysis by subprogrammes.

**Figure 5:** Analysis by subprogramme



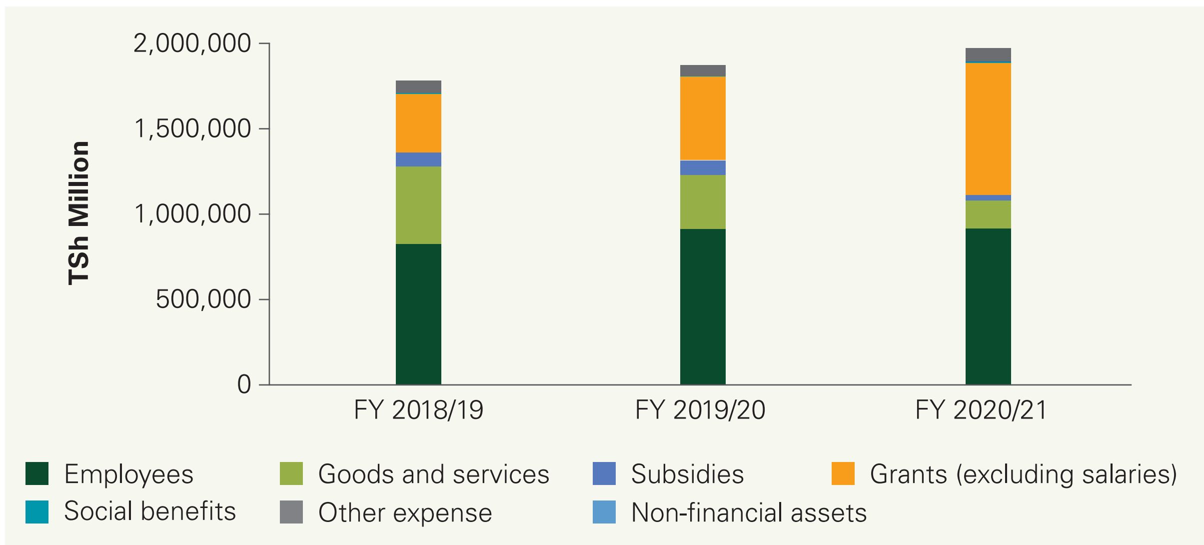

*Source: MoFP data files.*

## Analysis by budget category

In FY 2021/22, payroll costs, including salaries and other personnel emoluments, constituted the largest expenditure category in the government's health budget at 47 per cent followed by grants, which accounted for 39 per cent of the total health budget.

Between FY 2019/20 and FY 2021/22, grants allocation increased by 128 per cent (TSh 443 billion) due to the increase in budget for MSD by 525 per cent (TSh 168 billion). The increase can be explained in relation to possible savings resulting from a decrease in budget for drugs/medicines under goods and services. Specifically, the allocation to goods and services dropped by 64 per cent (TSh 295 billion) between FY 2019/20 and FY 2021/22. The reduction was due to a 98 per cent (TSh 107 billion) decrease in the budget for drugs and medicines and an 82 per cent reduction (TSh 206 billion) in the budget for specialized medical supplies. Nevertheless, during the same period, the budget for medical stores department (MSD) increased significantly from TSh 32 billion to TSh 200 billion between FY 2019/20 and FY 2021/22. (Figure 6)

**Figure 6:** Health budget allocation by budget category between FY 2019/20 and FY 2021/22



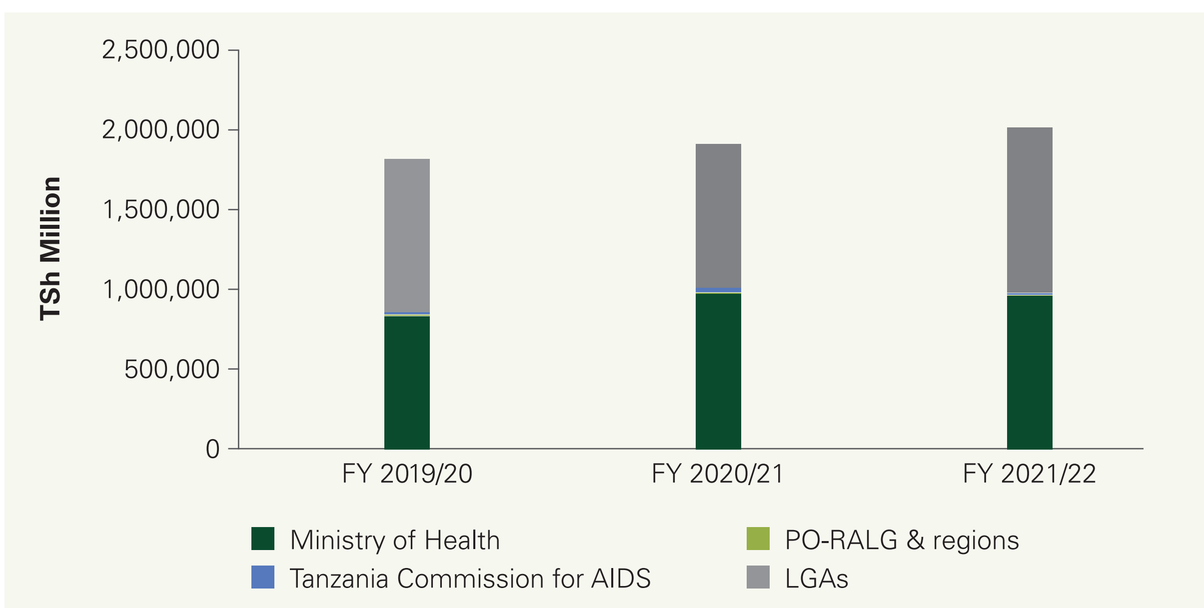

*Source: Analysis of MOFP budget data.*

## Analysis by level of delivery

Most of the health sector budget is held by the Ministry of Health (MoH) (Figure 7), which benefited from an 8 per cent increase in its resources between FY 2019/20 and FY 2021/22. During FY 2021/22, 54 per cent of the funding for MoH was allocated to the recurrent fund, 34 per cent to the local development budget and 12 per cent of the Ministry's budget funded foreign development programmes.

The other major component of the health budget is held by LGAs, whose budget increased by 15 per cent between FY 2019/20 and FY 2021/22. Most of the LGA funding was allocated towards recurrent expenditure (33 per cent) followed by foreign development funds (8 per cent) and local development fund (7 per cent) (Figure 7).

**Figure 7:** Health sector budget allocations by level of delivery




*Source: Analysis of MOFP budget data.*

# Budget execution

## Analysis by funding category

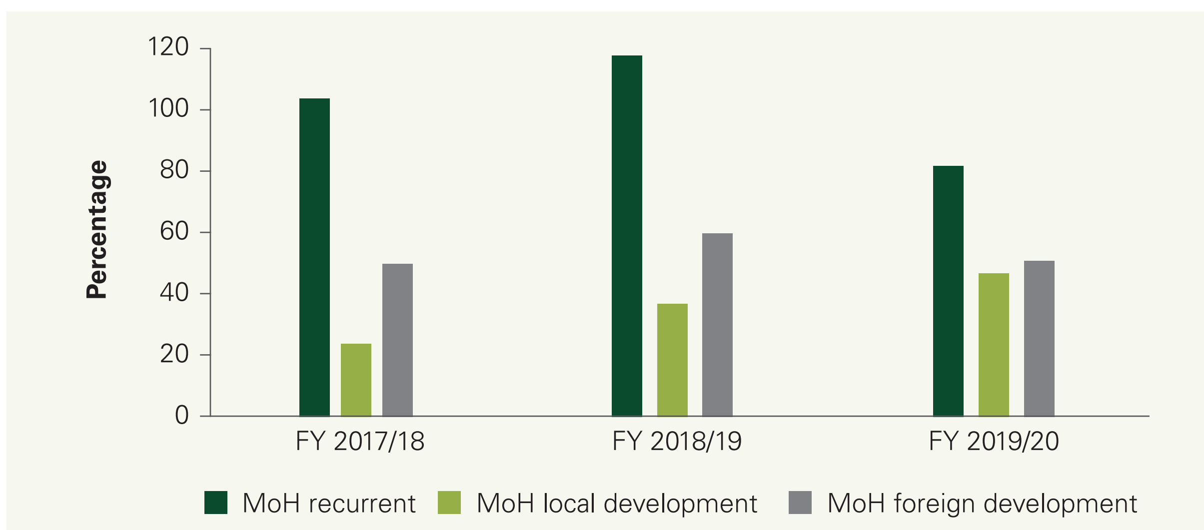
Between FY 2017/18 and FY 2018/19, the total budget execution rate for MoH increased from 57 per cent to 70 per cent, subsequently dropping to 63 per cent in FY 2019/20.

Significant variations in the execution rates by funding category were noted with consistently high rates for recurrent funds, low rates for the local development fund, and fluctuating values for foreign development funds. The execution rates of the recurrent budget fluctuated between FY 2017/18 and FY 2019/20. This can be explained in relation to changes in the number of health-care staff whose salaries constitute a significant part of the recurrent budget.

Between FY 2017/18–2018/19 and FY 2018/19–2019/20, the local development fund execution rate rose by 13 per cent and 10 per cent, respectively. However, execution remained under 50 per cent in FY 2019/20.

There was an increase in execution rates for foreign development funds, which firstly increased between FY 2017/18 and FY 2018/19 from 60 per cent to 70 per cent, followed by a subsequent decrease from 60 per cent to 51 per cent in FY 2019/20. Figure 8 represents execution rates by funding category.

**Figure 8:** MoH execution rate by fund category




*Source: Analysis of MOFP budget data.*

Important progress has been realized in the health sector. However, in order to accelerate progress towards the achievement of national objectives, it is critical to further increase the availability of human resources for health, address the PFM bottlenecks affecting budget execution rates and increase the availability of donor funding on budget.

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