Interfaith Standing Committee on Economic Justice
And Integrity of Creation

MAKE IT POSSIBLE

How Tax Commitments Can Move Tanzania towards Universal Health Coverage

Dar es Salaam, September 2018
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This study was commissioned by religious leaders through the Interfaith Standing Committee on Economic Justice and Integrity of Creation (ISCEJIC). We appreciate all members of the ISCEJIC namely, Tanzania Episcopal Conference (TEC), National Muslim Council of Tanzania (BAKWATA) and Christian Council of Tanzania (CCT) for their invaluable inputs during the research and production of this report.

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Our sincere thanks to Norwegian Church Aid (NCA) for financial support and continued partnership in implementing our development agenda.

Rt. Rev. Dr. Stephen Munga
Chairperson ISCEJIC
# Contents

ACKNOWLEDGEMENT ..............................................................................................................................................2  
EXECUTIVE SUMMARY .............................................................................................................................................6  
Introduction ................................................................................................................................................................9  
1. Methods .............................................................................................................................................................10  
   2. Universal Coverage and the Right to Health ..............................................................................................11  
      2.1 The International Commitments ..........................................................................................................11  
      2.2 Why Universal Health Coverage? .........................................................................................................11  
      2.3 International cases of expanding health coverage by allocating tax revenues ..................................12  
      2.4 Policy Framework ...................................................................................................................................13  
      2.5 Health sector allocation – the budget perspective ...........................................................................14  
      2.6 Health sector allocation – the expenditure perspective ..................................................................14  
      2.7 Social Protection in Tanzania ...............................................................................................................16  
      2.8 Contribution of FBO hospitals in providing health services in Tanzania ......................................20  
3. Tax Regime .......................................................................................................................................................22  
4. Make it Possible -Towards Universal Health Coverage ...........................................................................23  
   4.1 Current government strategy ...............................................................................................................23  
   4.2 Estimating funding gaps ........................................................................................................................23  
       International benchmarks .........................................................................................................................23  
       Financing need for Tanzanian government plans ......................................................................................24  
   4.3 Possible sources of funding ..................................................................................................................24  
       Extractive Sector ....................................................................................................................................24  
       Other sources ..........................................................................................................................................24  
   4.4 Recommendations ..................................................................................................................................27  
       Short term fiscal options ..........................................................................................................................27  
       Structural and non-fiscal options; ...............................................................................................................29  
       Structural and fiscal options; ..................................................................................................................29  
References ...............................................................................................................................................................30
### LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCT</td>
<td>Christian Council of Tanzania</td>
</tr>
<tr>
<td>CHF</td>
<td>Community Health Fund</td>
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<td>EPZ</td>
<td>Economic Processing Zone</td>
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<td>EWURA</td>
<td>Energy and Water Utilities Regulatory Authority</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FY</td>
<td>Financial Year</td>
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<td>FYDP</td>
<td>Five Year Development Plan</td>
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<td>GEPF</td>
<td>Government Employees Provident Fund</td>
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<td>GoT</td>
<td>Government of Tanzania</td>
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<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<td>iCHF</td>
<td>Improved Community Health Fund</td>
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<td>ISCEJC</td>
<td>Interfaith Standing Committee on Economic Justice and Integrity of Creation</td>
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<td>MOHCDGEC</td>
<td>Ministry of Health, Community Development, Gender Elderly people and Children</td>
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<td>MOHISW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>MSD</td>
<td>Medical Store Department</td>
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<td>NBS</td>
<td>National Bureau of Statistics</td>
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<td>NCA</td>
<td>Norwegian Church Aid</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<tr>
<td>NHIF</td>
<td>National Social Security Fund</td>
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<td>MSPF</td>
<td>Public Service Pension Fund</td>
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<td>RC</td>
<td>Regional Commissioner</td>
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<td>REA</td>
<td>Rural Electrification Authority</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>SHD</td>
<td>Sustainable Health Development</td>
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<td>SNHI</td>
<td>Single National Health Insurance</td>
</tr>
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<td>SP</td>
<td>Social Protection</td>
</tr>
<tr>
<td>SUMATRA</td>
<td>Surface and Marine Transport Regulatory Authority</td>
</tr>
<tr>
<td>TANROADS</td>
<td>Tanzania National Roads Agency</td>
</tr>
<tr>
<td>TASAF</td>
<td>Tanzania Social Action Fund</td>
</tr>
<tr>
<td>TEC</td>
<td>Tanzania Episcopal Conference</td>
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<tr>
<td>TEIT</td>
<td>Tanzania Extractive Industries Transparency Initiative</td>
</tr>
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<td>TRA</td>
<td>Tanzania Revenue Authority</td>
</tr>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>VAT</td>
<td>Value Added Tax</td>
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<td>VICOB</td>
<td>Village Community Banks</td>
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<td>WCF</td>
<td>Workers Compensation Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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The Interfaith Standing Committee for Economic Justice and the Integrity of Creation (ISCEJIC) is a faith-based committee comprising of religious leaders from Christian Council of Tanzania (CCT), Tanzania Episcopal Conference (TEC), and The National Muslim Council of Tanzania (BAKWATA). The Committee was formed in 2008 to facilitate religious leaders to effectively advocate for social and economic justice. This resolve emanates from the fact that advocating for the rights of the marginalized, the poor, and the voiceless is one of the cornerstones of our faith.

"Make It Possible: How Tax Commitments Can Move Tanzania towards Universal Health Coverage" is another research-based report commissioned by the Interfaith Standing Committee. We thank God who empowered us with courage and strength during the whole path of preparing this report. Let this report depict three realities. The first one is related to the life and strength of the Interfaith Standing Committee and its commitment to serve communities in Tanzania for a better life. This report is therefore an expression of the Committees commitment to its mission and vision. The second reality is that no one person can do it all alone. This report, as it was with the previous ones, is a result of combined efforts of different key players who pulled together their energies, talents, knowledge, time, and human and financial resources. All these key players had one aim in common: to make a better life possible for Tanzanians through access to universal health coverage. The third reality is the fact that challenges and obstacles along the way towards producing this report did not defeat and overcome us. The unity of will and the focus we had towards our common cause was the driving force inside each one of those who contributed to the conclusion of this report.

Now, this report is out. It is one thing to produce a report and another to translate the content of the report into the life situations of the people. We often hear people saying that the world hosts volumes of reports, shelved in libraries and archives but which had never had an impact on to the life situations of the intended people. If the intention was just to produce a report as an end of itself, then we are done with our work. However, if our intention is to have this report as a tool towards transforming the lives of the people, then this report is just the start of a long process. In other words, we have a big task ahead of us: to follow up the implementation of this report with key players on the ground to make universal health coverage a reality for all Tanzanians and especially those who are most vulnerable. As we walk the journey of implementing this report, we shall continue to stand united and encourage one another so that we push together towards our common goal of benefiting and transforming communities in our country. Together we can make it possible and may God help us and go with us!

God Bless Tanzania.

Christian Council of Tanzania
Tanzania Episcopal Conference
The National Muslim Council of Tanzania

**DEFINITION OF KEY TERMS**

In this study the follow terms have been used to mean the following:

**Extremely/destitute poor**: A household that is said to be poor or extremely poor if it falls below basic needs poverty line or food poverty line (National Bureau of Statistics 2012).

**Ring-fencing**: Earmarking a specific percentage of a tax or tax source, and directing the revenues from this towards financing a particular purpose.

**Lost tax revenue**: Legitimate tax that has not been collected or received by the tax authority due to either inefficiency, evasion or avoidance.

**Marginalized/vulnerable groups**: disadvantaged individuals or households in terms of accessing and utilizing health services

**Household**: Refers to people who live together, share income and basic needs. In other words, residents of a household share the same centre of production and consume from that centre (National Bureau of Statistics 2012). Under the iCHIF, a household has been defined as unit comprising 6 people, where one of them is designated head of the household.
EXECUTIVE SUMMARY

Universal health coverage (UHC) is when all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services do not expose the user to financial hardship.

This report shows how Tanzania can reach Universal Health Coverage by way of tax revenue commitments. It takes stock of where Tanzania stands today with regards to UHC, analyses efforts and achievements recorded so far, along with gaps in the social health protection system in Tanzania. It proposes short to medium term fiscal and non-fiscal measures that could be considered for Tanzania to attain UHC.

The report was commissioned and produced by religious leaders and faith-based organisations within the ambit of the Interfaith Standing Committee on Economic Justice and Integrity of Creation (ISCEJIC), in collaboration with the Norwegian Church Aid (NCA). The ISCEJIC is a high-level platform of religious leaders, comprised of Tanzania Episcopal Conference (TEC), National Muslim Council of Tanzania (BAKWATA) and Christian Council of Tanzania (CCT).

Methodology

The study mainly involved an analytical review of relevant documents and reports on health financing, balancing these with key informant interviews and focus group discussions (FGDs) with relevant stakeholders in the most vulnerable sections of society, primarily being rural areas. A review of documents allowed for establishing trends of multi-dimensional UHC, including global and national policy frameworks, strategies and practices towards realization of UHC. Key informant interviews and FGDs in Dar es Salaam and in the regions of Kilimanjaro, Manyara, Singida and Dodoma were instrumental in grasping perceptions and insights into the challenges of the existing social health protection system. These national and local dynamics are situated in current global discussions and trends in universal health coverage to draw lessons and best practices from selected countries. Global best practices are leveraged in this study as evidence to advocate for a suitable Tanzanian model for health financing.

Key Findings

The report recognizes that there is a clear policy commitment towards Universal Health Coverage in Tanzania that is oriented to international commitments to the Right to Health and the achievement of UHC. Despite the commitments, the report found that there are implementation challenges. The challenges are evident in the mismatch between budget allocations, health system needs and the discrepancy between allocated budget and disbursed/executed budgets.

In a nutshell, the following are the key findings of the report:

- Actual budget allocation to health has averaged around 10.8% of total government spending annually for the past decade, but it is below the Abuja Declaration (15%) and we observe a has a downward trend in percent allocation;
- The health budget release rate has declined proportionally from 72% (2014/15) to 57% (2016/17). In real terms, the health budget has not increased significantly over the past years;
- Current total health expenditure in Tanzania is 31 USD per capita in 2015 (including external and private expenditure), but this is below the World Health Organization (WHO) standard target of 60 USD;
- Only 32% of the population are covered by health insurance schemes, leaving the majority (68%) of Tanzanians uncovered. Of the population covered, 8% are covered by the National Health Insurance Fund (NHIF), 23% are covered by Community Health Funds (CHF) and 1% by private health insurance providers;
- There are gaps in the implementation of social assistance schemes targeting vulnerable and poor groups due to inadequate resource allocation, along with public health governance challenges including corruption;
- Existing exemption systems from user fees for poor and marginalized groups are implemented randomly, leading to more barriers to accessing health care;
- It is possible for government to finance health insurance cover for the remaining 68% of its population by ring-fencing small percentages of taxes from specific revenue sources for health insurance. By targeting at least 17% coverage of total uncovered households per year, the government can attain full coverage of the 28% extremely poor and reach between 91% to 99% coverage of the entire population by 2025;
- The current financing sources for health expenditure are government allocations (35%), development partners (37%), and private expenses (28%), showing a relative dependency on external funding. The resources from government are financed from the general budget; there is no ring-fenced tax revenue allocation for health care in place.

Opportunities

Given that current government strategy has considered the introduction of ring-fencing tax proportions for other sectors, we believe ring-fencing can be introduced to grow financing and ensure sustainability in the provision of health care to all Tanzanians. International experience shows that ring-fenced funding, combined with strong political will, leads to substantial improvements in health care financing and broad health coverage of the population.

The government is willing to increase the level of financing of health in Tanzania, but there is the clear challenge of limited sources. Health care is conveyed as an investment on a policy level, but actual allocation decisions do not reflect that commitment. The following observations are relevant: Progress towards the establishment of a single national health insurance scheme has been slow despite its multiple potentials (e.g. unified minimum benefits package for all beneficiaries, coverage for the poor from government budget). The government is rolling out an improved government allocations (35%), development partners (37%), and private expenses (28%), showing a relative dependency on external funding. The resources from government are financed from the general budget; there is no ring-fenced tax revenue allocation for health care in place.

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In the report “One Billion Dollar Question”, the ISCEJIC discovered that Tanzania loses up to 4 trillion TZS annually due to tax evasion, generous exemptions and illicit capital flight. These occurred in Economic Processing Zones (EPZ) and the extractive industry sector. If government fiscal management and ring fencing of taxes can recover at least half of these lost revenues, this could create relevant fiscal space to increase health financing and health coverage, especially for poor and marginalized groups.

The continued efforts by the government to block tax leakages, complimented by the recovery of the past lost tax revenues, could allow the health sector budget to match the 15% Abuja Declaration target. This could cover up to 90% of the whole expenses of the government’s comprehensive health sector strategy (Health Sector Strategic Plan IV), including the introduction of a health insurance system for all Tanzanians with the aim of reaching Universal Health Coverage.

**Recommendations**

Based on the key findings, this study recommends the following general and specific recommendations bring all Tanzanians access to health care.

**General recommendations:**

1. The government should prioritise covering health insurance costs of its population by reinforcing tax collection, recovery of lost revenues and investment into its people. The positive contribution that health has on development is incontestable; therefore, investment in health should be viewed as a societal and economic investment, not a general service.

2. The government should focus on covering the health insurance costs of the 28% extremely poor households, equivalent to 14.4 m or 3,004,292 households, uncovered and unable to currently pay for their own health care services in the current system. At the proposed iCHIF rate of TZS 60,000 per household, the government should contribute TZS 50,000 to the affordable health insurance scheme while the poor households contribute TZS 10,000 to the scheme per year. To achieve this, the Government requires setting aside only TZS 150 billion in the next six (6) years. To reduce the burden, the government can spread coverage over the 6-year period by targeting 17% of the uncovered population every year cumulatively, as illustrated in this report.

3. The government should institute proper enforcible mechanisms to ensure that the remaining 40% (equivalent to 21.2 M people or 4,239,997 households) of the population, which is currently uncovered but able to pay, is enrolled into the iCHIF scheme. To achieve this the government needs to set aside only a total of 127 billion in the next six (6) years as matching funds to meet any new enrolment whereby the government will contribute TZS 30,000 and the households an equal amount.

4. The government should ring-fence a small percentage of taxes from earmarked sources such as Value Added Tax (VAT), extractives industry, petroleum levy, sin taxes and tourism and gaming taxes, and channel these towards financing health insurance coverage. At the current rates, the government requires a total of TZS 277.415 billion in the next six (6) years (from 2019 to 2025) to cover the entire population. This study shows that with a small percentage of ring-fenced taxes, the government can ably raise this amount at a very minimal cost.

5. The government should minimise administrative and transaction costs imposed on iCHIF contributions and increase the percentage of reimbursement to health facilities.

6. Raise efficiency gains in the overall health sector by 20-40% by cutting corruption, stock outs, delayed and under disbursements to health facilities. Increase budget disbursement and execution performance from current average of 57% to 100%, by prioritizing health care disbursement, realistic budgeting on the one hand, and unlocking inefficiencies within the ministries, the medical store department (MSD) and local government. International experience shows that improved efficiencies of 20%-40% could release up to Tzs 400-800 billion.

7. Increase the capacity of faith based and government health facilities located in remote, hard-to-reach areas to deliver health care services in areas where there are no public health facilities. Strive to reduce the medical personnel–patient ratio overload, erratic cash flow problems and medicine stock outs.
8. The government should strive to continue improving portability, minimum benefit packages and the overall quality and efficiency of social delivery as a motivation for current and new enrolment recruitments. The infrastructure, staffing and medical supplies deficiencies should be addressed as mechanisms for improving overall care delivery in Tanzania.

Considering the above, the study puts forward the following options for the government to provide health care access to uncovered populations by 2025.

**Option 1:**
1. Provide improved CHF coverage for all Tanzanians living below the poverty line (28% of the population) by making a government contribution of TZS 50,000 per household. This would amount to TZS 150 billion over six years;
   In this, we recommend the following (all figures in five-year terms)
   a. Ring-fence only 0.9% of VAT revenues;
   b. Collect 1.32% of the lost tax revenues;
   c. Ring fence 1.2% from Extractives tax payments
   d. Collect 1.32% of the lost tax revenues;
   e. Ring fence 15% of sin taxes.

To effectively reach the target population with minimal financial burden, the government can roll out implementation by targeting only 17% (500,714 households every year) of the population annually on an incremental basis over the next five to six years. This reduces the annual tax revenue requirements substantively.

**Option 2:**
2. Provide improved iCHF coverage to the 40% of the population currently outside the iCHF at a matching rate of TZS 30,000 per year. In total that will require only 127 billion by 2025.

To achieve this, the government must:
   a. Ring fence only 1.8% of VAT revenues;
   b. Ring fence 2.4% of TEIT reported revenues payments;
   c. Collect 2.03% of lost revenues;
   d. Collect 2.4% of Petroleum levy;
   e. Ring fence 1.2% of withholding taxes on properties and rates;
   f. Ring fence 1.8% of gaming taxes; and
   g. Ring fence 30% of sin taxes.

Besides the above fiscal options, the study proposes various other structural non-fiscal options for the government to optimize the health financing and access in Tanzania.

I. Strengthen and mobilize health insurance registration for increased enrolment and improved benefits package of the iCHF and NHIF systems. This is motivation to include the remaining 68% of the population enrolled, which is currently not covered by any health insurance scheme. Special attention should be placed on the youth.

II. To compliment government efforts in mobilizing registration, religious leaders and faith-based institutions should contribute in terms of mobilizing their members and faith constituencies to enrol into iCHF and facilitate their facilities to participate in the new improved iCHF system.

III. Hold districts authorities accountable for recruiting poor households, planning and budgeting for their iCHF contributions and improving access to health services for this group. Building on the TASAF database of poor households, along with the local government database of most vulnerable individuals in the communities, there should be a mechanism put in place to identify the poor with clear and unified criteria.

In the long term, there are several fields of action that can improve access to health care for all and move Tanzania towards Universal Health Coverage:

I. **Create a National Fund for Universal Health Coverage.** The recent legislation on extractive industries will increase the already remarkable revenues from these sources. Based on the already existing structure of the Oil and Gas Fund, it can be expanded by establishing a national health fund financed by revenues from both the petroleum and mining resources. Earmarking a specific percentage of this fund and channelling it towards social health protection would be in line with the government’s spirit of ring-fencing specific volumes of funds and channelling these to specific expenditures as demonstrated in the various sections of the Oil and Gas Fund law.

II. **Advocate for introduction of the Single National Health Insurance within the framework of the Health Sector Strategic Plan IV, to establish a sound and sustainable health insurance system for all Tanzanians.**

III. **Increase complementarity between faith based and government health facilities located in remote and hard to reach areas to deliver health care services in places where there are no public health facilities.**

IV. **By these recommendations, the report shows that achieving full health care coverage of the poor and 91% of the entire population by 2025 is possible.** It shows clear shortcuts and long-term measures for the Tanzanian government to increase health coverage on a phased basis, by committing tax revenues to closing gaps in the current social health protection system. The most in need, the poor and marginalized, can be addressed directly and efficiently at an affordable cost. Ring fencing of tax revenue can create more long-term sustainability for health financing. Combined with long term options to raise sufficient taxes and to increase health sector funding, the Tanzanian government can indeed reach Universal Health Coverage.
In the recent years, Tanzania has made significant progress in providing health care to all its citizens. However, the country’s health system is underfunded, leading to gaps in health coverage. Poor and marginalized groups are most economically and socially affected.

Providing equal access to health care to all citizens and making the necessary funds available is an ethical imperative for governments. This is also enshrined in the recognition of the Right to Health as a Human Right, stipulated in the Universal Declaration of Human Rights of 1948 by the United Nations (UN). In representative democracies, like Tanzania, the citizens delegate their power and sovereignty to their representatives to make policies and pass laws on their behalf and in their interest. Accordingly, the country’s tax revenues are owned by the government on behalf of its citizens, and it is imperative that these revenues are utilized in the best possible way to serve the people.

The role of religion and religious leaders in promoting development is hard to ignore in the Tanzanian context and beyond. Besides providing social services like education and health, religious institutions have been active participants advocating for rights, well-being and welfare of marginalized groups. One current initiative is the ‘Make it Possible’ project. This is a religious leader led project that seeks to propose and advocate for a universal health insurance system funded by the government tax collection. The Tax Funded Social Protection Strategy for health in Tanzania is developed by the Interfaith Standing Committee on Economic Justice and Integrity of Creation (ISCEJIC), in collaboration with Norwegian Church Aid (NCA). Internationally, the ‘Make it Possible’ project conforms with the Sigtuna Statement of 2017, passed by a broad alliance of Christian organizations worldwide that, among other things, calls for government action to reduce the growing inequality of access to health care. Fair taxation and social protection through public money are considered cornerstones of equitable and just societies.

In its two recent reports “The One Billion Dollar Question” on lost tax revenues, the ISCEJIC showed how Tanzania can increase its tax revenues to the benefit of its citizens by closing loopholes in tax evasion, reducing generous exemptions and illicit capital flight. International experience shows that it is possible to increase health coverage by significant margins by committing tax money to closing coverage gaps and addressing the need of the poor and vulnerable. This report names the current gaps in Tanzania and points out various short and long-term actions that can make it possible for Tanzania, too.

This report takes stock of where Tanzania stands today with regards to equitable access to health care. Despite remarkable efforts and achievements, the health sector is still suffering from underfunding, and most people do not have any financial protection in the event of sickness. People that become sick are more likely to be pushed into poverty, and poor people cannot access life-saving health care.

The report is informed by a study conducted as a multi-purpose tool to be used by FBOs and religious leaders in advocacy and lobbying of decision and policy makers in the country. Specifically, the study intends to:

i. Suggest tested and proven solutions to providing social health protection to all Tanzanian citizens within the context Tanzania’s tax regime;

ii. Recommend ways how increased tax funding of the social protection system in Tanzania can move the country significantly towards universal health coverage;

iii. Recommend methods of how lost tax revenues can be better used to fund social services and social security, with a focus on the health sector.
1. Methods

The study builds on a review of relevant documents and research along with key informant interviews and focus group discussions with strategic stakeholders. The review of documents was vital to understand trends and the current state of the multi-dimensional nature of UHC, such as global and national policy frameworks, strategies and practices towards realization of UHC. Documents reviewed include health and social protection policies, strategies, laws, budget analysis, tax laws, trends and practice in Tanzania along with the “One Billion Dollar Question” reports produced by ISCEJIC. Key informant interviews and FGDs were instrumental in grasping perceptions and views for and/or against the proposition of social protection in the form of universal health insurance in Tanzania and tax funding for social health protection. Key informant interviews involved diverse stakeholders in the health sector with direct and indirect stake on universal health insurance at national, regional, district and local levels. Government and non-government officials as well as representatives from relevant international organizations were consulted.

Although a greater section of stakeholders for the present study were found in Dar es Salaam, it was imperative to conduct interviews and FGDs in selected communities in the regions of Kilimanjaro, Manyara, Singida and Dodoma. The purpose of engaging with rural and urban communities was to capture case studies illuminating experiences and challenges towards developing UHC in Tanzania. These included, but not limited to, the existing models, costs, health coverage and how they are financed. Although the named sites are not statistically representative, they shed light on experiences across Tanzania.

To benchmark, the study considered selected international initiatives and experiences with UHC. This allowed for documenting the current global discussions and trends on universal health coverage. This is critical for situating the ongoing national efforts into the global normative contexts.

Equally important, cases and best practices from selected countries were considered in terms of how these can be used as evidence to advocate for a suitable Tanzanian model. In that respect, the Norwegian tax and health financing models has been considered. The contexts in Nordic countries and Tanzania are different, but history offers important lessons that can inform the Tanzanian system and link benefits from natural resources with financing social systems. Best practices from Thailand and Ghana shed light on the possibility of UHC in Tanzania and how to move towards universal health coverage in low/middle income contexts.
2. Universal Coverage and the Right to Health

2.1 The International Commitments

Historically, churches, monasteries and other religious institutions provided health care to those in need. In the Islamic world, religious and civic leaders founded the first medieval hospitals. This was the clear consequence of the charitable philosophy of religions and their commandments to provide care to the needy and poor, coining the provision of care as a display of faith and charity. Later, the moral obligation to provide health care and support to the poor shifted responsibility to governments in their duty to their citizens. However, the recognition of health as a human right marks a change in paradigm for these responsibilities, moving from health regarded as charitable obligation towards health as a right to be claimed by the individual. Most prominently, the Right to Health has been enshrined in the Universal Declaration of Human Rights from 1948, when the UN was founded. From there, it has been the basis of declarations like the Alma Ata Health for All Agenda (1978), which specified more on ways how to ensure the right to health for all humans.

In 2011, the 64th World Health Assembly adopted the Resolution on Sustainable Health Financing Structures and Universal Coverage, which calls for all countries to move towards Universal Health Coverage. Since then, Universal Health Coverage is the guiding principle in health financing. The resolution does not make prescriptions on the institutional setup or the financial architecture of social health protection systems that shall be applied to achieve UHC. The key mission is that no one is put into financial hardship or pushed into poverty due to health needs. This can be achieved through sustainable health insurance mechanisms that are sensitive to poverty and income levels, as well as tax financed health care provision. In many countries, there is a combination of financing mechanisms.

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

In terms of today’s development agenda, these rights and conventions are reflected in the UN’s Sustainable Development Goals (SDG), which were adopted in 2015 by the United Nations General Assembly and serve as the primary guidelines for development policies worldwide. The achievement of Universal Health Coverage is explicitly mentioned in SDG 3 “Good Health and Wellbeing”. Additionally, there is a strong link to SDG 1 “No Poverty” that stipulates the establishment of appropriate social protection systems and will be supported by UHC to reduce impoverishment through sickness.

2.2 Why Universal Health Coverage?

Pricy health expenditure that has the potential to impoverish people is usually referred to as catastrophic health expenditure. Catastrophic health expenditures are among the main reasons of impoverishment, or of people being trapped in poverty. These occur when there is no financial protection against the expenditure needed in case of sickness, and people are confronted with high and unforeseen out-of-pocket payments.
Globally, it is estimated that 100 million people are pushed below the poverty line every year due to catastrophic out-of-pocket payments. There are clear correlations between poverty and out-of-pocket payments for health care.

A social health protection system has the potential to reduce significantly the level and adverse impacts of out-of-pocket payments. In case of economic shocks, social protection mechanisms prevent households from falling back into poverty and from resorting to negative reactions like selling productive assets or removing children from school.

In addition to that, there are significant positive economic growth effects of social protection. Social protection programmes that reduce poverty or impoverishment have manifold positive impacts on local economic level through multiplier effects on consumption. Protecting people from high expenditures helps them to keep their businesses and livelihoods in case of sickness. Social health protection systems contribute to many different development goals besides of improved health, namely economic development, poverty reduction, education and empowerment. The main point is that whereas many people become sick because of poverty, many others are subjected to poverty because of sickness.

2.3 International cases of expanding health coverage by allocating tax revenues

**Thailand: strong political will achieved full insurance coverage within few years.**

In 2001, Thailand embarked on a strong initiative to expand coverage of health insurance. The “30 Baht” scheme (named after the co-payment users had to make, equivalent to 0.75 US$ at the time), helped the government achieve roughly 100% health coverage across Thailand. The scheme provides comprehensive benefits, including inpatient and outpatient care, surgery and drugs. It is financed mostly from tax revenues and grew coverage to 45 million people after just one year of implementation. As the out of pocket payments reduced at the same speed the scheme was rolled out, a clear impact on reducing poverty risks can be seen. Furthermore, the overall health spending did not increase due to this compensatory effect. Therefore, the economy remained stable and benefits were distributed more equitable across society. Strong political will and elaborate planning of the roll out with door-to-door campaigns were key factors in its success.

**Ghana: Earmarking taxes in order to expand coverage**

The Ghanaian National Health Insurance Scheme (NHIS) was introduced in 2003 after an era of complete absence of relevant social health protection mechanisms that put many of its citizens into poverty. The scheme reached about 40% of the population after ten years, and out of pocket payments were reduced. The scheme is predominantly (70%) financed by the National Health Insurance Levy (2.5% on goods and services that are under VAT), alongside social security system contributions from formal sector workers, and some other smaller sources. The Ghana case illustrates the method of introducing an earmarked tax to expand coverage and to provide financial stability to the health sector. Even if challenges remain, like cost containment and coverage of the poor as well as disbursement of funds, the introduction of the NHIS has improved access to health care and reduced private risks for a large part of the population.

**Norway: Using revenues from natural resources for securing social sector needs**

Norway is a very resource rich county due to its large oil reserves. The government receives 32% of its national revenues from petroleum activities. This is also reflected in expenditure in social sectors, whereby 85% of the total health expenditure comes from government sources. In addition to its dominant share of resource dependent revenues, Norway has set up its Government Pension Fund, which is funded by petroleum revenues and is meant to cover social systems expenses in the future when the society will be aging and the petroleum boom over. Already today, interests and dividends from the Government Pension Funds represent a relevant part (17%) of the government revenue and are covering budget deficits due to pension and health expenses. Using revenues from natural resources for securing financial sustainability of the social sectors has been a key cornerstone of the Norwegian fiscal policy for many years.
Health Financing and Social Protection in Tanzania – Coverage and Gaps

2.4 Policy Framework

Upon independence in 1961, Tanzania proclaimed war on the nation’s three archenemies; poverty, ignorance and disease. The commitment to achieving Universal Health Care (UHC) and social protection (SP) has been articulated since then through various national policies, plans and strategies. However, the achievement of these goals has been hampered by clear lack of sufficient resources.

Article 14 of the Constitution of the United Republic of Tanzania of 1977 provides that “every individual is entitled the right to life and protection of his life by the society in accordance with law”. This relates to the Right to Health, but it does not reflect it.

The current National Health Policy 2007, currently under review, envisions a healthy community that contributes effectively to individual as well as to the nation’s development. The policy is committed to facilitating the provision of basic health services that are of good quality, equitable, accessible, affordable, sustainable and gender sensitive. The overall objective is improved health and wellbeing of all Tanzanians, with a focus on those most at risk, and encouraging the health system to be more responsive to the needs of the people. It also emphasizes the need for inclusive health interventions covering needs of vulnerable groups such as infants, children under-five years old, pre-school and school children, youths, people with disability, women of reproductive age and elderly people.

Strategically, the policy recognizes that “good health is a major resource essential for poverty eradication and economic development”. In line with the SDGs, the current Five-Year Development Plan II acknowledges that promoting equitable growth requires a holistic sustainable human development policy framework that is pro-people, pro-jobs and pro-nature (environment). Interestingly, the FYDP II perceives the health sector as multi-dimensional, acknowledging that while it is an end (e.g. reduced deaths, longevity, etc.), providing quality health care ensures that people are fit to participate in economic activities. The plan intends to sustain and consolidate achievements in the health sector, especially in reducing child mortality, combating malaria, addressing non-communicable diseases, among others. The slow pace in lowering maternal mortality is also singled out in the plan, whereby the plan calls for strengthening of health service delivery system to improve the health of mothers and children as well as to address the human resource crisis which constrains provision of adequate health care.

Since 2003, implementation of national health policies has been done within the framework of four health sector strategic plans (HSSP I, II, III and IV). Currently, the HSSP IV is the guiding reference for the preparation of annual plans at the levels of agency, department, programme, health facilities and council.

The mission of the HSSP IV is derived from the Vision 2025, and in line with the National Health Policy of 2007. The overall objective of HSSP IV is “to reach all households with essential health and social welfare services, meeting as much as possible expectations of the population and objective quality standards, applying evidence-based, efficient channels of service delivery”.

UHC is one of the central components in the strategic framework for the HSSP IV. Categorically, the HSSP IV admits that without removing financial barriers for the population to access quality it is impossible to achieve UHC. It also asserts that the lack of effectiveness and efficiency in health financing cripples the move towards UHC.

As a result of business development training IR VICOBA members scaled up their enterprises which enabled them to subscribe for the health insurance. Photo by NCA
Cost-effective, quality health services should be available to all residents without financial barriers at the time of need. The goal of Tanzania’s health financing strategy is to enable equitable access to affordable and cost-effective, quality health care and financial protection in case of ill health, according to a nationally defined standard, minimum benefit package.

To translate the above into reality, it is anticipated in the HSSP IV that there shall be a Single National Health Insurance (SNHI) covering all Tanzanians by 2020. This is described in the Health Financing Strategy within the HSSP IV. It foresees the introduction of a Single National Health Insurance (SNHI), being merged with today’s NHIF and CHF, and will be mandatory for all Tanzanian citizens. It will guarantee a unified minimum benefit package to all beneficiaries, and tax funded subsidies from the government will cater for the poor. In line with the ‘Make it Possible’ project seeking tax funding to achieve UHC, HSSP IV (2015-2020) and the new HFS (2015-2025) shed needed light on how to address the challenge of resource gap, whereby levies and special taxes are considered among the best options.

A primary focus of the HFS will be to make a standard minimum benefit package of primary and secondary health care services fully accessible to all Tanzanians with a focus on the poor and vulnerable groups, and to ensure that these services are fully funded. As an essential part of this vision, the country will aim to reduce the dependency on external funding sources and move towards more sustainable domestic avenues for funding, with a clearly defined role for the private sector.

2.5 Health sector allocation – the budget perspective

It is clear from the previous section that at the level of policy and strategies, Tanzania’s commitment to the UHC agenda is concrete and firm. Nevertheless, desired policy outcomes remain limited by many standards because of resource constraints. In the Abuja Declaration 2001, heads of states of the African Union pledged to set a target of 15% of government expenses to be allocated for health. Although this figure has not been derived from a calculation or estimation, it has become a powerful and widely accepted benchmark for governments’ commitments to health care in their countries.

Despite significant increases in the health budget over the last decade, Tanzania has not yet attained the target set by the Abuja Declaration in 2001 to increase the percentage of the health sector budget to at least 15 percent of the total national budget. However, it is not alone in this regard as only four countries—Ethiopia, the Gambia, Malawi, and Swaziland—were above the Abuja target in 2014. Nonetheless, the health sector is among the top three priority sectors in Tanzania, and its allocated budget ranks third after infrastructure and education.

### TABLE 1: TRENDS OF BUDGET ALLOCATION TO THE HEALTH SECTOR IN TANZANIA

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Health budget in billions TZS.</th>
<th>% of total budget</th>
<th>% annual change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>1,205.9</td>
<td>10.4%</td>
<td>25.2%</td>
</tr>
<tr>
<td>2011/12</td>
<td>1,209.1</td>
<td>8.9%</td>
<td>0.26%</td>
</tr>
<tr>
<td>2012/13</td>
<td>1,289</td>
<td>10.0%</td>
<td>6.6%</td>
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<tr>
<td>2013/14</td>
<td>1,498</td>
<td>8.2%</td>
<td>16.2%</td>
</tr>
<tr>
<td>2014/15</td>
<td>1,588.2</td>
<td>7.9%</td>
<td>6%</td>
</tr>
<tr>
<td>2015/16</td>
<td>1,821.1</td>
<td>8.0%</td>
<td>14.7%</td>
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<tr>
<td>2016/17</td>
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<td>9.2%</td>
</tr>
<tr>
<td>2017/18</td>
<td>2,222.3</td>
<td>7.0%</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

Compiled from Citizen’s Budget edition of 2010/11 to 2017/18

Between 2011/12 and 2015/16 the public health budget increased nominally by 50.6%. However, the health budget as a percentage of the overall government budget has remained relatively constant. If adjusted for inflation, the budget allocation of the Government of Tanzania for health is estimated to have increased for the FY2017/18 by 2.7% in real terms from the previous year and 3.8% overall since 2015.

**FIGURE 1: PERCENTAGE OF THE TOTAL GOVERNMENT BUDGET ALLOCATED TO HEALTH (2006/7–2017/18)**

The above data suggest that Tanzania allocates between 9% and 10% of its budget on health. For the past 10 years, Tanzania’s actual budget allocation to health has averaged around 10.8% of total government budget, with a downward trend, and since 2011, around 1.8 percent of gross domestic product (GDP) (inclusive of on-budget support to the health basket fund from donors).

2.6 Health sector allocation – the expenditure perspective

Health budget analysis indicated that despite a relative increase in budget allocation in the past decade, Tanzania’s health sector is still underfunded. Certainly, it is almost impossible to meet the targets set by the government in the Health Sector Strategic Plan IV (2015–2020) without substantive addition of financial resources to the health sector.

Nevertheless, a recent analysis of the government budget performance indicates that budget allocations to health sector have not always translated into real health expenditures. For example, the government release rate to MOHCDGEC declined from 72% in 2014/15 to 54% in 2015/16 and 57% in 2016/17. Overall government budget execution stands at 80%, however. Some budget items may get an even lower proportion of what is allocated. For instance, disbursements made for medical stores department (MSD) debt repayments and supply chain management and procurement expenses only accounted for 15% of the original related budget allocations in the 2017/18 budget. This highlights the need to improve budget release and execution to benefit the intended health providers and users. Unlocking resources that have been approved but are not being expended is necessary for attaining UHC.
Figure 2: % SHARE OF GOVERNMENT EXPENDITURE ON TOTAL HEALTH EXPENDITURE, 2015

% Share of government expenditure on total health expenditure, 2015

Source: WHO Data Repository

Even if the absolute figures of the Tanzanian health budget have been increasing, the allocation is not keeping pace with the population growth, as per capita spending of government sources is stagnating at around 11 USD.

Figure 3: HEALTH EXPENDITURE PER CAPITA USD 2008 - 2015

Health Expenditure per capita USD 2008-2015

Source: WHO Data Repository

At the household level, health care spending was found to contribute to impoverishment. 15 percent or more of the poorest Tanzanians spent 20 percent or more of their non-food household budget on healthcare, and 8.4 percent spent more than 30 percent.

Tanzania’s health financing system is dominated by a tax and donor funded health delivery system. Development partners contribute to the health basket fund within the MOHCDGEC development vote. Foreign donors (development partners) contribute substantively to the health budget with estimates putting the figures at an average of 29% of the total budget over the past 10-year period. In the fiscal year 2017/18 foreign contributions to the health basket fund within the MOHCDGEC development vote are reported to have increased by 2 billion TZS or 27%. Donor contributions reached their highest level in 2013/14 where they peaked at 38%. This has been reduced gradually since then with the lowest contribution recorded at 18% in 2016/17.

This suggests the need to consider new mechanisms for widening the fiscal space for health financing from government revenues. The HSSP IV vows to reduce the dependency on external funding sources and to move towards more sustainable domestic avenues for funding, with a clearly defined role for the private sector.
Although the HSSP IV has reached the midterm of its implementation, there is a clear admission that “government revenue to fund the plan and other social-sector objectives did not meet initial projections”.

2.7 Social Protection in Tanzania

According to Article 22 of the Universal Declaration of Human Rights of 10th December 1948; social protection is a human right. Likewise, Article 11(1) of the Constitution of the United Republic of Tanzania stipulates that:

“The state authority shall make appropriate provisions for the realisation of a person’s right to work, to self-education and social welfare at times of old age, sickness or disability and in other cases of incapacity...”

Accordingly, the National Social Security Policy of 2003 provides the framework for social protection services in Tanzania in line with the framework of the International Labour Organization (ILO). The framework seeks to utilize various funding sources for provision of better protection to the country’s population. The general objective of the policy is to ensure that every citizen is protected against economic and social distress resulting from substantial loss in income due to a variety of contingencies. Accordingly, the social security system in Tanzania has three key elements:

I: Social assistance schemes: these are non-contributory and income-tested and provided by the state to groups such as people with disabilities, elderly people and unsupported parents and children who are unable to provide for their own minimum needs. It is provided in the National Social Security Policy that “The Government shall enhance the capacity to attend to the social assistance programs that constitute services such as primary health; primary education, water, food security and social welfare services to vulnerable groups such as people with disabilities, the elderly and children in difficult circumstances on a means tested basis. Moreover, the government shall create an enabling environment for other institutions such as Non-Governmental Organizations (NGOs), charitable organizations, families and mutual assistance groups to supplement the government’s effort in the provision of such services”. The scheme also covers social relief, which is a short-term measure to provide relief from an individual or community crisis. Regarding access to health services, exemptions from health facility user fees for the elderly, pregnant women, children under five years old and selected categories of the poor falls under the social assistance scheme.

A World Bank-led evaluation report provided that the community-based conditional cash transfer program led to improved outcomes in both health and education. Households used the resources to invest in livestock, in children’s shoes, in insurance, and—for the poorest households—in increased savings. It is a common misconception that they support only people that are unwilling to work. Evidence shows that the investment in agricultural productive assets and livestock increases with conditional cash transfers, and the economy gets stimulated on local level. It

The Tanzania Mainland Social Action Fund (TASAF) is implementing a donor-funded programme on community conditional cash transfers targeting extreme poor households in the country (approx. 15% of the population). Eligible households are identified with a community-based income test that uses socioeconomic proxy markers to categorize potential beneficiaries. These proxy means tests by nature have inclusion and exclusion errors, leading to tensions amongst locals. The TASAF programme seems to perform adequately compared to similar programmes accordingly. However, the TASAF targeting mechanism is not meant to replace the waiver and exemption system from the local government mentioned above. Conditional cash transfer programmes provide grants to poor and vulnerable families, which are usually invested in human capital concerns, such as keeping children at school or taking them to health centres on a regular basis. It has been reported that conditional cash transfer programmes increase enrolment rates in CHF and improve preventive health care.

Despite the potential to extend UHC, the actual implementation of such schemes and the extent to which target groups benefit have proved problematic. In practice, these exemptions are ineffective due to structural and individual challenges that hamper the implementation of the policy. Therefore, significant portions of the impoverished in Tanzania do not receive the exemptions they are entitled to. Participants in FGDs in Singida, Dodoma and Manyara confirmed that the groups exempted are in most cases required to pay for services that they are ideally entitled to.
must be noted that TASAF beneficiaries are being encouraged to a significant extent to use their cash benefits for enrolling in CHF. The TASAF grants, however, are supposed to provide food security to the beneficiaries. Moreover, according to CHF legislation, the LGAs have been obliged since many years to set aside sufficient budget for covering the CHF contributions for those who cannot afford them\(^{10}\). However, this has been implemented only very rarely. Now the TASAF program is being used to close this gap, but actively facilitating TASAF pay outs into CHF contributions is distorting the initial purpose of the CCT.

II: Contributory schemes: This entails contributions of employees through the employers to pension or provident funds alongside contributions from employers. The National Social Security Policy underlines that, “Mandatory social security institutions that shall operate under the social insurance principles in accordance with minimum acceptable standards and benchmarks”.

According to Hon. Kairuki (2017),\(^{37}\) contributory schemes in Tanzania include the National Health Insurance Fund (NHIF), Community Health Fund (CHF), National Social Security Fund (NSSF), Public Service Pension Fund (PSPF), Local Authority Pension Fund (LAPF), Parastatal Pension Fund (PPF), Government Employees Provident Fund (GEPF) and Workers Compensation Fund (WCF).

Although other contributory schemes have health insurance packages, NHIF and CHF are the main contributory social protection schemes for health developed within the health sector reforms in Tanzania. NHIF commenced its operation in 2001 as an obligatory scheme offering a comprehensive benefit package for public sectors employees. It has extended its coverage to individuals from the private sector and community groups, but coverage remains low (8%). The premium for formal sector employees is 6% of the employee’s salary. The employer contributes 3% and the employee pays the remaining 3%. Informal sector workers pay a flat fee of about TZS 75, 000/= and above in group insurances. Benefits of the scheme include basic diagnostic tests, out-patient services, and in-patient service care at fixed rates per day, minor surgery, and major in- and out-patient specialized services among others. Services are provided by the accredited health facilities and pharmacies. The annual fee for a full benefits package over all service levels for a family in the self-employed sector is 1.5 m TZS.

There is a big difference when you have health insurance because, it is hard to predict as to when one will fall sick since illness usually comes at a time when you are not prepared. But if you have health insurance you don’t have to think of costs for treatment when going a health facility (...) you only think about transport and food so even if you have no money at all the insurance protects you (kama huna hela mfukoni bima inakubeba). In addition, with health insurance, it has been easy to access specialists (kupata maspecialist kiurahisi sana) (FGD, Member of NHIF from informal sector, Singida).

Since majority of Tanzanians live in rural areas and are not employed in the formal sector, the Community Health Fund (CHF) was established in 2001. The objective of CHF as established by the Community Health Fund Act of 2001 is to mobilize financial resources from the community for provision of health care services to its members, provide quality and affordable health care services through sustainable financial mechanism and to improve health care services management in communities through decentralization by empowering them in making decision\(^{38}\).

Over all, health insurance schemes in Tanzania cover about 32% of the entire population, of which 8% are covered by the National Health Insurance Fund (NHIF), and 23% by the Community Health Fund (CHF). Only 1% is covered by private health insurance\(^{39}\). This
means 68% of Tanzanian citizens do not have access to social health protection to reduce the burden of out-of-pocket payments. However, not all the uncovered populations can afford to contribute. The current household budget survey conducted by the National Bureau of Statistics (NBS) highlights that 28% of the population in Tanzania constitute the poor of the poorest, i.e. they are living below the basic need poverty line\textsuperscript{60}. This means that, the remaining 40% can be mobilized to join the CHF. A greater section of participants in FGIs across the study settings felt that contributing between TZS. 10,000 and 30,000 TZS per year is not a problem, especially for members of VICOA. But it was also declared that for people who rely on farming, especially when they encounter prolonged draught, they might not afford contributions. This is estimated by the authors to be the case for majority of the poor households in rural areas of Tanzania. Explaining the need to contribute for those who can afford, a female participant in her 50s from Singida noted, nonetheless a different view was raised by a female participant in her 40s in Dodoma who observed that it is possible for the government to provide free health because “the economy is growing, the possibility is huge (uwezekano ni mkubwa)”. To further justify the claim that was supported by other participants, she noted that even poor citizens are paying taxes (tunatoa kodi kupitia manunuzi ya kila siku) through their daily purchases. This view suggests the need to consider ring-fencing some percentage of VAT to subsidize health insurance for the poor.

However, for health insurances to effectively promote UHC, the package of minimum benefits needs to be relatively comprehensive and the scheme should be able to cater for costs involved in the provision of services. For instance, the CHF scheme faces several challenges including, but not limited to, low enrolment rates in most districts, inability to cater for medicines and supplies in health facilities, limited sphere for referrals, confinement of the services within the ward or districts among others\textsuperscript{61,62}. The root cause for these challenges is that CHF is heavily underfunded. An average contribution of 10,000 TZS, matched by another 10,000 TZS from the government (financed by donor budget support in recent years) is meant to cover basic medical expenses of up to six persons for a full year. The financial failure of the CHF to meet the beneficiaries’ needs and expectations, especially the persisting medicines stock-outs, has led to low enrolment, and even lower re-enrolment rates.

Predictability and ability to provide adequate services for health including social health protection is necessary in guaranteeing confidence in the health delivery system and increasing enrolment on the Social Health protection systems such as the NHIF and CHF. Considering the government not disbursing all the allocated funds, it is clear that matching funds to the NHIF and CHF beneficiaries are not disbursed to the respective facilities in a timely way. The net cost is a burden on health facilities as they must improvise means for providing services to those who need them. In some instances, vital medical supplies cannot be provided to CHF card holders. This creates disinterest in accessing the health services within the CHF system. Without guarantees that treatment and medicine will be available to CHF members, the morale to enlist more citizens into

Everything has changed (Kila kitu kimebadilika), the government cannot fulfil everything (serikali haiwezi kutimiza), and we have to contribute (inatubidi kuchangia). This was supported by a male participant in his 40s noting that, “in the past people enjoyed free health services because the population was small but today the number of people has increased (awali watu walikuwa wanatibiwa bure kutokana na uchache wa watu, maana siku hizi wananchi wameongezeka). I am advising the government to make the issue of joining CHF mandatory not voluntary to allow every citizen to contribute to improve services (Kila mwananchi achangie kuboresha huduma).”
The scheme is negatively jeopardised. These concerns were voiced in the FGDs with CHF community members across the consulted communities:

I once had CHF card but one of its condition is that you are entitled to services within the catchment areas of one facility (lakini kwa sharti la kutibwa sehemu moja tu nilipo bila kwenda mahala pengine). I was once supposed to attend health care at one health facility (Mafinga peke yake) and it covers six people, me, my husband, and four children. The challenge is when you’re travelling, it happened to me when I had to remove a tooth while travelling in Dar es Salaam there my CHF could not cover the treatment. This is why I thought of joining NHIF because with this card now I get treatment whenever I go (kadi ya NHIF maana unatibiwa popote) (FGD, IR VIKOBA, Singida).

Once you join the insurance, the major challenge is when you go to the facility and find yourself required to pay (pale unapojikuta umaenda kupewa matibabu unajikuta na madeni). We are asked to pay even for testing simple problems like typhoid while we are on CHF, noted one of a female participant in Singida, “I myself did not get treatment because I did not have money to pay for typhoid test... I think it is better for us to get at least basic diagnosis“ (FGD, CHF members, Manyara).

When you possess CHF card at the registration point (dirishani) you don’t get disturbed, but the challenge is in the services. At first, when the fifth government came to power, we enjoyed the services from the health facilities because health providers feared to be held into account (kutumbuliwa) but now things has even become worse. For instance, I witnessed a motorcyclist (bodoboda) who had an accident, he had CHF but his treatment at the regional hospital required him to pay TZS. 500,000 (laki tano) but they admitted him (FGD, Vulnerable group members, Dodoma)

Due to such negative experiences, other people have been discouraged from enrolling into CHF as noted by the following

“I have not yet paid for the CHF card despite being convinced by others because I hear many people complaining about it” (FGD, Vulnerable groups, Dodoma).

“I have CHF card but I doubt if I will renew it at the end of the year because I don’t see its value given the difficulties I have encountered to secure services from health facilities. We often rely on dispensaries which are out of stock most of the time and they are lacking most of the key equipment for testing even some of the common health problems” (FGD, Community members, Same)

III: Supplementary Schemes: These have been established to cater to different social services like health, pensions and other types of insurance beyond those provided by mandatory and social assistance programmes. According to the policy, these schemes shall be run by employers, private companies, professional bodies and community-based organizations (CBOs). These are comprised of private savings where people voluntarily save for retirement, working capital and insure themselves against events such as disability and loss of income. Most of the members of IR-VICOBA confirmed that their groups have a social fund that caters to emergencies such as illness and diseases, but the base is often limited to small amounts of money with few exceptions.

Issues and Gaps

There is a strong commitment to UHC at the policy level in Tanzania but there is a clear implementation gap. Due to resource constraints, the gap is evident in the mismatch between budget allocations versus the health system needs, and the discrepancy between allocated budget and disbursed/executed budget. Likewise, there are gaps in the implementation of social assistance schemes targeting vulnerable and poor groups due to inadequate resource allocated, along with health governance challenges such as corruption. Equally important, the coverage of existing health insurance schemes has remained relatively low, leaving the majority of Tanzanians uncovered.

Currently in her 50s, she is responsible for the basic provision of her household. She has managed to provide five members of her household with health insurance under CHF. One of the members under CHF is her grandson who is seven years old and currently attending primary school. Four months ago, she was informed from school that the grandson fell down suddenly, and she had to rush to the school and pick him to the regional referral hospital. Upon initial investigation by practitioners, it was suspected that the boy could have a heart problem, but she was asked to pay a total of TZS.30,000/= for him to be examined further. The CHF insurance could not cover him at that level, so the grandson did not receive further medication and they left the hospital for home. It is now four months after they left the hospital the grandson has to been subjected to serious (harmful?) medication because his grandmother has not secured the money. In her own words the grandmother complains, “ I have CHF for my grandson but I have not been able to raise another TZS.30,000/= for him to be examined further and start medication but my worry is even when he is examined the treatment may cost up to one million Tanzania shillings...where do I get the money?”

The above cases illustrate the challenges that many of the poor people in Tanzania encounter in access to health services. The fact that people must postpone or delay treatment because they cannot afford services is among the factors leading to morbidity and mortality, hence costing the lives of many in marginalized groups in rural areas of Tanzania.
2.8 Contribution of FBO hospitals in providing health services in Tanzania

Due to their historical role, until today the majority of FBO facilities largely serve people in rural and remote areas of the country. FBO-owned health facilities over time built trust and confidence among the population because of their diaconal values and approach in serving the poor.

Church-based health facilities are the second largest health care provider in the country after government-owned public facilities, owning an estimated 40% of hospitals and 13% of all health care delivery facilities.

Table 2: Health facilities in Tanzania by ownership

<table>
<thead>
<tr>
<th>Category of health facility</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>National general hospital</td>
<td>1</td>
</tr>
<tr>
<td>National specialized hospital</td>
<td>4</td>
</tr>
<tr>
<td>Regional referral hospital (Government)</td>
<td>15</td>
</tr>
<tr>
<td>Regional referral hospital (FBO)</td>
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<td>Zonal hospital</td>
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<td>Council hospital</td>
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<td>Council designated hospital</td>
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<td>Voluntary Agency hospital</td>
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<tr>
<td>Parastatal hospital and health centres</td>
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<td>Health centres</td>
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<tr>
<td>Dispensaries</td>
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<tr>
<td>Parastatal dispensaries</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6882</strong></td>
</tr>
<tr>
<td>Private sector Facilities (2014)</td>
<td></td>
</tr>
<tr>
<td>Private hospital</td>
<td>39</td>
</tr>
<tr>
<td>Private health centre</td>
<td>78</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>1123</td>
</tr>
<tr>
<td>Private clinics</td>
<td>40</td>
</tr>
<tr>
<td>Private dental clinics</td>
<td>26</td>
</tr>
<tr>
<td>Private eye clinic</td>
<td>5</td>
</tr>
<tr>
<td>Maternity homes</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,333</strong></td>
</tr>
<tr>
<td><strong>Health sector total</strong></td>
<td><strong>8,215</strong></td>
</tr>
</tbody>
</table>

Source: HSSP (2015)
However, management of FBO-owned health facilities still perceive that preference and priority in allocation of government resources and medicine from the basket fund is given to government-owned facilities.

**St Luke Bwambo Roman Catholic Health Centre is a faith-based organization owned health facility in Bwambo village in the mountains of Same district. The health facility is served by one doctor who also doubles as the priest and assisted by one medical assistant.**

We do not receive direct financial support from the government, although the government pays salaries for the doctor and three nurses. Our biggest challenge has been to provide adequate health care with little funding and a constrained staff. Funding from the CHF is not enough. We only receive TZS 9,100 of the total government matching fund of TZS 30,000 allocated per household of six per year. This translates into TZS 850 per patient per month. The situation would significantly improve if government either increased its contribution or efficiency to ensure a bigger portion of the matching fund to the CHF reach the health facilities. The health service delivery cost and contributions do not tally. We sometimes run at deficits, rely on well-wishers, and this at times makes it difficult for us to provide quality health care to the poor who need it. Enrolment rates to CHF are still low. Youth are not enrolling, and this makes CHF unviable from an insurance point of view, since the youth are the majority and less vulnerable to morbidity. If enrolled in large numbers, their contributions would cross-subsidize the others who fall sick and seek treatment.

Under the current health plan, the government plans to construct a health facility at each ward. Why can’t government consolidate and strengthen existing faith-based organization-owned health facilities in areas such as Gonja and Bwambo instead of constructing other health facilities very close to these facilities, yet the numbers show that more people prefer to go to the faith based-owned facilities in these areas. It is a duplication of efforts. These scarce government resources could be spent to improve health service delivery by the FBOs in these wards.

The government's policy of establishing government health facilities in every ward, including areas where already strong FBO-owned health facilities exist was uncoordinated. In some, this led to the duplication of resources would have been better spent to compliment health service delivery by FBO-health facilities in these wards.

The Mountainous topography of Bwambo and Gonja villages in Same district which is currently served by two major faith based organization-owned health facilities. Strengthening health facilities in remote areas such as these would be a major boost to increasing access to health care for the poor and vulnerable. **Photo by NCA/Researchers**
The tax regime in Tanzania is comparatively progressive. Main sources of tax revenues are income taxes, which are progressive, followed by VAT and excise taxes. VAT as an indirect tax is prone to being regressive, but in Tanzania its adverse effects towards poor and low-income households are mitigated by broad exemptions on goods for basic needs. To maintain the pro-poor maxim of improving access to health care also on the taxation side, earmarking tax revenues or increasing taxes for social health protection should be done in a way that it is still progressive.

However, there is a broad need to increase tax revenue to sustainably finance the needs of Tanzanian development. Tanzania has low tax collection. This is due to both low tax collection on the government side and low tax compliance on the taxpayers’ side. The social contract between government and citizen, with citizen obligation to pay taxes and the government administering revenues and expenditures in a transparent and accountable way, requires improved tax justice from both the government’s and the citizen’s sides. Increased accountability, predictability and equitable taxation across sectors and regions has the proven potential to increase tax compliance and reduce tax evasion by citizens also and strengthen the social contract between the government and its citizens.

The fifth government has embarked on increasing tax collection, and tax revenues are rising. However, there are also concerns that overly rigid collection measures and shortcomings on the government side like delayed payback of verified arrears to private sector entities might suffocate businesses, eliminating them as future tax payers.

The Interfaith Standing Committee of Economic Justice and Integrity of Creation has shown how much money Tanzania loses on taxes, with a focus the mining sector. It is estimated that the government loses 1.8bn USD (equivalent to 4.09 trillion TZS) annually in revenues from the extractive industries through channels such as tax evasion, transfer mispricing, generous exemptions and illicit capital flight through conduits such as EPZs, loopholes in the extractive sector and general under taxation. This figure is estimated to have increased from 1.3bn USD (2.06 trillion TZS) in 2012. The government loses an additional USD1.3bn (TZS2.6trillion) through corruption in provision of the national budget.

In its efforts to increase revenues from the extractive sector, the current government has already taken several actions. Most prominently, the government came to an agreement with Acacia Mining, a subsidiary of Barrick Gold Corp of Canada, to increase the government’s share of the profits from Acacia’s mining operations in Tanzania to 50% and a one-off payment of 300m USD as a “good will payment” to resolve an ongoing tax dispute. Furthermore, the Tanzanian government will gain a 16% stake in the company. However, it must be noted that this is an individual agreement with one company after issuing it a huge tax bill of 190m USD, a multiple of the company’s annual profits, for alleged unpaid taxes of 20 past years.

Similar moves seem to be underway for other mining sectors. The parameters of the agreement with Acacia shall be used as a blueprint for the mining sector, by introducing a government 16% capital share and the 50% profit share as general rules.

According to the ISCEJIC report on lost tax revenues 2017, Tanzania can increase its tax collection permanently and sustainably from the mining sector by a multiple of the volume of the recent Acacia agreement through the implementation of fair and transparent tax regulations. Transparent and predictable taxation can avoid conflicts like the Acacia disputes and create more sustainable revenues in the future.

This study’s findings show weaknesses in the country’s tax policy framework on health financing. The tax regime is susceptible to revenue losses, but also implicitly biased towards mobilising financing for specific sectors. Decisions with regards to financing social protection in health are at the mercy of decision makers and political players. The tax and legal framework is conspicuously silent on social health financing. This designates allocations for financing social health protection to be charged from the consolidated fund.

The Education Fund Act 2001 (Section 13) has ring fenced a share (2.0%) of the total annual government budget to be channelled to the education fund authority. No revenues streams in Tanzania are ring fenced and earmarked towards social health protection. Government financing for the health sector is done through general tax and budget support. As noted in the HSSP IV, the MOHCDGEC is considering a request to ring fence 30% from value-added tax and excise tax collected from alcohol and tobacco sales to be set aside for the SNHI. In the next sections of this report it is proposed that a relatively small percentage of existing revenues can be ring fenced for the health sector.

Further, other sector concerns in infrastructure, energy, education and agriculture are financed through specific designated sources such as levies on petroleum products. Revenues from these designated sources are channelled to the Energy and Water Utilities Regulatory Authority (EWURA), Rural Energy Agency (REA), Tanzania National Roads Agency (TANROADS) Fund, Surface and Marine Transport Regulatory Authority (SUMATRA).

The Tanzanian Income Tax Act (CAP332) foresees, that expenditures for agricultural improvement, research and development and environmental expenditure can be deducted from a person’s or an entity’s taxable income as well.

To incentivize expenditures and donations towards social health protection, such payments should be deductible from the taxable income as well. Social health protection would benefit greatly from an amendment of sections of the Income Tax Act, EWURA Act, REA, SUMATRA and TANROADS, Gaming Tax and Customs & Excise Acts to categorically channel an ear marked percentage of funds collected under these acts towards social health protection.
4. Make it Possible  
-Towards Universal Health Coverage

4.1 Current government strategy

It can be said that in as much as the government is willing to increase the level of financing on health in Tanzania, there is the clear challenge of scarce sources. Unfortunately, competing priorities coupled with limited resources cripple’s efforts to making UHC a reality. Political will has also not been galvanised towards channelling resources to achieve UHC. Although health is articulated as an investment in some of the development policies and strategies, such commitments are yet to be translated into political action.

In the recent years, the government has developed a health financing strategy that seeks to achieve universal health coverage by 2025. It is also part of the current Health Sector Strategic Plan IV. It foresees four key building blocks:

- Mandatory health insurance for all Tanzanian citizens
- A unified minimum benefits package for all beneficiaries
- The creation of a single national health insurance (SNHI) by merging CHF and NHIF
- Coverage for the poor by subsidies from the government budget.

This strategy was put forward in 2015. Submission to the cabinet is still pending. The most common concerns to move into the SNHI include resource constraints, sustainability and legal implications (i.e. each scheme was established by different legal frameworks). There is a clear reluctance to committing more resources to Universal Health Coverage.

Meanwhile, as the overall health financing strategy of 2025 is still pending, the government is about to roll out an improved CHF scheme (iCHF) from May 2018 onwards. The scheme has already been successfully piloted in a few districts. Key features of the iCHF are

- portability among districts (current CHF cards are only valid in the respective district)
- increased benefits package, mainly through coverage up to regional referral hospital level (most regional referral hospitals are not participating in CHF currently)
- Increased contributions to channel more resources to health facilities (30,000 TZS to be paid by the household, plus 30,000 TZS from the matching funds). This shall improve the financial basis of facilities and reduce medicines and equipment stock outs.

However, this scheme will still be voluntary and therefore prone to adverse selection, and there is not yet any direct provision for the poor.

4.2 Estimating funding gaps

International benchmarks

There are two major international benchmarks related to health financing. One is the Abuja Target on budget allocation for health. In 2017/2018, Tanzania had an allocation of 7.0% of the total budget, equalling 2,222 bn TZS. Hitting 15% (the target value) would therefore have required an additional allocation of 2,539 bn TZS.

The other benchmark refers to WHO calculations on financial needs in order to secure essential services for the population. The initial calculation was done 17 years ago in 2001, leading to a benchmark value of 34 USD per capita. More recent estimations stipulate...
that this amount would have to rise to 60 USD by 2015\textsuperscript{40}. Current total health expenditure in Tanzania is 31 USD per capita in 2015 (including external and private expenditure). The difference of 29 USD per capita would translate into approx. 3,700 bn TZS.

**Figure 5: Health sector funding gap in Tanzania.**

![Graph showing health sector funding gap in Tanzania](image)

Source: MOHSW (2015)\textsuperscript{81}

Financing need for Tanzanian government plans

Looking at the implementation of the full HSSP IV, according to the MOHCDGEC, there are substantial resource needs. In total the needs are estimated around 21,945 billion TZS from 2015–2020\textsuperscript{82}, or 4,389 billion TZS per year.

Tanzania’s population was an estimated 52.5m in 2017\textsuperscript{83}. The government estimates that 32% of the population are covered with health insurance. Out of these, 8% are covered by NHIF, 23% covered by CHF and 1% by private health insurance providers. This means that 68% of the total population are not covered.

In the current iCHF concept, the allocation per household of six people is 60,000 TZS, and it is geared to reach all Tanzanians that do not have NHIF or private insurance, or 91% of the population. If 30,000 TZS per household will be contributed by the government in the form of matching grants and if iCHF reaches full coverage of the 91% Tanzanians outside NHIF (equivalent to 46,594,000 people), then the total financial volume of iCHF matching grants to be paid by the government would be 291 bn TZS per year.

4.3 Possible sources of funding

**Extractive Sector**

From the recent ISCEJIC report on tax income losses, Tanzania loses 4.09 trillion TZS per year from potential tax losses through tax evasion, generous exemptions in conduits such as EPZs and in the extractive industry sector and due to general under-taxation. According to the 6\textsuperscript{th} report of the Tanzania Extractive Industries Transparency Initiative (TEIT),\textsuperscript{84} the Government of Tanzania received 1,2 trillion TZS in payments from extractive companies in 2013/14. In 2015/16 the government received 465 bn TZS. The decrease in mining revenues by 6% was matched by an increase in the oil and gas payments by 6%, contributing to 19% of the total government extractive sector receipts. The size of the extractive sector was estimated at 4,975,991 Million TZS. The subcategory of mining and quarrying inclusive of petroleum products contributed up to 4.8% of the GDP in 2015/16. The GDP share of crude oil and natural gas was 0.74% in 2015/16.

This compares well with 2014/15, where the size of the extractive industry was estimated at 3,659,599 ml TZS, of which petroleum was 832,165 ml TZS. The subcategory of Mining and Quarrying inclusive of petroleum products contributed up to 4.0 % of the GDP in 2015. The GDP share of crude oil and natural gas was 0.9% in 2015\textsuperscript{26}.

In 2017 the government enacted three pieces of legislation that will substantively change the extractive sector into the future. These include the Natural Wealth and Resources Contract (review and re-negotiation of unconscionable terms) Act 2017 and written laws (miscellaneous amendments). Collectively, the mining laws introduce major changes to revenue collection and management of the extractive sector. These include the introduction of provisions for review of existing natural resource contracts, establishing a mining commission to oversee the mining sector, advancing local benefits to the country, limiting use of offshore banking accounts and giving government an assured free-carried interest of no less than 16% in mining companies and the right to acquire up to 50% of any mining asset commensurate with the total tax expenditure incurred by government in favour of the company. The government also made changes to the oil and gas sector aimed at increasing transparency and oversight.

With these changes, it is possible that the revenue contributions from the extractive sector will be substantive in the future. Allocation of a portion of this towards social protection in health could be a major source of financing.

The Oil and Gas revenue management Act 2015 established an Oil and Gas fund\textsuperscript{86}. The objective of this fund is to ensure fiscal and macro-economic stability, financing investment in oil and gas, enhancing social and economic development and safeguarding resources for future generations. The fiscal rules governing expenditure of this fund (Section 6) require that the fund is spent on
specially designated expenditures. In any fiscal year, a maximum amount of 3% of the GDP (Section 17 (c) (ii)(aa) is to be transferred to the consolidated budget for budgetary uses. At least 60% of such transfer is dedicated to funding strategic development expenditure including human capital development, particularly in the field of science and technology. Money equivalent to 0.1% of GDP (Section 17 (1) (e) iii) is ring fenced annually into the RSA of the fund for the National Oil Company (Tanzania Petroleum Development Corporation) strategic investment to be spent through normal budgetary processes. Allocation of spending from this fund for social sectors would create a sustainable funding source for health, like the Norwegian model.

Other sources
Tax revenues in general are very likely to increase and become unable for social services, as Tanzania’s economy is deemed to be one of the fastest growing on the continent... The current government has a strong focus on increasing tax revenues and reducing tax evasion, meaning that tax funded social protection in health needs could be feasible.

<table>
<thead>
<tr>
<th>Tax Item</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross VAT-</td>
<td>958.3</td>
<td>1,179.08</td>
</tr>
<tr>
<td>Net VAT-Local</td>
<td>810.5</td>
<td>1,163.2</td>
</tr>
<tr>
<td>W/Holding tax on IRMDs (direct)</td>
<td>107.7</td>
<td>97.9</td>
</tr>
<tr>
<td>Excise duty (Local) on beer, alcoholic drinks and tobacco/cigarettes</td>
<td>408.8</td>
<td>399.8</td>
</tr>
<tr>
<td>Excise duty on petroleum imports, fuel levy and petroleum fees (REA)</td>
<td>1,640.8</td>
<td>1,807.8</td>
</tr>
<tr>
<td>Gaming taxes on sports betting</td>
<td>18.99</td>
<td>26.5</td>
</tr>
<tr>
<td>Perfumes and cosmetics</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: TRA tax collection statistics
Tanzania Revenue Authority (TRA) statistics does not show how much is collected from the last category as a tax source suggesting either its unclear classification or non-existence.

Ring-fencing tax revenues for health will create more stability and sustainability in health funding (see the Ghana experience), as health allocations are less dependent on the annual mercy of political decision makers. Channelling or ring-fencing income from sin taxes towards social health protection has a double effect, as it does not only increase the financial basis for universal health coverage but also discourages consumption of tobacco and alcohol, having a direct health impact.

The idea of ring-fencing selected revenue to finance the health sector is well articulated in the HSSP IV (2015-2020). The government draft plan suggests three sources of financing from which a percentage of revenue can be ring fenced for health as follows: the surplus of public corporations (20%), air time taxes of mobile phones (17%) and alcohol and tobacco taxes (33%).

<table>
<thead>
<tr>
<th>Sources</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation from the surplus of public corporations</td>
<td>129</td>
<td>138</td>
<td>146</td>
<td>156</td>
<td>166</td>
</tr>
<tr>
<td>Airtime taxes</td>
<td>100</td>
<td>106</td>
<td>113</td>
<td>120</td>
<td>128</td>
</tr>
<tr>
<td>Alcohol and tobacco taxes</td>
<td>260</td>
<td>276</td>
<td>294</td>
<td>313</td>
<td>333</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>489</strong></td>
<td><strong>520</strong></td>
<td><strong>553</strong></td>
<td><strong>589</strong></td>
<td><strong>627</strong></td>
</tr>
</tbody>
</table>

Source: Health Sector Strategic Plan (2015-2020), MOHSW 2015

A healthy population is the key for development
Photo by NCA/Håvard Bjelland
4.4 Recommendations

From the gaps and figures outlined in this report, there is a variety of measures that can be taken to move toward universal health coverage, inclusive of the poor and marginalized in Tanzania. Increasing tax-funded parts in social health protection systems does not equal a shift to a 100% tax financed system or to abolish existing insurance mechanisms. However, every health financing system worldwide has tax-funded elements, typically for poor and marginalized groups or for sustainability subsidies.

The recommendations made in this report aim to improve coverage and close gaps by allocating tax money to those of the population in need, within the framework of the existing health financing set up in Tanzania and upon reflection of its future strategies towards universal health coverage. There are several short to medium term fiscal options that the government can implement in a reasonable time frame of one budget year as explained below:

Short term fiscal options

Option 1:

Make iCHF affordable for all Tanzanians living below the poverty line by 2025

The 28% of the population, or approximately 14,400,000 people, are currently living below the poverty line. Their ability to spend money for health care are clearly limited, with all the negative consequences for the vicious cycle between poverty and sickness. Assuming an average household size of 4.8, this translates into 3 million households to be covered including those within the TASAF program.

The cost of this measure would amount to TZS 180 bn if the government paid for the full package of Tsh60,000 per household. However, if the poor household contributes TZS 10,000 the amount required as government top up over the five-year period would be equal to TZS 150 bn. To reduce the burden, the government can spread coverage over the 6-year period by targeting 17% of the extremely poor every year cumulatively as illustrated in the tables below.

Extremely poor households should match government contribution by making some small contributions of TZS 10,000/ per year.

Table 4: Amount in billions required to cover 28% of the poor households by 2025 at TZS 50,000 government contributions and 10,000 TZS by the beneficiaries

<table>
<thead>
<tr>
<th>Years</th>
<th>H/Holds Covered</th>
<th># of Beneficiaries</th>
<th>Required Amount</th>
<th>Lost Taxes: 4tr</th>
<th>Net VAT: 1.2tr</th>
<th>TEITI revenues</th>
<th>Petroleum: 1.8tr</th>
<th>Sin taxes: 399 bn</th>
<th>Total Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>500,716</td>
<td>2,503,580</td>
<td>25.035</td>
<td>8.80</td>
<td>1.80</td>
<td>0.93</td>
<td>3.60</td>
<td>9.98</td>
<td>25.11</td>
</tr>
<tr>
<td>2020/21</td>
<td>1,001,431</td>
<td>5,007,155</td>
<td>50.072</td>
<td>17.60</td>
<td>3.60</td>
<td>1.86</td>
<td>7.20</td>
<td>19.95</td>
<td>50.21</td>
</tr>
<tr>
<td>2021/22</td>
<td>1,502,146</td>
<td>7,510,730</td>
<td>75.107</td>
<td>26.40</td>
<td>5.40</td>
<td>2.79</td>
<td>10.80</td>
<td>29.93</td>
<td>75.32</td>
</tr>
<tr>
<td>2022/23</td>
<td>2,002,862</td>
<td>10,014,310</td>
<td>100.179</td>
<td>35.20</td>
<td>7.20</td>
<td>3.72</td>
<td>14.40</td>
<td>39.90</td>
<td>100.42</td>
</tr>
<tr>
<td>2023/24</td>
<td>2,503,577</td>
<td>12,517,885</td>
<td>125.179</td>
<td>44.00</td>
<td>9.00</td>
<td>4.65</td>
<td>18.00</td>
<td>49.88</td>
<td>125.53</td>
</tr>
<tr>
<td>2024/25</td>
<td>3,004,292</td>
<td>15,021,460</td>
<td>150.215</td>
<td>59.85</td>
<td>21.60</td>
<td>5.58</td>
<td>150.63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the above tables it is evident that the government can cover the 28% extremely poor and destitute with health insurance by allocating only 19% of the proposed ring-fenced taxes. The percentage contribution from VAT as a proportion to this tax mix would be as low as 0.15% annually reaching to a maximum of 0.9% in 2025. One among the strength of this funding option is the commitment and willingness of the Government in collecting taxes. So far there are indications that the volume of taxes collected will increase. If well managed and couple with proper prioritisation, that could substantively increase the volume of resources available to spend on health.
Mobilize for increased enrolment (coverage) in iCHF and improve the minimum benefit package as a motivation towards getting the remaining 40% percent of the population in the informal and non-formal sector which is currently not covered by any health insurance scheme to join. Allocate adequate matching funds for new enrolments for all 40% Tanzanians in the informal and non-formal sectors (excluding the extremely poor) by 2025.

Table 6: Amount required to cover 40% uncovered (informal and non-formal sectors) by 2025

<table>
<thead>
<tr>
<th>Years</th>
<th>H/Holds Covered</th>
<th># of Beneficiaries</th>
<th>Req'd amount</th>
<th>Lost Taxes: 4trln</th>
<th>Net VAT: 1.2trln</th>
<th>TEITI Payments: 465bn</th>
<th>Petroleum: 1.8Trln</th>
<th>Sin taxes: 399bn</th>
<th>W/H Taxes IRMDS</th>
<th>Gaming Taxes</th>
<th>Total Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>706,667</td>
<td>3,533,335</td>
<td>21.2</td>
<td>4.68</td>
<td>1.80</td>
<td>0.93</td>
<td>3.60</td>
<td>9.98</td>
<td>0.19</td>
<td>0.08</td>
<td>21.26</td>
</tr>
<tr>
<td>2020/21</td>
<td>1,413,333</td>
<td>7,066,665</td>
<td>42.4</td>
<td>9.36</td>
<td>3.60</td>
<td>1.86</td>
<td>7.20</td>
<td>19.95</td>
<td>0.39</td>
<td>0.16</td>
<td>42.51</td>
</tr>
<tr>
<td>2021/22</td>
<td>2,119,999</td>
<td>10,599,995</td>
<td>63.6</td>
<td>14.04</td>
<td>5.40</td>
<td>2.79</td>
<td>10.80</td>
<td>29.93</td>
<td>0.58</td>
<td>0.23</td>
<td>63.77</td>
</tr>
<tr>
<td>2022/23</td>
<td>2,826,665</td>
<td>14,133,325</td>
<td>84.8</td>
<td>18.72</td>
<td>7.20</td>
<td>3.72</td>
<td>14.40</td>
<td>39.90</td>
<td>0.78</td>
<td>0.31</td>
<td>85.03</td>
</tr>
<tr>
<td>2023/24</td>
<td>3,533,331</td>
<td>17,666,655</td>
<td>106.0</td>
<td>23.40</td>
<td>9.00</td>
<td>4.65</td>
<td>18.00</td>
<td>49.88</td>
<td>0.97</td>
<td>0.39</td>
<td>106.29</td>
</tr>
<tr>
<td>2024/25</td>
<td>4,239,997</td>
<td>21,199,985</td>
<td>127.2</td>
<td>28.08</td>
<td>10.80</td>
<td>5.58</td>
<td>21.60</td>
<td>59.85</td>
<td>1.16</td>
<td>0.47</td>
<td>127.54</td>
</tr>
</tbody>
</table>

Ring fence percentages of revenue sources such as extractive sector payments, VAT, petroleum levy, airtime taxes, tobacco and alcohol taxes, cosmetics and gaming taxes, payments to EWURA, TANROADS towards financing social health insurance.

In this case the current roll-out of iCHF will change the contribution rates for iCHF from 10,000 to 30,000 TZS. In the financial setup of iCHF, the households will contribute TZS 30,000 and the government will contribute another 30,000 TZS as matching funds, leading to a deposit of 60,000 TZS in total per household enrolled. 40% of the population translates into 21,199,985 Tanzanians or 4,239,997 households (assuming 5 persons/household). The government would require TZS 127.2 bn as financing need for the respective matching funds from the next five/six years. This amount can be generated from multiple sources as shown below. As the payment process of matching funds is already in place, implementation can follow existing structures.

Table 7: Percentages of ring-fenced taxes required to cover 40% of uncovered population (informal and non-formal sector) by 2025

<table>
<thead>
<tr>
<th>Years</th>
<th>H/Holds Covered</th>
<th>No of Beneficiaries</th>
<th>Amount Required</th>
<th>Lost Taxes: 4trln</th>
<th>Net VAT: 1.2trln</th>
<th>TEITI Payments: 465bn</th>
<th>Petroleum: 1.8Trln</th>
<th>Sin taxes: 399bn</th>
<th>W/H Taxes IRMDS</th>
<th>Gaming Taxes</th>
<th>Total Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>706,667</td>
<td>3,533,335</td>
<td>21.2</td>
<td>0.117</td>
<td>0.15%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>2.5%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>21.26</td>
</tr>
<tr>
<td>2020/21</td>
<td>1,413,333</td>
<td>7,066,665</td>
<td>42.4</td>
<td>0.0234</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>5%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>42.51</td>
</tr>
<tr>
<td>2021/22</td>
<td>2,119,999</td>
<td>10,599,995</td>
<td>63.6</td>
<td>0.351</td>
<td>0.45%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>7.5%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>63.77</td>
</tr>
<tr>
<td>2022/23</td>
<td>2,826,665</td>
<td>14,133,325</td>
<td>84.8</td>
<td>0.468</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>10%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>85.03</td>
</tr>
<tr>
<td>2023/24</td>
<td>3,533,331</td>
<td>17,666,655</td>
<td>106.0</td>
<td>0.585</td>
<td>0.75%</td>
<td>1%</td>
<td>1%</td>
<td>12.5%</td>
<td>1%</td>
<td>1.5%</td>
<td>106.29</td>
</tr>
<tr>
<td>2024/25</td>
<td>4,239,997</td>
<td>21,199,985</td>
<td>127.2</td>
<td>0.706</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>15%</td>
<td>1.8%</td>
<td>1.8%</td>
<td>127.54</td>
</tr>
</tbody>
</table>

Ring fence percentages of revenue sources such as extractive sector payments, VAT, petroleum levy, airtime taxes, tobacco and alcohol taxes, cosmetics and gaming taxes, payments to EWURA, TANROADS towards financing social health insurance.

The following tables show the financing need of these measures related to sources of income as per sources of income and potential ring fencing needs.

Table 8: Total amount required to finance 68% of the uncovered population and thus reach 91% coverage by 2025 by contributing TZS 50,000 for the extremely poor and TZS 30,000 as matching funds for the other new enrolments to iCHF

<table>
<thead>
<tr>
<th>Years</th>
<th>H/Holds Covered</th>
<th>No of Beneficiaries</th>
<th>Amount Required</th>
<th>Lost Taxes: 4trln</th>
<th>Net VAT: 1.2trln</th>
<th>Extractive tax payments: 465bn</th>
<th>Petroleum: 1.8Trln</th>
<th>Sin taxes: 399bn</th>
<th>W/H Taxes IRMDS</th>
<th>Gaming Taxes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>1,207,383</td>
<td>6,036,915</td>
<td>46.235</td>
<td>0.34%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>5%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>6.94%</td>
</tr>
<tr>
<td>2020/21</td>
<td>2,414,764</td>
<td>12,073,820</td>
<td>92.472</td>
<td>0.67%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>10%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>13.87%</td>
</tr>
<tr>
<td>2021/22</td>
<td>3,622,145</td>
<td>18,110,725</td>
<td>138.7</td>
<td>0.01%</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>15%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>20.81%</td>
</tr>
<tr>
<td>2022/23</td>
<td>4,829,527</td>
<td>24,147,635</td>
<td>184.979</td>
<td>1.35%</td>
<td>1.2%</td>
<td>1.6%</td>
<td>1.6%</td>
<td>20%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>27.75%</td>
</tr>
<tr>
<td>2023/24</td>
<td>6,036,908</td>
<td>30,244,540</td>
<td>231.179</td>
<td>1.69%</td>
<td>1.5%</td>
<td>2%</td>
<td>2%</td>
<td>25%</td>
<td>1%</td>
<td>1.5%</td>
<td>34.69%</td>
</tr>
<tr>
<td>2024/25</td>
<td>7,244,289</td>
<td>36,221,445</td>
<td>277.415</td>
<td>2.03%</td>
<td>1.8%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>30%</td>
<td>1.8%</td>
<td>1.8%</td>
<td>41.63%</td>
</tr>
</tbody>
</table>

From the above table if government was to a set aside TZS 277bn today, it would be able to reach 91% coverage by 2025. The government can achieve full coverage by allocating TZS 290 bn to spread over the next 5-6-year period.

1 Special attention should be placed on the youth who are not joining in big numbers. These still largely depend on out of pocket payment for health care. Increased mobilization will not only ease the uncovered population from the risk of morbidity and mortality but also contribute to poverty eradication taking into account the fact that vulnerability to health problems heightens the risk of further impoverishment through out of pocket payment for health care. It will also make iCHF feasible and sustainable. To compliment government efforts in that respect, religious leaders and faith-based institutions can contribute in terms of mobilizing their members and faith constituency to enroll into iCHF and facilitate participation of faith-based organization owned facilities in iCHF. Community groups such as IR-VICOBA can be vehicles for mobilization and enrollment.
**41.6% is out of 700% of the total revenue collection from these sources. This is very low considering the contribution of a healthy population towards development**

These calculations show the proportion of ring-fencing need for several revenue sources for each short-term fiscal option. They are completely within the current tax revenues. Additional potential funding sources are

- Gaming taxes and levies on sports betting.
- Special levies on perfumes and cosmetics.
- Ring fence a per centum of revenues from the Oil and Gas Revenue Fund established under section 8 of the Oil and Gas Revenue Management Act, 2015.
- Ring fence levies from tourism
- Mobile data use levy
- Air ticket levy

Therefore, there are multiple potential resources for increased health funding in favor of especially the marginalized groups. For mobilizing these resources, resource envelopes can be defined by combining different revenue sources to make allocations and ring fencing volumes politically more feasible.

**Structural and non-fiscal options;**

- Once the necessary funds to fully cover the poor has been allocated, it is important to empower and hold districts authorities accountable for recruiting poor households, budgeting for the ICHF contributions, and improving access to health services for this group. Building on the TASF database of poor households, along with the local government database of most vulnerable individuals in the communities, a mechanism for identifying all the poor with clear and unified criteria should be put in place.

- Consider some best practices from facilities run by FBO and mainstream these into the public health facilities as an interim measure. Notably, the practice of treating patients who cannot afford to pay and have no health insurance coverage, on arrangements that they would pay after recovery. Health facilities can liaise with local government authorities to guarantee that they know the patients and would follow up to ensure payments are done after discharge. The extreme poor as identified by the social welfare department of the health facility should be exempted.

**Structural and fiscal options;**

- Mobilize lost tax revenue of TZS 4.09 tr as per the “One Billion Dollar Question” report to reach WHO and Abuja targets. Whereas reaching the Abuja target requires a recovery of 62% of the lost revenue under the extractive sector per year, attaining the WHO spending benchmark requires 90% of the same to be recovered. The complete HSSP IV could almost (more than 90%) be financed by the revenues lost due to various channels including in the extractive sector and by general under taxation. HSSP is a very comprehensive health sector development plan and is including the setup of a mandatory universal health insurance for all Tanzanian citizens inclusive of covering the poor from tax subsidies.

- Create a National Health Coverage fund. The recent legislation on extractive industries will increase the already remarkable revenues from these sources. Based on the already existing structure of the Oil and Gas Fund, it can be expanded by establishing a national health fund financed by revenues from both the petroleum and mining resources. Earmarking a specific percentage of this fund and channelling it towards social health protection would be in line with the government’s spirit of ring fencing specific volumes of funds and channelling these to specific expenditures as demonstrated in the various sections of the Oil and Gas Fund law.

- Increase budget disbursement and execution performance from current average of 57% to 100%, by prioritizing health care disbursement, realistic budgeting on the one hand, and unlocking inefficiencies within the ministries, MSD and local government on the other hand.

- Raise efficiency gains in health sector (20-40% potential, 400-800 bn TZS). International comparisons show that there are potential efficiency gains of 20-40% in health systems. These relate to a variety of reasons from inappropriate drug prescription and inefficient staff allocation to corruption and fraud. Efficient use of taxpayer’s money, reducing waste and fighting corruption and fraud belong as well to the ethical foundations of taxation.

- Advocate for introduction of the Single National Health Insurance within the framework of the Health Sector Strategic Plan IV, to establish a sound and sustainable health insurance system for all Tanzanians.

- Increase the capacity of faith based and government health facilities located in remote and hard to reach areas to deliver health care services in places where there are no public health facilities. Strive to reduce the medical personnel –patient ratio overload, erratic cash flow problems and medicine stock outs. Avoid duplication of efforts by avoiding constructing public facilities where FBO facilities are already providing services.

Table 9: Summary of ring-fencing options for short term recommendations TZS billions

<table>
<thead>
<tr>
<th>Health Insurance Coverage</th>
<th>Amount needed in Bn TZS</th>
<th>Lost tax revenue</th>
<th>VAT Revenue</th>
<th>Extractive tax payments</th>
<th>Petroleum Levies</th>
<th>Sin Tax</th>
<th>W/H tax</th>
<th>Gaming taxes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICHF coverage for all the extremely poor (28% of total population)</td>
<td>150</td>
<td>1.32%</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>15%</td>
<td>-</td>
<td>-</td>
<td>19.62%</td>
</tr>
<tr>
<td>ICHF government contribution for remaining 40% of uncovered population</td>
<td>127.2</td>
<td>0.706%</td>
<td>0.9%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>15%</td>
<td>1.2%</td>
<td>1.8%</td>
<td>22.006%</td>
</tr>
<tr>
<td>Total Coverage of all 68% uncovered</td>
<td>277.2</td>
<td>2.026%</td>
<td>1.8%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>30%</td>
<td>1.2%</td>
<td>1.8%</td>
<td>41.626**</td>
</tr>
</tbody>
</table>

**Table 9: Summary of ring-fencing options for short term recommendations TZS billions**
References


40 WHO Data Repository http://apps.who.int/gho/data/node.main.HEALTHFINANCING?lang=en accessed March 20, 2018

41 WHO Data Repository http://apps.who.int/gho/data/node.main.HEALTHFINANCING?lang=en accessed March 20, 2018


