HEALTH BUDGET BRIEF

FY 2011/12–FY 2015/16

Key messages

» Allocations to the health sector have grown by 65 per cent in terms of budgeted amounts (FYs 2012/13–2015/16) and by 29 per cent in terms of actual spending (FYs 2012/13–2014/15). Health spending per capita has increased accordingly.

» Health sector spending as a share of the entire state expenditure has slightly increased from 6.3 per cent in FY 2012/13 to 6.6 per cent in FY 2014/15 (while declining if budgeted amounts are considered), as well as a share of GDP, reaching 3.5 per cent in FY 2015/16.

» Moreover, the health sector is third, lagging behind education and infrastructure sectors, when it comes to sectoral shares of the overall national budget. It has less than half of the budget share of the education sector.

» The budget execution rate of the sector has been relatively good, averaging 91.7 per cent. The share of the recurrent budget has been on the decline to the advantage of development spending (these are 71.4 and 28.6 per cent respectively in FY 2015/16). Actual spending on preventive care has gradually outpaced curative services over the past five years. The share of decentralised health sector resources averaged 43 per cent over the period.

» Foreign resources account for over one third of total spending, far above the averages for sub-Saharan Africa and lower middle countries.

» Several challenges persist, ranging from insufficient budgetary allocations to the Health Sector Strategic Plan, inequitable sub-national allocations, the recent significant decline in transfers to hospitals, and geographic variations in budget execution rates.

» In terms of sector performance, while significant progress has been made in reducing child mortality, neonatal and maternal mortality remain high, as well as sub-national inequities.

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1. How is the health sector defined and guided?

For budgetary purposes, the health sector includes expenditures by the former Ministry of Health and Social Welfare — now called the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), and health-related expenditures of the President's Office for Regional Administration and Local Government (PO-RALG), previously located under the Prime Minister's Office. It also covers spending by the National Health Insurance Fund (NHIF) and the Tanzania Commission for AIDS (TACAIDS).

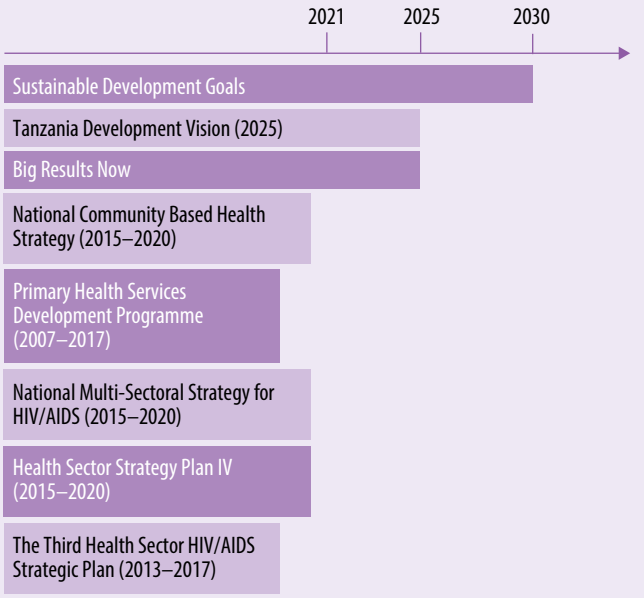
The health sector operates at both national and sub-national levels based on a decentralised approach introduced in 2001. Core responsibilities lie with MoHCDGEC and PO-RALG. The former coordinates overall planning, financing and monitoring, whereas local level planning and service delivery are delegated to local governments under PO-RALG.

At the sub-national 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 specialized and consultant hospitals.

The National Health Policy was first launched in 1990 and updated in 2007. The sector is guided by the Health Sector Strategy Plan (HSSP), which is about to enter its fourth cycle, and complemented by a number of specific strategies and plans (Figure 1).

To accelerate the provision of primary health care services for all, the government developed the Primary Health Care Service Development Programme 2007–2017. The programme intends to strengthen health systems, human resource development and referral mechanisms, as well as increase health sector financing and improve the provision of medicines, equipment and supplies. MoHCDGEC implements Primary Health Care Service Development Programme in collaboration with local governments. The programme addresses key health issues, including maternal and child health and priority diseases.

FIGURE 1 FRAMEWORK OF STRATEGIC PLANS GUIDING THE HEALTH SECTOR

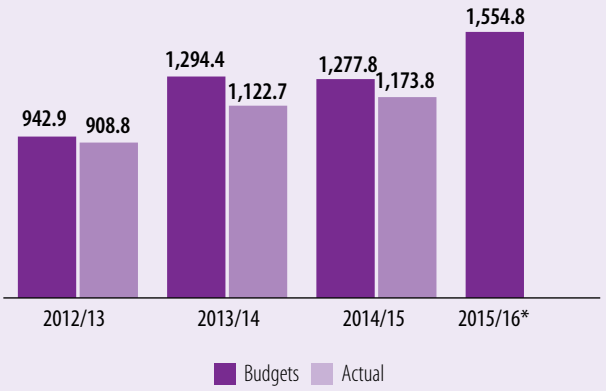


2. What trends emerge from the health sector budget?

The overall state budget has been expanding at a nominal annual average rate of 19.5 per cent (and a real annual average growth rate of 10.5 per cent) over the past five years. In absolute terms, the budget has expanded from TShs 14.1 trillion (FY 2011/12) to TShs 23 trillion (FY 2015/16). The state budget to gross domestic product (GDP) ratio reached 23.9 per cent during FY 2015/16, from 21.4 per cent in FY 2011/12. Development expenditure comprises around 30 per cent of the total budget, with the remaining 70 per cent covering wages and salaries (27 per cent) and other charges (OC) (43 per cent). Domestic tax revenue has been on the rise as well, from TShs 6.5 trillion (FY 2011/12) to TShs 9.9 trillion (FY 2014/15). However, as a share of GDP, domestic tax revenues have increased marginally from 12 to 13 per cent over the same period of time[1]. Budget execution improved overtime, from 84 per cent in FY 2011/12, to 94 per cent during FY 2014/15.

Allocations to the health sector increased over the past five years, both in terms of budgeted and actual amounts. In FY 2015/16, the health sector was allocated over TShs 1.5 trillion (Figure 2), representing a 32.5 per cent nominal increase (26.6 per cent in real terms) over the sector's actual spending in FY 2014/2015. The year-on-year increase between FYs 2011/12–2015/16 averaged 20.2 per cent.

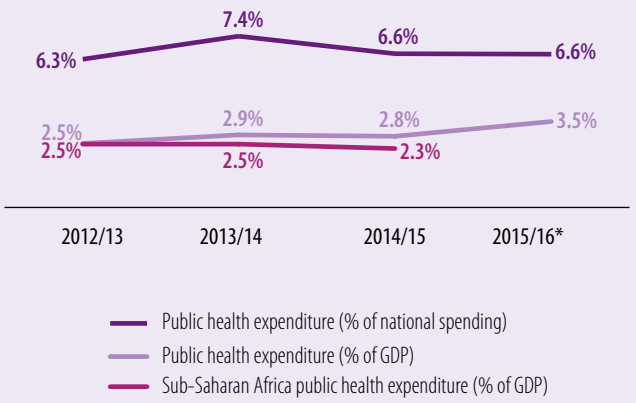
FIGURE 2 TRENDS IN THE BUDGETS AND ACTUAL SPENDING OF THE HEALTH SECTOR (TSHs BILLION)



Source: *UNICEF calculations based on MoFP IFMS data*
** Budgeted figures*

Over FYs 2012/13–2015/16, the health sector's share of the total state spending increased slightly while growing significantly as a share of GDP, above the average in sub-Saharan Africa (Figure 3).

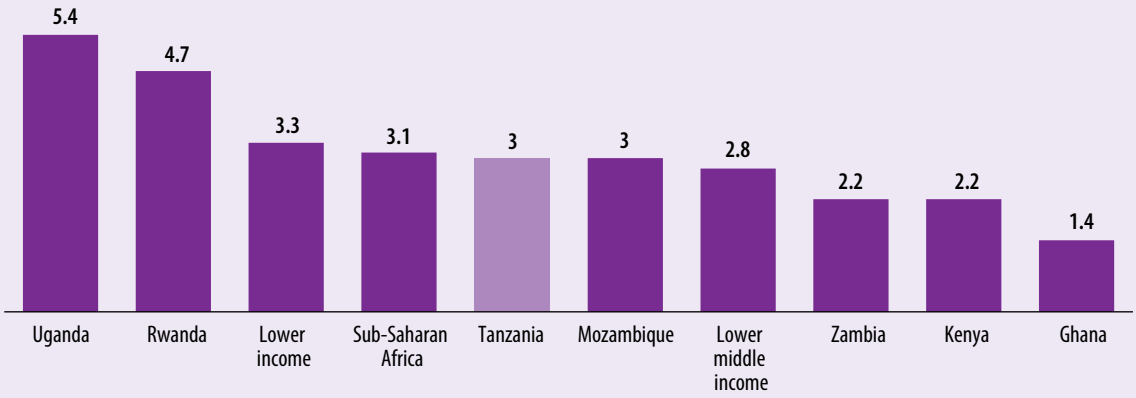
FIGURE 3 TRENDS IN HEALTH EXPENDITURE % OF TOTAL PUBLIC SPENDING AND GDP



Source: *UNICEF calculations based on MoFP IFMS data and World Bank World Development Indicators dataset (2016)*
** Budgeted figures*

Private health expenditure in Tanzania, whose share of GDP grew from 1.9 per cent in 2009 to 3 per cent in 2014, is higher than the average for lower middle income countries and close to the average for sub-Saharan African countries (Figure 4). Private health expenditure includes direct household (out-of-pocket) spending; private insurance; charitable donations; and direct service payments by private corporations. As a share of private health expenditure, out-of-pocket contributions declined from 52 per cent in 2010 to 43.3 per cent in 2014[2], but remained the same in per capita amounts[3].

FIGURE 4 PRIVATE HEALTH EXPENDITURE (% OF GDP): CROSS-COUNTRY COMPARISON (2014)

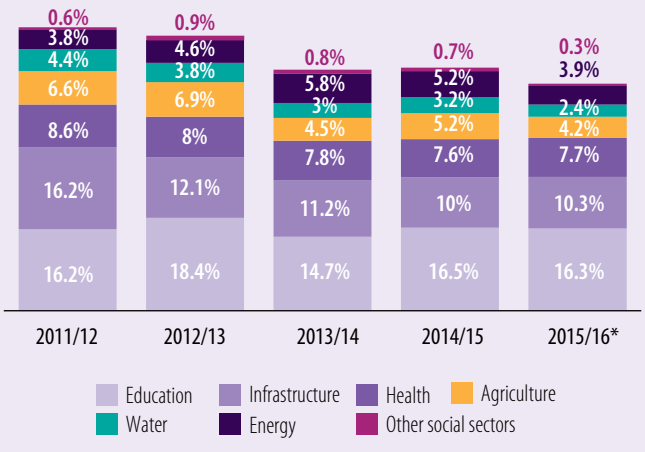


Source: *World Bank World Development Indicators dataset (2016)*

Allocations to the health sector have grown over time. In terms of budget share, health remains far behind education and infrastructure.

In terms of the share of the national budget allocated to priority sectors, health lags behind education and infrastructure, showing a declining trend (Figure 5). Further, over FYs 2011/12–2015/16, the six priority sectors covered 49.5 per cent of the overall state budget, with the share of health in the total allocation to priority sectors averaging 15.6 per cent, which is about half that of education.

FIGURE 5 THE SHARE OF THE HEALTH SECTOR IN THE TOTAL BUDGET COMPARED TO OTHER PRIORITY SECTORS (FYs 2011/12–2015/16)



Source: UNICEF calculations based on data from MoFP priority sector analysis
** Budgeted figures*

Public health expenditure per capita is on the rise. It increased from TShs 20,228 (US$ 9.2) in FY 2012/13 to TShs 31,948 (US$ 14.7) in FY 2015/16[4], however, still well below the WHO recommended target of US$ 54 per capita to address health challenges. The average growth rate over the period was 17 per cent.

3. Where do heath sector resources come from?

Health sector financing is characterised by diverse sources including the government budget; the Health Sector Basket Fund (HSBF) comprising funds from development partners; resources from non-governmental organisations (NGOs); out-of-pocket payments; and funds from health insurances. At the central level, MoHCDGEC and other health-related central units (such as regional and national hospitals and the Medical Stores Department (MSD), which are under the direct supervision of MoHCDGEC, are funded through transfers from the Treasury. Funding for Local Government Authorities' (LGAs) health expenditures comes from their own votes and subsidies from the Treasury, user fees (cost sharing) and community-based health insurance schemes (i.e. the Community Health Fund (CHF), which serves rural areas, and *Tiba kwa kadi* (TIKA) in urban centres). It is common to find donors and NGOs directly financing health-related initiatives at the local level.

Foreign resources account for over one third of total spending, far above the averages for sub-Saharan Africa and lower middle countries (Figure 6). The health sector has adopted a sector-wide approach (SWAP) for medium- and long-term planning since the 1990s, which has had a positive impact on foreign funding coordination. However, external resources remain highly volatile.

FIGURE 6 TRENDS IN EXTERNAL RESOURCES FOR HEALTH (% OF TOTAL PUBLIC EXPENDITURE ON HEALTH)

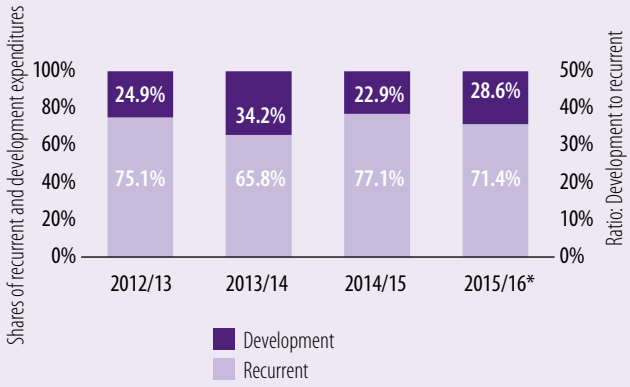
Source: *World Bank World Development Indicators dataset (2016)*

4. How are health resources used?

4.1 Recurrent expenditure versus investment

Over FYs 2012/13–2015/16, the share of the recurrent budget declined in favour of investments (Figure 7). Overall, the recurrent budget averaged 72.3 per cent, while the development budget averaged 27.7 per cent over the four-year period. The share of wages and salaries (personal emoluments) in the overall health budget has been declining over time (from 4 per cent in FY 2012/13 to 3.7 per cent in FY 2014/15, and then dropping to 2.8 per cent in FY 2015/16), an indication that much of the increase in the health budget is consumed by non-salary expenses.

FIGURE 7 INCREASING SHARE OF RECURRENT RESOURCES IN TOTAL PUBLIC BUDGET (FYs 2012/13–2015/16)



Source: *UNICEF calculations based on MoFP IFMS data*
** Budgeted figures*

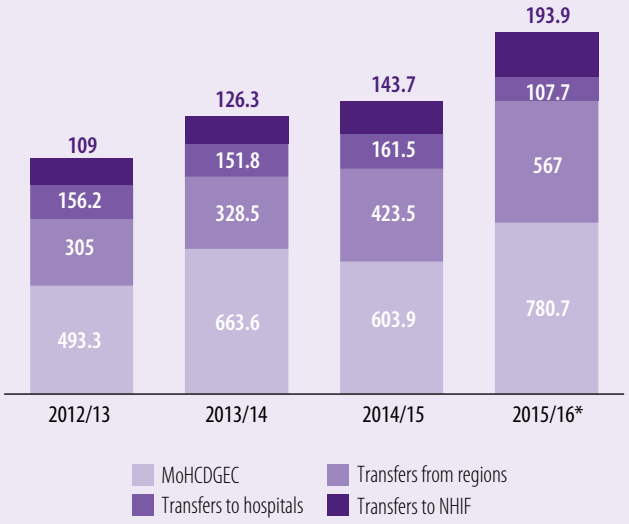
4.2 Expenditure analysis

MoHCDGEC expenditure as a share of the overall health sector public spending has increased over time by nearly 60 per cent (Figure 8). Resources to the ministry are expected to further increase considering the emphasis placed by the Five Year Development Plan (FYDP II) on health-related priorities that are directly under the MoHCDGEC mandate. Key priorities under FYDP II include: (i) strengthening health systems (primary and referral); (ii) equipping district, regional and referral hospitals with modern equipment; (iii) training health staff (short and long courses); (iv) management of non-communicable diseases; (v) improving the working environment for health personnel (e.g. commensurate remuneration, housing in close proximity to work premise); and (vi) ensuring comprehensive health care, focusing on preventive medicines and timely and effective control of epidemic diseases.

Transfers (budgeted resources and actual spending) to NHIF increased over the years. NHIF was established in 1999 as a statutory health insurance fund for all formal sector workers and offers a wide range of medical care benefits. The premium for the employee is 6 per cent of the wage or salary, where the employer contributes half and the employee the other half.

Transfers of financial resources to hospitals show a declining trend. Such transfers were TShs 156.2 billion in FY 2012/13, declining to an approved estimate of TShs 107.7 billion in FY 2015/16. The major reason for this drop is the dramatic reduction in the recurrent budgets of hospitals, which decreased from TShs 157.5 billion in FY 2014/15 to TShs 65.6 billion in FY 2015/16.

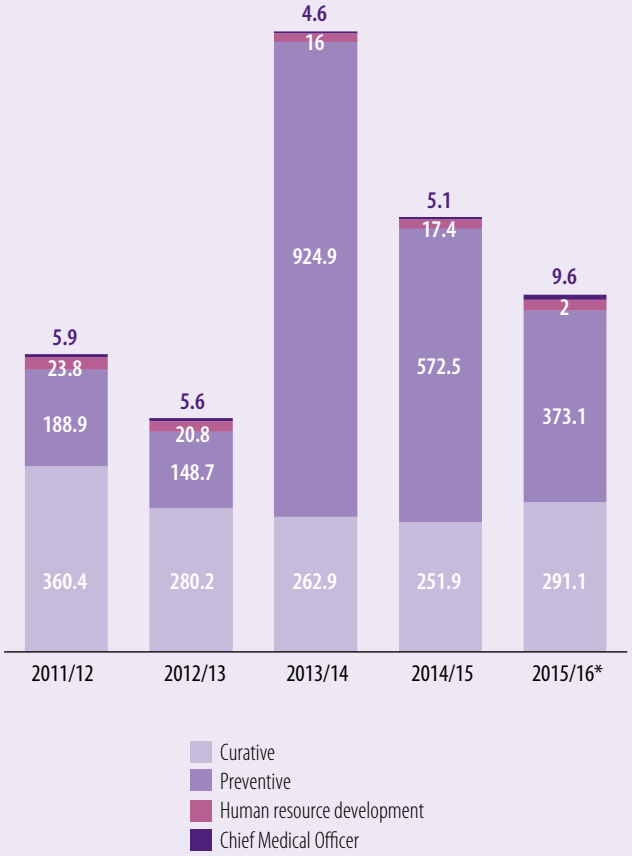
FIGURE 8 TRENDS IN SPENDING OF DIFFERENT HEALTH-SECTOR COMPONENTS (TSHs BILLION)



Source: *UNICEF calculations based on MoFP's IFMS data*
** Budgeted figures*

Actual spending for preventive services has outpaced spending on curative since FY 2013/14. Figure 9 shows that actual spending in curative services was double that of spending in preventive services in FYs 2011/12–2012/13. Since then preventive services have outpaced spending on curative activities.

FIGURE 9 TRENDS IN ACTUAL SPENDING ACROSS DIFFERENT MoHCDGEC SUB-VOTES (TSHs BILLION)



Source: *UNICEF calculations based on MoFP's IFMS data*
** Budgeted figures*

The budget for drugs and medical supplies has decreased from TShs. 358 billion in FY 2013/14 to TShs. 258 billion in FY 2014/15, a decrease of 31 per cent in real terms[5]. Foreign donors contributed TShs 183 billion towards the medicines budget while government contribution was TShs 75 billion (with the latter representing an 80 per cent increase from FY 2013/14, attributable to a rising locally funded essential medicines budget). The main contributor to the decrease is foreign funding, which has decreased by 42 per cent, primarily due to the reduction of the budget of the Global Fund to Fight AIDS, Tuberculosis and Malaria. The local contribution towards the medicines budget for preventive services has increased three fold to TShs 15 billion in FY 2014/15. This includes allocation for family planning (TShs 4.6 billion) and new vaccines (TShs 10 billion). This is in line with the government's pledge made at the 2012 London summit for family planning to increase investment in this area over time.

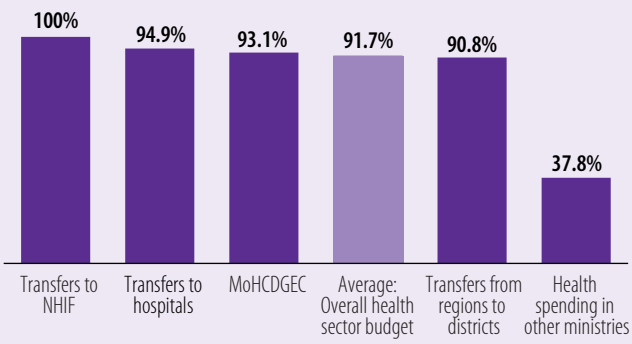
Resource allocations to HIV and AIDS programmes are on the rise (from TShs 7 billion in FY 2012/13 to 18.1 billion in FY 2015/16). Most of the increase benefited the development budget, which grew from TShs 3.6 billion in FY 2012/13 to TShs 15.3 billion by FY 2015/16.

Overall, annual government resources for financing HSSP III have been on the decline. While in FY 2011/12, 92 per cent of the resources required to implement HSSP III were allocated, the ratio declined significantly to 70 per cent by FY 2015/16[6].

5. How well has the health sector executed its past budgets?

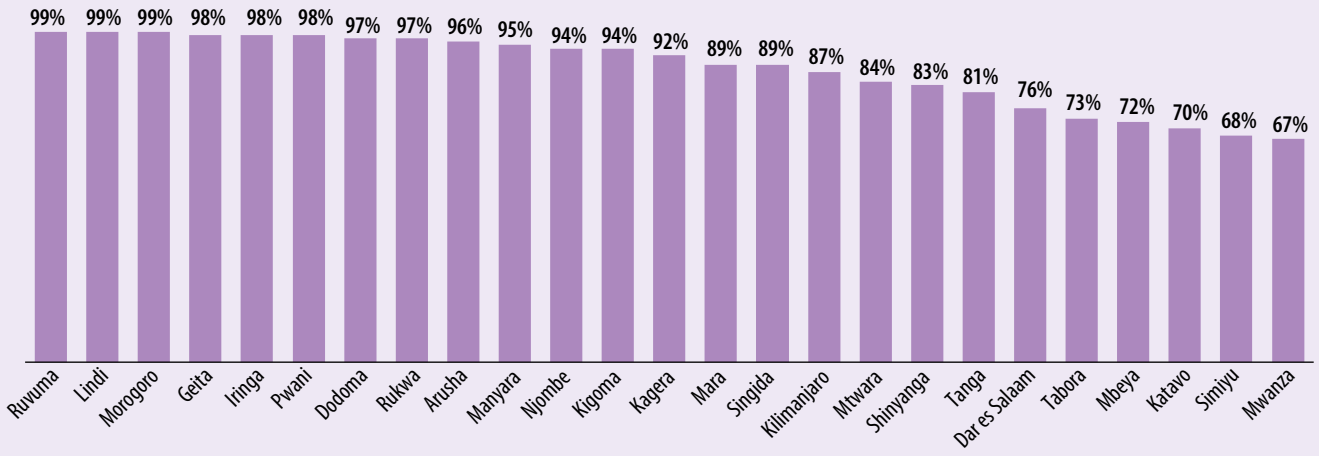
The budget execution rate of the health sector averaged 91.7 per cent over FYs 2012/13–2014/15. The execution rates varied across different spending categories as shown by Figure 10, with NHIS and hospitals the best performing, and health-related spending in ministries other than MoHCDGEC experiencing poor execution rates. Budgetary execution rates fluctuated over time. For instance, while the execution rate for transfers to hospitals was 99.9 per cent in FY 2011/12, it declined to 88.2 per cent in FY 2014/15. **Geographic variations in budget execution rates also persist** (Figure 11).

FIGURE 10 EXECUTION RATES ACROSS DIFFERENT HEALTH SPENDING COMPONENTS (AVERAGES, FYs 2012/13–2014/15)



Source: *UNICEF calculations based on MoFP IFMS data*

FIGURE 11 HEALTH BUDGET EXECUTION BY REGION (FY 2013/14)

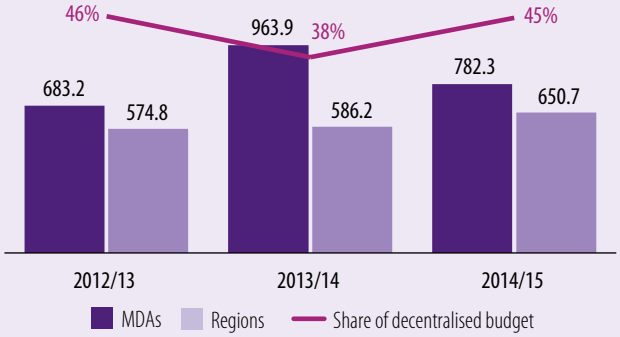


Source: *Rapid Budget Analysis for Health (UNICEF, 2014)*

6. Decentralisation and equity in resource allocation

The decentralised share of the health budget experienced fluctuations and averaged 43 per cent over FYs 2012/12–2014/15 (Figure 12). An increase in nominal budgets going to regions can also be observed over the same period.

FIGURE 12 TRENDS IN THE DECENTRALISATION OF HEALTH RESOURCES (TSHs TRILLION)



Source: *Development partners' 2014 health sector rapid budget analysis*

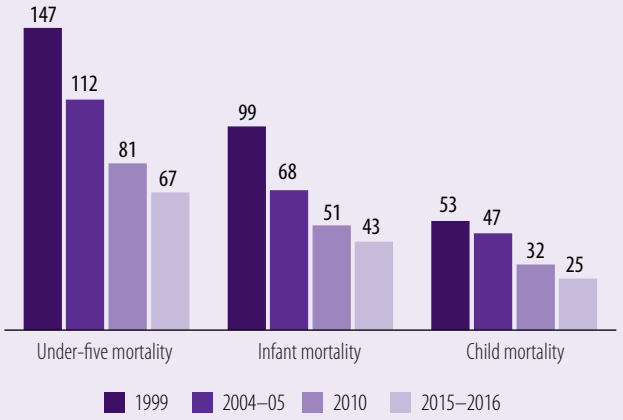
Health sector resources are allocated from the central government to local governments based on an allocation formula introduced in 2004. The formula takes into account regional characteristics and variations in the poverty level, population size, district medical vehicle route, and child mortality. However, the application of the allocation formula needs to be enhanced, as analyses show a high variance between the allocation predicted by the formula and actual allocation (Sikika 2012, Simon 2015[7]).

The distribution of the health block grant (OC and PE) among LGAs remains unequal[8]. The top five districts—Mwanga, Mafia, Kibaha, Kisarawe and Siha—average about TShs 31,000 per capita in FY 2014/15 (3.2 times the national average); while the bottom five—Nzega, Itilima, Kyerva, Uvinza and Bariadi—average about TShs 3,035 per capita (0.3 times the national average). In FY2013/14 the top 10 percent richest districts received 5 times the per capita budget of the bottom 10 percent poorest districts. This ratio grew to 6.4 times more in FY2014/15, showing an increase in funding inequalities between districts.

7. How has public expenditure on health impacted sector performance?

Significant progress has been observed in reducing under-five mortality, which declined from 147/1,000 live births in 1999 to 67 in FY 2015/16 (Figure 13). Infant mortality also declined from 99/1,000 live births to 43. These gains can largely be credited to sustained efforts in a few high impact programme areas, including high coverage of routine under-five immunisation, Vitamin A supplementation, integrated management of childhood illness, the use of insecticide-treated bed nets and improved treatment for malaria.

FIGURE 13 TRENDS IN UNDER-FIVE, INFANT AND CHILD MORTALITY (DEATHS PER 1,000 LIVE BIRTHS)



Source: TRCHS 1999, TDHS 2004/05, TDHS 2010 and TDHS 2015–2016

However, challenges remain such as high maternal and neonatal mortality where nearly 6,500 women and 39,000 newborns die every year during pregnancy and child birth, with the main causes including haemorrhage, hypertensive disorders, abortion complications and sepsis. It is estimated that 5.9 per cent are due to HIV and AIDS-related causes[9]. Eight per cent of all adolescents (aged 10–19) living with HIV globally reside in Tanzania; only 29 per cent of 181,403 HIV-positive children who require treatment receive it. There is also not enough health staff: the national average for density of clinicians and nurses per 10,000 population is low at 7.74, against the WHO recommendation of 22.8 per 10,000 population[10].

Geographic inequities in accessing health services also persist. The percentage of children with all basic vaccination coverage ranges from a high of 83 per cent percent in the Central, Southern Highlands, and Eastern zones to a low of 67 per cent in the Southwest Highland zone and 66 per cent in the Western zone[11]. Rural-urban differences in the availability and access to children's health services are also evident.

Conclusions

The analysis reveals some encouraging progress, as well as challenges. Budgetary allocations to the health sector have consistently been on the rise over the past five years. Moreover, the sector has been relatively successful in executing its overall budget, though with some variations between spending entities and across local governments. The increase in per capita health spending is an important achievement, in the wake of rapid population growth. Evidence shows that investments of US$ 5 per person per year in 74 countries with high disease burdens, including Tanzania, would yield high rates of return, producing nine times the economic and social benefit by 2035. These returns include greater GDP growth through improved productivity, and prevention of child and maternal deaths[12].

Challenges include concerns about the equity of health spending, the extent of fiscal decentralisation, geographic variations in budget execution rates, inadequate allocations to the HSSP, reduced prioritization of health in the national budget, and the heavy reliance on foreign resources, which compromises the sustainability of services. Concerns about the equity and efficiency of health spending call for better monitoring and tracking of budget execution, including at the LGA level. Issues related to the adequacy of funding and donor reliance indicate a need for stronger domestic resource mobilization. At the same time, the potential for increased efficiency and effectiveness of current spending should also be explored. This includes assessing the extent to which weaknesses in the execution of budgets affect health outcomes.

The rationale for further enhanced investments is strong, particularly on younger children. Low investment in early childhood development leads to lost human potential and 20 per cent loss in adult income[13]. US$ 1 spent on programmes in early childhood is estimated to have a return of US$ 7–16, based on improved education, health and economic outcomes[14]. In this light, key priorities that should be considered to enhance health outcomes include increased access to emergency obstetric and newborn care services, with the focus on underserved areas; increased production, deployment and retention of human resources for health, including a better trained cadre of community-level workers to bring services and key health information closer to the people; and further scale up the HIV response to end AIDS by 2030, with a focus on adolescents given the transformative life-long effects that intervening at this critical age have, with important implications for stability, productivity and economic growth.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BRN	Big Results Now
FY	Financial Year
FYDP	Five Year Development Plan
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
IFMS	Integrated Financial Management System
LGA	Local Government Authority
MDAs	Ministries, Departments and Agencies
MMAM	Primary Health Care Service Development Programme 2007–2017
MSD	Medical Stores Department
NHIF	National Health Insurance Fund
NCD	Non-Communicable Disease
OC	Other Charges
PE	Personal Emoluments
PO-RALG	President's Office for Regional Administration and Local Government
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
TShs	Tanzanian Shillings

GLOSSARY OF BUDGET TERMS

Budget execution: The ratio of actual spending over approved estimates.
Consolidated Fund Service: Government resources to pay for debt servicing and state house expenses.
Development budget: Government resources that are intended for investment purposes.
Expenditure (actual figures): Allocated funds spent on investment and recurrent costs (versus ***budgeted figures***, which refer to allocation of funds, approved by Parliament).
Fiscal decentralisation: The devolution of financial resources by the central government to sub-national governments for financing specific functions.
Foreign grants: Financial aid from foreign countries and aid agencies that the recipients do not need to pay back.
Nominal values: Numbers not corrected for the effect of inflation over time.
Non-tax revenue: Income earned by the government from sources other than taxes.
Other charges: Non-salary expenses (excluding investment).
Per capita: Per person.
Real values: Numbers corrected for inflation.
Recurrent budget: Government resources that are intended for salaries and wages, and non-salary expenses (excluding investment related expenses).
Tax revenue: Income earned by the government from taxes.
Treasury bonds: Debt instruments issued by the government in exchange for money borrowed from the public.

END NOTES

[1] World Bank (2016). *Tanzania Economic Update: The Road less Travelled: Unleashing Public Private Partnerships in Tanzania*. World Bank. Washington.

[2] World Bank's World Development Indicators dataset.

[3] US$ 12 (World Health Organization, Global Health Expenditure Database).

[4] UN exchange rate (August 2016): TShs 2,187 for US$ 1

[5] Rapid Budget Analysis for Health (UNICEF, 2014).

[6] Development partners' 2014 health sector rapid budget analysis .

[7] Sikika (2012). *Tanzania Health Sector Budget Analysis 2005/06–2011/12*; Simon, B. (2015). *Resource Allocation for Health in Tanzania–Determinants and Development Implications*. Rheinischen Friedrich-Wilhelms-Universität Bonn

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[9] World Bank and IMF, *Rural-Urban Dynamics and the MDGs: Global Monitoring* Report, Washington DC, USA, 2013.

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