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HEALTH BUDGET BRIEF 2020 | MAINLAND TANZANIA

KEY MESSAGES

- The sector budget remains significantly below the Abuja Declaration target allocation for health by all member governments of at least 15 per cent of their national budgets. The situation is critical. Just in order to keep up with the effects of the major factors of inflation and population growth, the downward trend of the proportion of the national budget allocated to health needs to be reversed.

- The health sector was allocated TSh 2.21 trillion in FY 2019/20, which amounts to a 0.4 per cent decline in nominal terms, when compared to TSh 2.22 trillion allocated in FY 2017/18. The allocation accounts for 6.7 per cent of the total national budget and 1.5 per cent of Gross Domestic Product (GDP), down from 7 per cent, and 1.8 per cent respectively over the same period.

- Budget execution rates are much lower for health than for the education sector, as well as the national budget. The overall health sector budget execution rate varied between 54.5 per cent and 71.6 per cent in FY 2017/18 and 2018/19 respectively. Setting up realistic fiscal envelopes for social sector and establishing a sound monitoring mechanism is very important for enhancing budget credibility.

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- There are variances in the allocation of health budgets across the regions. For instance, Geita region with the lowest rate of births attended by skilled health personnel, the health budget per capita was TSh 8,570, which was below the regional average of TSh 13,437 in FY 2018/19. It is critical to strengthen equity elements in the formulas of the sectoral block grants provided by the central government, which should be more strongly based on performance indicators and health outcomes.

- The accessibility of essential health services for vulnerable groups and people in hard-to-reach areas remains a real challenge. Therefore, it is very important to diversify and enhance the sustainability of funding sources for the health sector to ensure that essential health services are accessible to vulnerable groups. For instance, enhancing the community health insurance schemes with government support for vulnerable groups can be a feasible option to improve social health protection platforms.

- The COVID-19 pandemic affects the government budget, and domestic resources cannot cover all funding needs. Therefore, it is proposed that attracting concessional loans and available global resources including from the African Development Bank (AfDB) and other international financial institutions be considered. The government should also discuss with donors the reprioritization of existing donor funds and the mobilization of additional grants.

1. INTRODUCTION

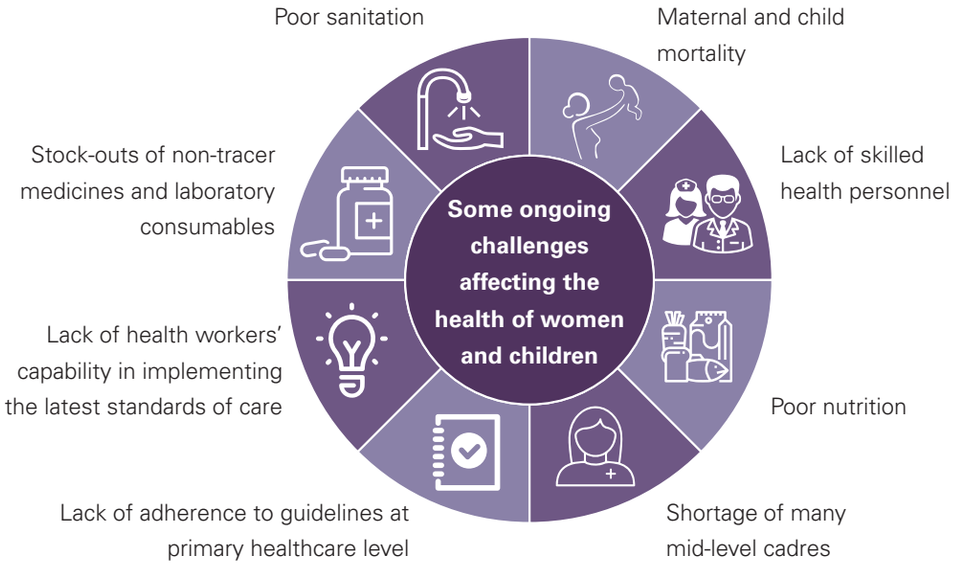
This Health budget brief update explores the extent to which Mainland Tanzania budget addresses the needs of children under 18 years. This brief analyses the size and composition of budget allocations for fiscal years between 2017/18 and 2019/20. It also offers insights into the efficiency, equity and adequacy of past spending. The main objective of the brief is firstly, to synthesize complex budget information so that it can be easily understood by all stakeholders and secondly, to put forth key messages which can inform policy and budgeting decision-making processes. The brief also discusses the implications of the COVID-19 pandemic on health sector financing and expenditure.

2. PERFORMANCE OF THE HEALTH SECTOR

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) is the leading ministry, department and agency (MDA) for most health sector policies. This ministry also administers largest health funds (42 per cent in FY 2018/19). As decentralization gathers pace, the President's office Regional Administration and Local Government is taking a greater role in coordinating the delivery of health services by local and regional authorities. Regional and local authorities were responsible for delivering 45 per cent of the total health budget for FY 2018/19.

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 permitted to opt for the NHIF. Direct transfers to the NHIF from the Government of Tanzania (GoT) were estimated to have accounted for 10 per cent of the health sector budget in FY 2019/20. The Community Health Fund (CHF) is a voluntary pre-payment insurance fund for health care. It has been rolled over to 144 out of 168 councils operating under local government authorities through NHIF coordinators. Participants pay an annual membership amount which entitles them to access basic medical care and medicine without making additional co-payments. The national government subsidizes these funds through a matching subsidy. The CHF subscription costs, and the services covered are defined by district governments.



Indicators for the health sector point to some ongoing challenges affecting women and children in spite of significant investment from the GoT and development partners (DPs) over time. The most important aspects of child and maternal health issues are highlighted below:

- While remarkable progress has been made in reducing preventable child deaths since 2004/05, maternal and child mortality remains high. The mortality rates for children under five and above five are 79 and 52 per 1000 live births respectively (Table 1). For example, 320 children under 5 years of age die every day due to preventable causes; 39 per cent of these deaths occur in the first 28 days of life and 70 per cent occur before the first birthday.[1] The maternal mortality rate is 556 for 100,000 live births.

- Approximately 1 out of 3 women who give birth are not attended by skilled health personnel. The result is not just maternal deaths, but also low levels of education about caring for newborns, including such issues as the importance of breast feeding and ensuring that babies receive the necessary vaccines required to be given directly after birth and during follow up visits for the remainder of early childhood. Similar to the link between poverty and mother and child mortality, the absence of doctors, nurses and skilled personnel for the delivery of children has a strong and perversely high link to the high rates of mortality affecting pregnant women, infants and all children under the age of five.

- Poor health is partly attributable to poor nutrition. The situation is particularly detrimental for pregnant women, from the period of gestation to the first 1000 days of their children's lives. Tanzania has quite high levels of stunting and wasting at 32.1 and 7.1 per cent respectively for children under the age of five. Increasing the number of women who deliver babies under the care of skilled health personnel, inclusive of pre-natal visits would help to ensure that mothers are taught the importance of eating healthy and fortified food during pregnancy, and the importance of breast feeding for at least six months. Families living below the food poverty line should also be given cash transfers to supplement their income to feed pregnant woman and later on their children with adequate, nutritious and fortified food. Investment in the early years of childhood has been demonstrated to lead to enormous gains in per capita and national growth as well as the reduction of poverty rates. Prevention of ill health is cheaper than trying to cure people who are already sick.

- The mid-term review of the Health Sector Strategic Plan (HSSP) IV revealed that key obstacles for fully achieving HSSP IV targets for quality are:

i. Shortage of many mid-level cadres in most health facilities;

ii. Non-availability of and/or lack of adherence to guidelines at primary healthcare level;

iii. Lack of health workers' capability in implementing the latest standards of care;

iv. Stock-outs of non-tracer medicines and laboratory consumables.

[1] Sustainable Development Goals and Children in Tanzania, UNICEF, 2019

- International Studies[2] continuously point to poor sanitation as a major cause of death from treatable afflictions such as diarrhoea, typhoid and cholera outbreaks which are the result of dirty and polluted water. These diseases are best avoided, but can also be treated cheaply if services are close by. Poorer segments of the population are particularly at risk, including malnourished children, pregnant women and the elderly. Only 3 in 5 people in Tanzania have an improved source of water, whereas in rural areas, 1 in 2 persons in the Mainland have access to it.[3] Moreover, poor sanitation in Mainland Tanzania is a direct result of limited water treatment options; plus 16.1 per cent of Tanzanians cannot access latrines or toilets leading to no option but polluting and disease spreading open defecation practices.

Table 1: Health indicators

Life expectancy at birth (years) for Mainland (2020)[2]	66	**Percentage of households with at least one insecticide-treated bed net for Mainland (2017) (%)[6]**	77.9
Infant mortality rate per 1,000 live births for Mainland (10-year period before 2015/16)[1]	52	**Total fertility rate for Mainland (2020)[4]**	5.0
Under-5 mortality rate per 1,000 live births for Mainland (10-year period before 2015/16)[6]	79	**HIV/AIDS prevalence rate for Mainland (among persons aged 15–49 years)(%)[5]**	4.8
Maternal mortality rate per 100,000 live births (10-year period before 2015/16)[1]	556	**Physicians per 10,000 population[3]**	0.75
% Wasting children < 5 for Mainland (2018)[4]	3.5	**Nurses per 10,000 population[3]**	3.80
% Stunted children < 5 for Mainland (2018)[4]	32.1	**Births attended by skilled health personnel (%)**	63.5[1] 79.4[3]
Prevalence of malaria in children aged 6-59 months for Mainland (2017) (%)[1]	7.5	**Measles immunization coverage at under one year (%)[3]**	95
Children under 18 as a % of total population for Mainland (2020)[2]	50.0		

Sources: [1] Tanzania Demographic and Health Survey (2015/2016) [2]; NBS Population Projections 2017; [3] Annual Health Sector Performance Profile 2019 ; [4] Tanzania National Nutrition Survey 2018; [5] Tanzania HIV Impact Survey (THIS) 2016/17; [6]Tanzania Malaria Indicator Survey 2017

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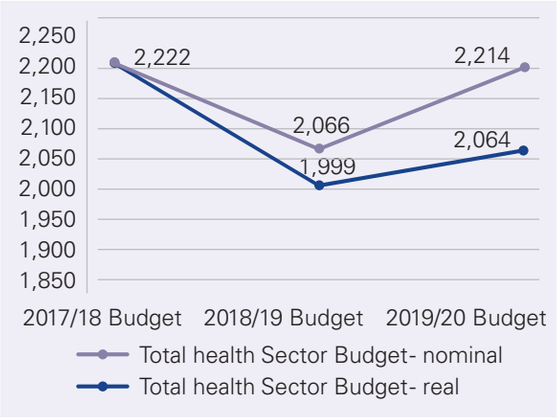
[2] A significant amount of disease could be prevented through access to safe water supply, adequate sanitation services and better hygiene practices. Diarrhoeal diseases alone amount to an estimated 3.6 per cent of the total DALY global burden of disease and is responsible for the deaths of 1.5 million people every year (WHO 2012). It is estimated that 58% of that burden, or 842 000 deaths per year, is attributable to unsafe water supply, sanitation and hygiene and includes 361 000 deaths of children under age five, mostly in low-income countries (WHO 2014).

[3] Sustainable Development Goals and Children in Tanzania, UNICEF, 2019

3. HEALTH SPENDING TRENDS

In nominal terms, total health budget allocations decreased by 0.4 per cent from TSh 2.22 trillion in FY 2017/18 to a forecasted TSh 2.21 trillion in FY 2019/20. In real terms, after accounting for inflation, this figure represents a decline of 7.1 per cent during the same period.

Figure 1: Approved budget for the health sector from FY 2017/18 to 2019/20 (TSh billion)

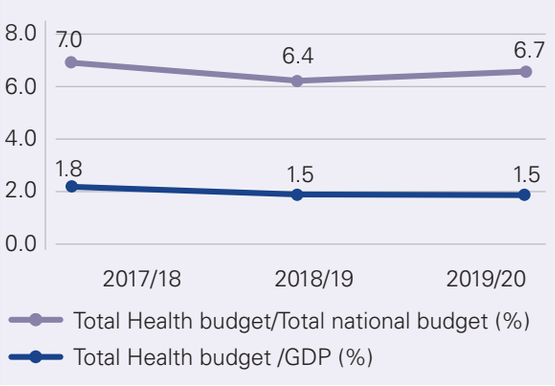


Source: UNICEF calculations based on data from Ministry of Finance, approved budget (various years). The year 2017/18 is the base year for inflation adjustments.

Overall spending for health stood at 7 per cent of the total budget for FY 2017/18, but has since declined to 6.7 per cent in FY 2019/20 (Figure 2). The relative share of the health sector has declined from 10 per cent to 9.3 per cent in the total budget excluding Consolidated Fund Services (CFS) during the same period.

International health targets suggest that total health spending should be 15 per cent of total government expenditure as defined by the Abuja Declaration. The GoT currently falls short of the target by a wide margin. The health budget as a share of GDP has declined from 1.8 per cent to 1.5 per cent between FY 2017/18 and 2019/20.

Figure 2: Health budget allocations as a share of total national budget and GDP From FY 2017/18 to 2019/20 (%)



Source: UNICEF calculations based on data from Ministry of Finance and Planning, Budget books FY 2019/20, volumes 1, 2 and 3.

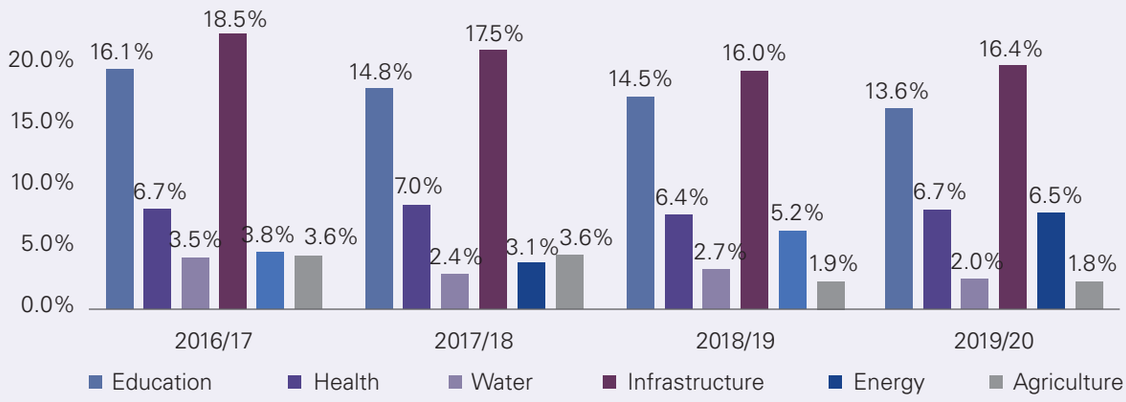
The health sector is one of the largest sectors in Tanzania, representing 6.7 per cent as a share of the total national budget for FY 2019/20 (Figure 3). Infrastructure is the largest sector at 16.4 per cent, followed by Education at 13.6, Health 6.7, Energy 6.5, Water 2 and Agriculture

1.8 per cent. However, some large budget components such as administrative services (including debt service) (23 per cent), defence (5.6 per cent), and minerals (4.5 per cent) were not captured in the analysis.

Given the population growth, shortages of human resource, and the implications of the COVID-19 pandemic, the share of the health sector should be increased. Better implementation of the existing costed strategies is pivotal to understand the financial gaps and for mobilizing resources to rectify current bottlenecks in the health system. Furthermore, the quality of health spending can be improved through enhancing budget execution performance and better monitoring of public expenditure.

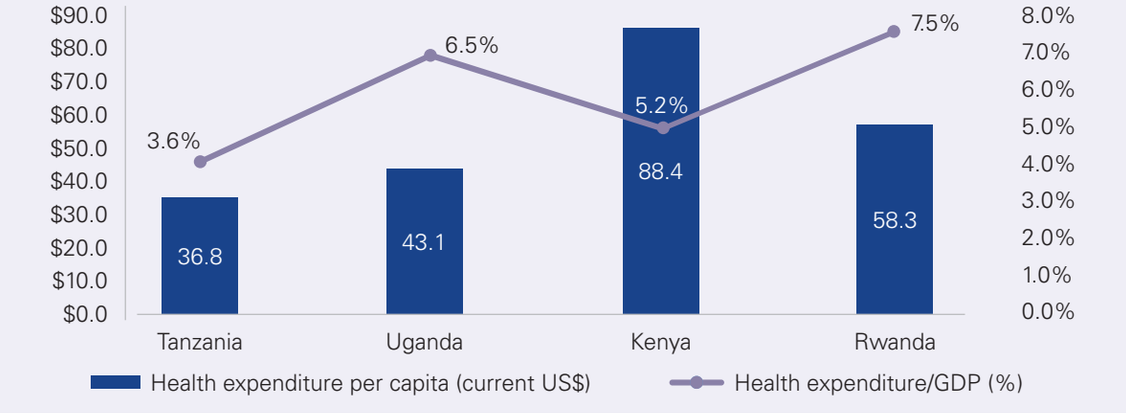
In comparison to neighbouring countries, Tanzania's health expenditure per capita is low, standing at US$ 36.8 compared with US$ 88.4 in Kenya and US$ 58.3 in Rwanda (Figure 4). Tanzania's health expenditure as a share of GDP was lower than that of Kenya, Rwanda and Uganda.

Figure 3: Health versus other key sectors–share of total budget (%), between 2016/17 to 2019/20



Source: Ministry of Finance and Planning, Budget books 2019/20, Volumes 1, 2 and 4.

Figure 4. Health expenditure figures for selected East African countries 2018



Source: https://data.worldbank.org/indicator

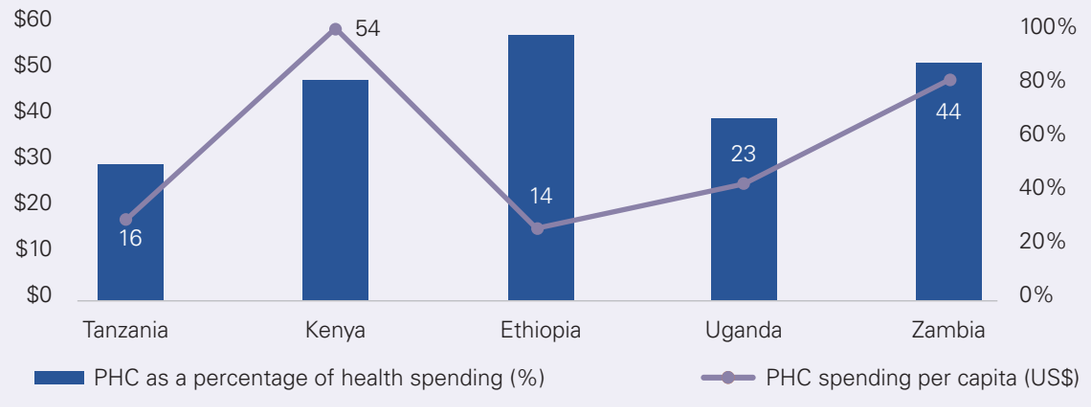
Moreover, Tanzania's Primary Health Care (PHC) per capita spending and PHC as a percentage of health spending are lower than those of neighbouring countries such as Kenya, Uganda, and Zambia (Figure 5).

According to the WHO global report on health spending, across 88 countries, published in 2019, PHC spending ranges from 33 per cent to 88 per cent of health spending. Per capita spending is higher in wealthier countries, but PHC takes a greater share of health spending in low- and middle-income countries. The priority governments give to PHC varies from 42 per cent of health spending in upper-middle-income countries to 55 per cent in lower middle-income countries and 65 per cent of health spending in low-income countries. Yet only a third of total PHC spending comes from governments. The lower the country income, the lower the public share: in low-income countries private sources represent half of PHC spending. Across all income groups, governments provide very limited funding for medicines.

The COVID-19 pandemic requires the mobilization of massive financial and human resources to address its direct and secondary impact, notably on vulnerable groups. This situation has implications for health, water, sanitation and hygiene (WASH), nutrition, education and social protection budgets.

In view of the COVID-19 pandemic, it is recommended that the national economic development priorities and targets for the FY 2020/21 be revised. In the reprioritization of expenditure, greater priority should be given to comprehensive economic stimulus packages, health, WASH, nutrition, education and (social) protection programmes. Setting up realistic fiscal envelopes for social sector and establishing a rigorous monitoring mechanism in respect of their spending (budget execution) should be among the priority measures. The health budget priorities should not only cover the increased expenditure related to the direct COVID-19 response, but also encompass stepped-up allocations to ensure access to essential health services that could include, for instance, immunization of mothers and newborns, management of common childhood illnesses, nutrition support, supplies and commodities for routine services, and treatment of pneumonia and malaria.

Figure 5: Comparative health expenditure on primary health care in selected East African countries



Source: WHO, Global Spending on Health: A World in Transition, WHO, Geneva, 2019.

TAKEAWAYS

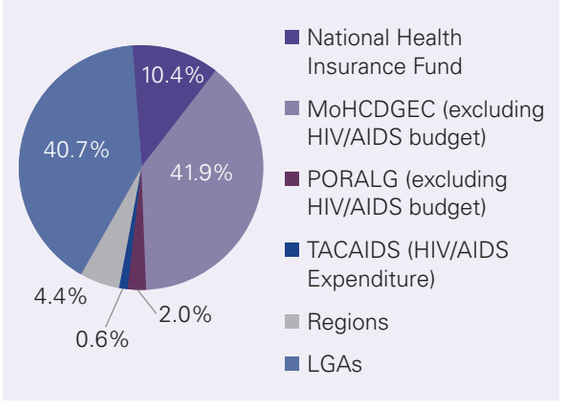
- Over the last three years, the share of public spending on health in relation to total public spending and the GDP has been declining. The sector budget therefore remains significantly below the Abuja Declaration target that all member governments allocate at least 15 per cent of their national budgets to health. Just to keep up with inflation and population growth, the downward trend of the proportion of the national budget allocated to health needs to be reversed.

- There is no costed health strategy of the GoT based on the country's demographic change and emerging needs of the population for health services, that addresses the shortage of skilled human resources and supplies in the health sector. Having such a strategy is critical for understanding the existing financial gaps and for mobilizing resources to rectify current bottlenecks in the health system.

4. COMPOSITION OF HEALTH SPENDING

About 54.9 per cent, the largest share of the FY 2018/19 health sector's budget, is managed by the central government through the MoHCDGEC (41.9 per cent), PO-RALG (2 per cent), NHIF (10.4 per cent) and TACAIDS (0.6 per cent). Disaggregated spending data shows that health is not quite decentralized. For instance, LGAs were allocated about 41 per cent of the sector's budget through fiscal transfers from the central government dedicated to recurrent and development spending.

Figure 6: Share of MDAs in total health budget FY 2018/19 (%)



Source: Ministry of Finance and Planning (2019)

4.1 Health budget by economic classifications

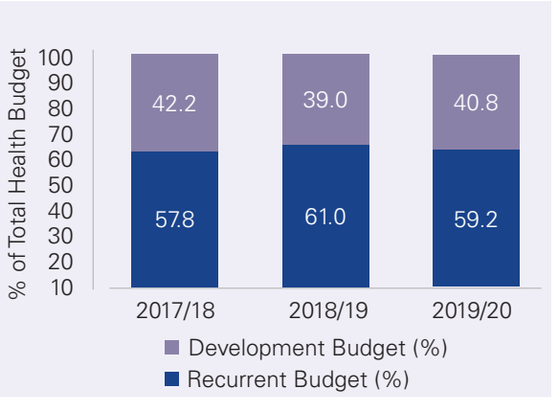
For FY 2017/18 the recurrent budget stood at 57.8 per cent and the development budget at 42.2 per cent, compared to 59.2 and 40.8 per cent respectively for FY 2019/20 (Figure 7). Health is traditionally a recurrent heavy sector because of the large numbers of nurses and doctors needed to deliver medical services. Currently, a higher recurrent budget allocation to hire more midwives, nurses, and doctors is required. It is also vitally important to balance recurrent spending for salaries and goods and services with development funds to invest in essential infrastructure.

Although progress has been made in the past few years, more could be done to ensure that health sector staff is motivated, skilled and is

retained. Incentives such as housing, water, electricity and good schools for their children, made available within a reasonable distance from the facilities in which they work, are some of the strategies that can help motivate and retain skilled health workers.

Since the introduction of the Direct Health Facility Financing Programme (DHFF) in 2018/19 the share of the budget allocated for LGAs has increased. However, due to data challenges at the LGA level of the budget, it is difficult to analyse the size and composition of spending. Based on available data, in FY 2019/20, 71 per cent of LGAs budget on health focused on recurrent items, including salaries and 29 per cent for development purposes.

Figure 7: Recurrent versus development budget allocations for health from FY 2017/18 to 2019/20 (% of total health budget)

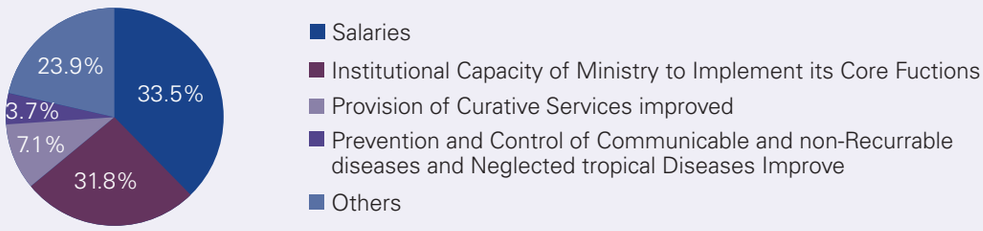


Source: Ministry of Finance and Planning, Budget book (2019/20)

4.2 Health budget by programmes

At present, the largest share of the MoHCDGEC budget goes to salaries at 33.5 per cent, which is followed by institutional capacity building at 31.8 per cent. Curative services were allocated 7.1 per cent of the budget, while prevention and control of communicable diseases was allocated 3.7 per cent for FY 2019/20.

Figure 8: Key budget allocations by institutional objectives of MoHCDGEC for FY 2019/20 (as a share of total budget of MoHCDGEC)



Source: Ministry of Finance and Planning, Budget book 2019/20 Volumes 2, 3 and 4 and Supply Votes (Ministerial)

TAKEAWAYS

- Although progress has been made in the past few years, more can be done to ensure that health sector staff is motivated, skilled and is retained. Incentives such as housing, water, electricity and good schools for their children, made available within a reasonable distance of the health facilities in which they work, are some of the strategies that can help to motivate skilled health workers and to retain them.

5. BUDGET CREDIBILITY AND EXECUTION

Total budget execution for the health sector has improved from 54.5 per cent in FY 2017/18 to 71.6 per cent in FY 2018/19. The recurrent budget more than doubled in terms of actual expenditure from 50.1 per cent to 113.8 per cent over the same period (Figure 9). Recurrent expenditure performances are generally determined by revenue shortfalls or windfall issues such as reporting too late into the financial year; late releases or issues of differences in local versus international procurement rules can often explain why donors disburse late or not at all by year-end. However, the development budget shows low or varying rates of execution for domestic and externally financed development projects. For instance, budget performance rates for foreign-financed development were stable at 59.6 and 59.9 per cent in FY 2017/18 and 2018/19. Budget performance for the locally financed development declined from 57.1 per cent to 43.4 per cent during the same period.

An assessment of the financial management of Health Basket Fund (HBF) revealed the following risks:

1. Delays in the quarterly disbursements to the health facilities causing interruptions in supplies and challenges to the procurement systems at health facility and LGA levels.

2. Repeated carryovers that accumulate over time and undermine the achievement of the agreed goals of the HBF. Delays in approval and release of HBF monies are associated with the process within Ministry of Finance and Planning (MoFP).

3. Low levels of approved budget ceilings for health facilities and LGAs that do not allow for a full expenditure of available HB funds or the feasibility of reallocation procedures in respect of unspent funds (especially at LGA level July–September) and mid-year reallocation (January).

Moreover, budget execution rates of the health sector are lagging behind the national budget performance, which stood at 87 per cent and 79 per cent in FY 2017/18 and 2018/19 respectively (Figure 10). Given the importance of this sector it could be valuable to identify where bottlenecks originate and then develop an action plan to remedy the problems.

Risks involved in financial management of Health Basket Fund (HBF)

Delays in the quarterly disbursements to the health facilities

Repeated carryovers that accumulate over time and undermine the achievement of the agreed goals of the HBF

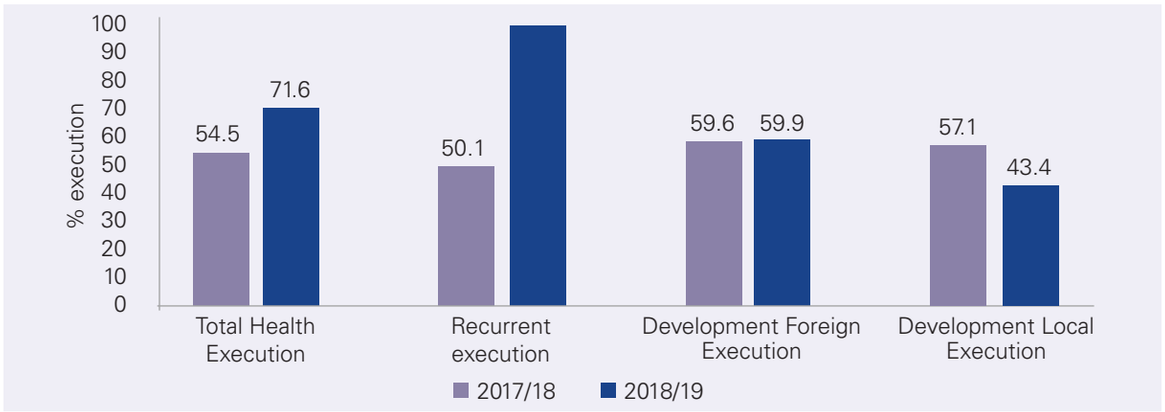
Low levels of approved budget ceilings for health facilities and LGAs

Analysis of budget execution rates for local authorities is not possible due to unavailability of information about expenditure. It is important to have an overview of spending for the whole sector and it should be possible to amend the Budget Execution Report format to include regional and LGA spending commitments and outturns for decentralized sectors including health. This action would greatly contribute to transparency, accountability and the effectiveness of decentralization from a credibility standpoint.

Setting up realistic fiscal envelopes for social sector and establishing a sound monitoring mechanism are both very important for enhancing budget credibility.

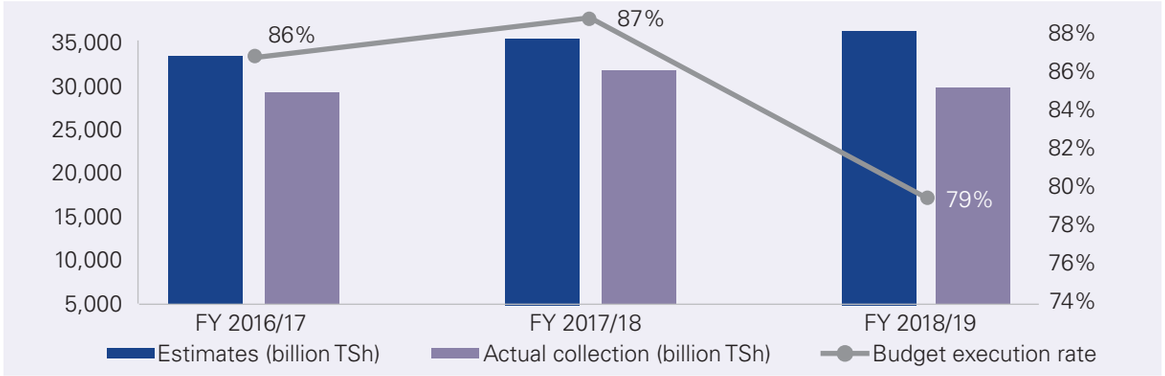
Tanzania faces a critical shortage of health staff. Reducing that shortage is a key priority for Tanzania, especially in poorer regions or hard-to-reach areas. However, at present it is difficult to understand, without data on salaries and posts filled, the number of ghost workers, non-attendees etc., especially outside central government institutions such as MoHCDGEC and the Tanzania Commission for AIDS (TACAIDS). Indeed, it is not even possible to identify the share of salaries for recurrent spending in respect of decentralized health services because of data constraints. Enhancing the use of EPICOR and FFARS can address the quality and accessibility issues of disaggregated data at LGA levels.[4]

Figure 9: Budget execution for the health sector – total, recurrent, development domestic, and foreign between FY 2017/18 and 2018/19 (% of total)



Source: Budget execution reports 2016/17, 2017/18 and 2018/19

Figure 10: National budget execution rates



Source: National Audit Office report 2018/19

[4] EPICOR and FFARS are Management Information systems (MIS) used by PO-RALG, LGAs and public services delivery entities to record and consolidate data on budget expenditure and financial transactions.

TAKEAWAYS

- Budget execution in the health sector has been lower than across other government departments. In particular there has been significant underperformance in relation to the development budget financed both by local and foreign sources. Setting up realistic fiscal envelopes for the development budget on health and establishing a sound monitoring mechanism is very important for enhancing budget execution.

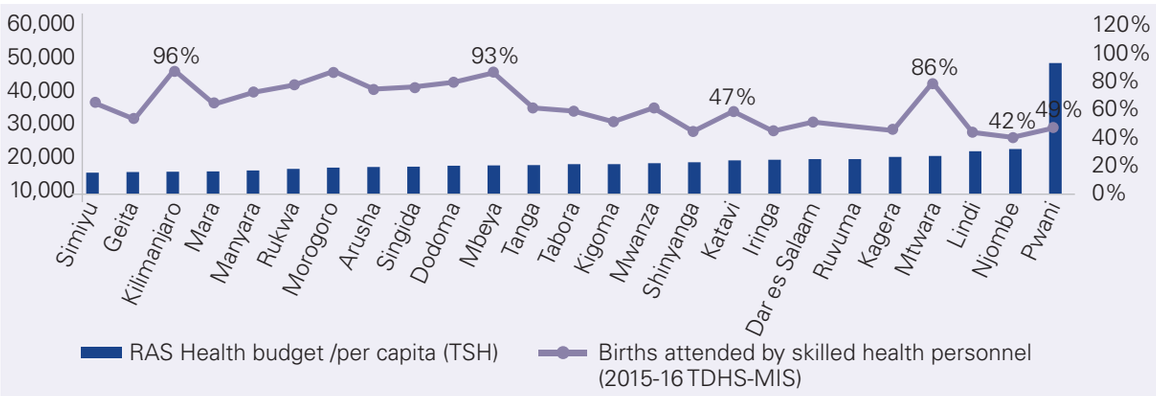
- Tanzania faces a critical shortage of health staff, but lack of some crucial information is preventing a full understanding of the problem. At present, without data on salaries and posts filled, it is not possible to assess the number of ghost workers, non-attendees etc., especially at the LGA levels. Enhancing the use of EPICOR and FFARS can address the quality and accessibility issues of disaggregated data at LGA levels.

6. EQUITY IN BUDGET ALLOCATION

There are significant variances in per capita health sector allocations to regions. For instance, Geita region with the lowest rate of births attended by skilled health personnel, the health budget per capita was TSh 8,570, which was less than the regional average of TSh 13,437 (Figure 11). It is clear that socio-economically disadvantaged regions face serious equity issues in the financing of key social services for children. It must be highlighted that, in many cases, disparities in the allocation of resources to LGAs are significantly affected by the availability, or otherwise, of health facilities and medical personnel.

Inter-governmental fiscal transfers play a critical equalizer role where socio-economic disparities are significant. Integrating more equity elements into the grant block transfers on recurrent and development budgets can address inequity issues in accessibility of health services in hard-to-reach areas. It is recommended that a study be commissioned with the object of shedding light on bottlenecks and to develop a set of recommendations for further enhancing the intergovernmental fiscal transfer formulas.

Figure 11: Per capita health budget allocation by regional administrations and births attended by skilled health personal



Source: PO-RALG 2018/19, NBS, TDHS-MIS 2015/16

TAKEAWAYS

- There are significant variances in per capita health sector allocations to regions. Disparities in the allocation of resources to LGAs are driven by the availability or lack of health facilities and medical personnel. Commissioning a study to shed light on bottlenecks, and to develop a set of recommendations for further enhancing the intergovernmental fiscal transfer formulas, would be advisable and feasible in our view.

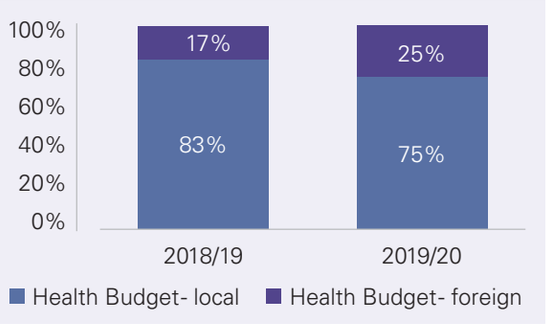
7. FINANCING THE HEALTH SECTOR

The health system in Tanzania is financed by multiple sources including the government budget, national and private health insurance systems, DPs, the private sector and also individuals.

An analysis of the sources of the health sector financing at MDA and LGA level reveals that the overall share of foreign financing increased from 17 per cent to 25 per cent between FY 2018/19 and 2019/20 (Figure 12.)

In FY 2019/20, the share of foreign financing of regional authorities increased significantly as compared with that of MoHCDGEC and local authorities (Figure 13). Most of the foreign financing at regional levels focused on supporting development activities such as training health workers, developing communication materials and equipping health facilities with modern technologies.

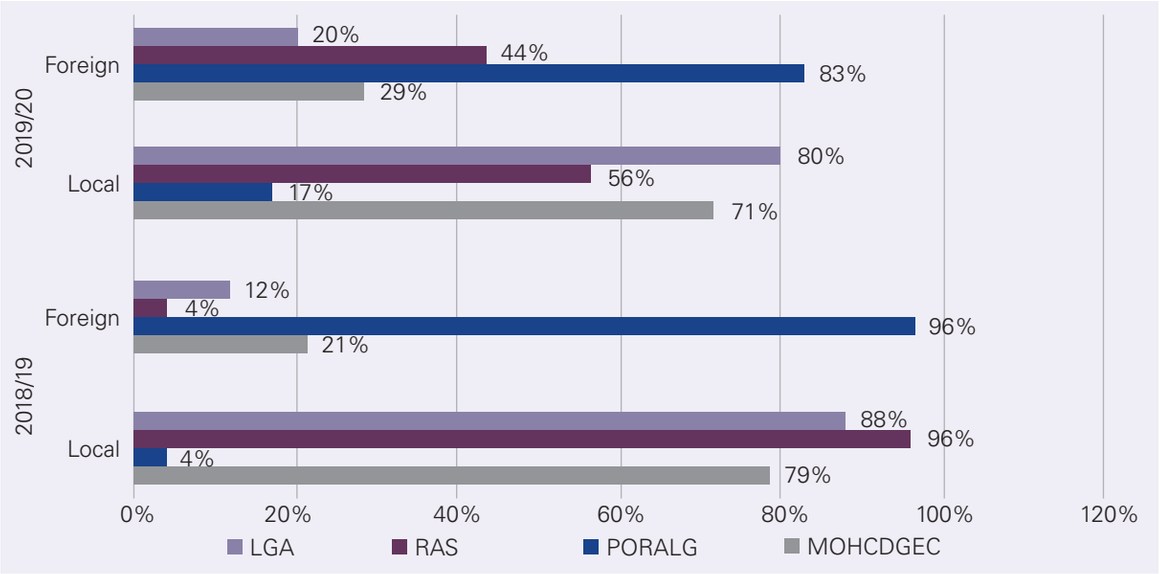
Figure 12: Local and foreign sources of finance of the health sector (consolidated for MoHCDGEC, RAS and LGAs) between FY 2018/19 and 2019/20 (%)



Source: Calculations based on budget books: Volumes 2,3, & 4 for various years published by MoFP for FY 2018/19 and 2019/20.

Photography: © Leslie Knott

Figure 13: Sources of finance for the health sector–Approved budgets for FY from 2018/19 to 2019/20 (%) of PO-RALG, MoHCDGEC, RAS and LGAs

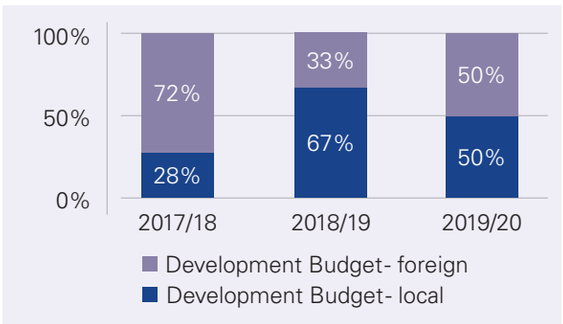


Source: Calculations based on budget books: Volumes 2,3, & 4 for various years published by MoFP for FY 2018/19 and 2019/20.

The source of funds for the development budget of the MoHCDGEC has changed substantially over the last 3 years. There has been a sharp decline in foreign finance, from 72 per cent in FY 2017/18 to 50 per cent in FY 2019/20. GoT has in response increased its share of financing for both the recurrent budget and the domestically financed development budget. Recurrent spending was increased from 34.2 per cent in FY 2017/18 to 43.3 per cent in FY 2019/20 and development funding more than doubled between FY 2017/18 and 2018/19 from 18.5 to 43.5 per cent respectively, as compared to the low rate of 28.2 per cent which had been forecast for the FY 2019/20.

In order to better support the implementation of HSSP IV an HBF was established by the GoT and DPs. The major objective of the HBF is to promote achievement of the HSSP IV target by increasing resources in the health sector and focussing on LGAs, so that underserved populations may be provided with essential, effective and affordable health services, and a contribution made towards enhanced and effective decentralization of the delivery of quality primary health care. The HBF is mainly supported by 8 partners: 5 bilateral (SDC, Danida Canada, KOICA and Ireland) and 3 multilaterals (World Bank, UNICEF and UNFPA).

Figure 14: Sources of finance for the development budget of MoHCDGEC from FY 2017/18 to 2019/20 (%)



Source: UNICEF's calculation based on budget books: Volumes 2, 3, & 4 for various years (published by MoFP)

Health Insurance Programmes

In FY 2017/18, NHIF and CHF served 17,425,329 beneficiaries compared to 15,675,396 in FY 2016/17, equivalent to an increase of 11.2 percent. Beneficiaries served by the Funds were the equivalent of 33 per cent of the total population of Tanzania Mainland. Of them, there were 3,918,999 NHIF beneficiaries and 13,506,330 CHF. During that period, TSh 371 billion were paid to service providers compared to TSh 303.8 billion paid in FY 2016/17, equivalent to an increase of 22.1 per cent. The increase was due to improvement of benefits offered to members as well as surgical services especially heart surgery, which is costly.

However, the accessibility of essential health services for vulnerable groups and people in hard-to-reach areas remains a real challenge. Therefore, it is very important to diversify and enhance the sustainability of funding sources for the health sector to ensure essential health services are accessible to vulnerable groups. For instance, enhancing the community health insurance schemes with government support for vulnerable groups can be a critical step towards improvement of the social health protection platform.

As mentioned earlier, the COVID-19 pandemic affects the government budget and domestic resources cannot cover all funding needs. It is proposed that attracting concessional loans and available global resources, including from the AfDB and other global financial institutions, should be considered. Another option is to negotiate the rescheduling of debt service obligations. The government should also discuss with donors the reprioritization of existing funds and the mobilization of additional grants.

TAKEAWAYS

- The accessibility of essential health services for vulnerable groups and people in hard-to-reach areas remains a real challenge. Therefore, enhancing the community health insurance schemes with government support for vulnerable groups can be a critical step towards improving the social health protection platform.
- The COVID-19 affects the government budget, and domestic resources cannot cover all funding needs. To relieve the burden placed on the health sector by the COVID-19 pandemic, it is imperative to develop and implement a sound resource mobilization plan.