The 2015 Sustainable Development Goals (SDGs) spurred momentum behind the drive for universal health coverage (UHC). UHC means providing all people with access to quality health services while ensuring that the use of these services does not cause financial hardship. As countries invest in health systems to increase access and provide financial protection, strengthening primary health care (PHC) systems will be a critical component of that effort.

Tanzania is embarking on health financing and PHC reforms that will have important implications for progress toward universal health coverage. The government is developing a new health financing strategy to enable access to financial protection as well as affordable and cost-effective quality care. To address current fragmented and low insurance coverage, the government is also developing a new single national health insurance scheme with the goal of reducing out-of-pocket expenditure (OOPS). Tanzania has elevated PHC as a strategic priority in both the health sector plan and greater development vision. Though key health indicators have improved over time (Table 1), maternal mortality remains a significant challenge and the government has recognized strengthening PHC systems as a means to address that. In order to realize the overarching health and development vision, it is important that Tanzania include PHC-centered reforms in the new financing strategy and health insurance system.

HEALTH FINANCING IN TANZANIA

Over half of all health financing in Tanzania comes from donor funds and OOPS—approximately 36 percent of total health expenditure (THE) is from donor funding, while OOPS constitutes 23 percent. Donor funding also makes up a majority of the government’s contribution to health, or general government health expenditure (GGHE). This raises sustainability concerns regarding the ability of the Tanzanian government to contribute if any donors withdraw their contributions (Table 2).

Currently, Tanzania is defining a new health financing strategy in alignment with achieving universal health coverage and the Health Sector Strategic Plan. Accordingly, the strategy will create a financing

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**TABLE 1: KEY HEALTH INDICATORS**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2005</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (M/F)</td>
<td>55/58</td>
<td>62/66</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>60</td>
<td>43</td>
</tr>
<tr>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td>94</td>
<td>61</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>605</td>
<td>398</td>
</tr>
</tbody>
</table>

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**TABLE 4: KEY HEALTH INDICATORS**

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**SNAPSHOT OF MAJOR HEALTH POLICIES:**

- Tanzania Development Vision 2025 (Vision 2025)
- Big Results Now (BRN) (2015-2018)
- Health Sector Strategic Plan (HSSP IV) (2015-2020)
- National Key Result Area in Healthcare (2015-2018)
- The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (2016-2020) One Plan II
- Health Financing Strategy (HFS) (2015-2025)
architecture centered on sustainable domestic financing. The Ministry of Health and Social Welfare (MOHSW) states that the goal of the new strategy is to enable access to financial protection as well as affordable and cost-effective quality health care in the case of ill health, according to a nationally defined standard minimum benefit package. A core focus will include making the standard minimum benefits package for primary and secondary health services fully accessible to all, with particular focus on poor and vulnerable groups.

RISK POOLING SCHEMES
Tanzania currently has multiple health insurance schemes—including a social security fund, a private insurance option, a community-based insurance program, as well as insurance schemes for both the informal sector and formal public sector. Collectively, population coverage among all of these schemes is approximately 15 percent. According to the MOHSW, the fragmented insurance schemes have not reached sufficient scale of proportional coverage among the population.

The new health financing strategy will propose consolidating existing fragmented insurance schemes into one mandatory risk pool: a single national health insurance (SNHI) scheme. Levies and special taxes will contribute to the SNHI scheme, which is set to be operational countrywide in 2020.

PROGRESS TOWARD UHC
Tanzania’s progress toward UHC has been limited, but there is significant potential in the new proposed SNHI scheme and health financing strategy.

Breadth of coverage—population: who is covered?
Approximately 15 percent of the population is covered by one of the health insurance schemes. The two largest insurance schemes are the National Health Insurance Fund (NHIF) and the Community Health Fund (CHF)/Tiba Kwa Kadi (TIKA). The former is largely for the formal public sector and coverage is approximately 6.6 percent of the population, while the latter is for the informal sector where coverage is approximately 7.3 percent. The remaining three insurance schemes are a social security fund as well as private and community-based health insurance, which collectively cover approximately 2 percent of the population. Enrollment in the NHIF is only mandatory for civil servants—enrollment for the remainder of the schemes is voluntary.

Depth of coverage—services: what is covered?
The range of benefits varies across all of the insurance schemes. Benefits are typically more comprehensive within the NHIF, social security fund and private insurance schemes—whereas benefits are sparse within the CHF/TIKA and community-based health insurance. The newly proposed health insurance scheme features a defined standard minimum benefits package, which will unify the covered services to eliminate such variance.

Height of coverage—direct costs: proportion of the costs covered
Out-of-pocket payments for health account for approximately 2 percent of Tanzanian’s incomes. Additionally, 1 percent of Tanzanians become impoverished because of these payments. This lack of coverage is especially problematic because it demonstrates that the cost sharing element of the risk pooling scheme does not provide sufficient financial protection.

Equity: how fair and just is the current situation?
OOPS disproportionately impacts the poorest segment of the population in Tanzania. Additionally, there are implications for equity given the variance of benefits coverage among the five core health insurance schemes. For example, those who are low-income tend to be enrolled in the CHF/TIKA and community-based health insurance programs. Given the differences in covered services, the poor may have different care than the rich—which is not equitable.
It will be important for the government of Tanzania to roll out the new SNHI scheme in a way that ensures reduced OOPS. Though enrollment in the new proposed scheme will be mandatory, expanding population coverage from the current 15 percent will require a concerted effort to enroll more Tanzanians, especially the poor and vulnerable.

As Tanzania defines a new insurance scheme and corresponding benefits packages, it is important to include a comprehensive package of services provided at the primary health care level. This is critical given that the primary health care level is the common entry point for most people.

Within the new benefits package, appropriate cost sharing is essential for services provided at primary health care facilities. Expanding coverage will require reducing or eliminating the amount of direct cost that Tanzanians have to pay out-of-pocket for those services.
ENDNOTES


