Universal Health Coverage to Industrialize the Tanzanian Economy - practical steps to take towards 2030

Analysis and recommendations by Health Promotion Tanzania and its partners to support Government efforts to have healthy work force for an industrialized economy.

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UHC 2030 Policy Recommendations for Tanzania_HDT_2019
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Authors motivation statement: *Good health allows children to learn and adults to earn, helps people escape from poverty and provides the basis for long-term economic development.*

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The authors would like to dedicate this report to Ms Graça Machel the founder and the board chair of Graça Machel trust, who initiated this idea in July 2017 when she visited a health center in Dodoma region with Hon. Ummy Mwalimu the minister for Health. We are also grateful to Graça Machel trust which funded this activity.
A: Executive Summary

Health policies in Tanzania already pledge to reach all households with quality health services, but to date budget allocations for health have been inadequate to cover the poor who are a priority for the President. For example, in 2014/15 the Government allocated 11.3 percent of the budget to health, but this decreased to 9.5 percent in 2015/16. In 2016 The World Health Organization reported that Tanzanian domestic spending on health was 1.7 percent of GDP, way below the recommended 4-5 percent of GDP.

The 2015, Health Financing Strategy aimed to provide guidance on how to reach everybody by reducing financial risk to access health services. Unfortunately, this strategy has not been approved, and this continues to hold back the creation of a National Financial Pool that will cover everyone and subsidize the poor. Lack of money to pay for health service on upfront (Out of pocket) continues to impoverish people and deny people access to life-saving services. According to the Ministry of Health (2018), 66 percent of people are not covered by any insurance. The World Health Organization (WHO) estimates that Tanzanian coverage of a package of essential services (SGD 3.8.1) is 39 percent, way below Kenya and Rwanda at 57 and 53 percent respectively. The proportion of the population in Tanzania with health expenditures larger than 25 percent (as a percentage of total income) is 2.5 percent, compared to Kenya 1.7 percent and Rwanda 0.9 percent.

Achieving universal health coverage (UHC) is instrumental to Tanzanian President Magafuli’s agenda to industrialize the economy because with UHC\(^1\): (a) the population covered by primary health care (PHC) will increase and hence be productive; (b) improved health services will lead to better client satisfaction hence voting the same government into power; and (c) the burden of cost-sharing will be reduced, making economic saving.

Using the recommended Gross Domestic Product (GDP) allocation to health

\(^1\) UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.
sector of 4 percent and lowest projected GDP growth of 2.6 percent, we have estimated that Tanzania would need to allocate TZS 4.58 trillion equal to USD 2.08 billion in the financial year 2019/2020 in order to progress towards UHC. In 2017/18 with an estimated GDP of USD 52.09 billion the health sector allocation was expected to be TZS 4.65 trillion, but the government only allocated TZS 2.2 trillion or 47 percent.

To achieve UHC and increase investments for health in Tanzania, we recommend that Tanzania implement an essential package of health services focusing on cost-effective PHC services, but also including vital hospital services for emergency and referred patients. This would achieve HSSPIV of reaching all households with quality health services and SGD agenda of leaving no one behind. To achieve full population coverage we suggest:

• Formalize social participation by bringing representative stakeholders together (Government, Donors, Private Sector and CSOs) to align all funding schemes such as GFATM, GAVI, PEPFAR/PEPFAR to reach UHC in Tanzania,

• Approving and implementing a health financing strategy as well as operational legal frameworks to replace private voluntary health financing (especially out-of-pocket payments) with compulsory progressive public financing and health system strengthening.

• Undertaking tax reforms to start pro-health taxation on items such as cigarettes, sugar and fossil fuels to generate resources and aim to allocate 4 percent of GDP by 2023.

• Accelerating the scale-up of the integrated national health insurance scheme by offering free, or heavily subsidized, improved community health fund (ICHF) membership to all households in the informal sector who are not eligible for the NHIF scheme.

By establishing sound governance and mobilizing substantial human, financial, and technological resources in implementation, the poorest and most vulnerable people who lack access to essential health services would decrease significantly, and individual, household and community satisfaction would increase, leading to political bonuses in the short, medium and long term.
B: Introduction: What is Universal Health Coverage (UHC)?

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO). It is based on three interrelated objectives namely:

- Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;
- The quality of health services should be good enough to improve the health of those receiving services; and
- People protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

It enables everyone to access the services that address the most important causes of disease and death and ensures that the quality of those services is good enough to improve the health of the people who receive them. It reduces the risk that people will be pushed into poverty because unexpected illness requires them to use their life savings, sell assets, or borrows – destroying their futures and often those of their children. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

When people have to pay most of the cost for health services out of their own pockets, the poor are often unable to obtain many of the services they need, and even the rich may be exposed to financial hardship in the event of severe or long-term illness. Pooling funds from compulsory funding sources (such as general taxation and mandatory insurance contributions) can spread the financial risks of illness across a population. UHC, therefore, emphasizes not only what services are covered and who is covered, but also how they are funded, managed, and delivered.

UHC is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma
Ata declaration in 1978. UHC cuts across all of the health-related Sustainable Development Goals (SDGs) and brings the hope of better health and protection for the world’s poorest. UHC will help Tanzania to achieve the SDG target 3.8 summarized below:

- **SDG target 3.8**: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
  - **SDG indicator 3.8.1**: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health; infectious diseases; non-communicable diseases; and service capacity and access; among the general and the most disadvantaged population).
  - **SDG indicator 3.8.2**: Proportion of population with large household expenditures on health as a share of total household expenditure or income

Achieving UHC will also contribute to achieving many of the other SDGs. Figure 01. below illustrates this.

![Figure 1: Impact of investing on UHC on other SDGs](image-url)
C: What benefits will UHC bring to Tanzania?

UHC can bring enormous benefits to countries and the leaders that bring UHC to their people as long as the approach is evidence based and tailored to each country’s identified needs and priorities. These benefits stretch way beyond the health sector into economic benefits and also societal and political benefits. These are outlined below:

C1: Political and Societal Benefits

Well designed and financed UHC is a vote-winning strategy. Every beneficiary will remember times of illness and appreciate how the Government took care of him/her. So political leaders are often prepared to invest their political capital in these processes because they recognise that overseeing successful UHC reforms can deliver significant political benefits. UHC reforms can be extremely popular with the public; politicians leading these processes have often seen their popularity increase as a result. Not surprisingly, many major UHC processes have been initiated by political leaders in the run-up to elections and immediately following a transition of power.

UHC reforms are particularly popular with politicians because they can deliver “quick-wins,” benefitting the entire population practically in a relatively short period. Large-scale infrastructure developments and economic policies rarely have the same rapid impact.

Examples of governments who have used UHC reforms and become national heroes in the process include, Japan, Thailand, and Indonesia. President Kenyatta in Kenya has also recently chosen UHC reforms as one of his “big four” priorities as part of his desired political legacy.

C2: Health Benefits

There is no better way for a President to demonstrate that they care for their people than improving their health and well-being. There is
conclusive evidence that UHC improves population health indicators. In a special edition of “The Lancet- Does progress towards universal health coverage improve population health?”, researchers from Imperial College London using longitudinal data from over one hundred and fifty countries found that: “broader health coverage generally leads to better access to necessary care and improved population health, with the largest gains accruing to poorer people.” Specifically, they found that a 10 percent increase in pooled, government health spending led to a reduction of 7.9 deaths per 1,000 children under-five. Conversely, higher proportions of out-of-pocket health expenditures (indicating lower financial protection from healthcare costs) resulted in higher levels of adult mortality.

Moreover, evidence demonstrates that UHC reforms can be a very effective way of reducing health inequalities within populations. For instance, a study of Thailand’s famous Universal Coverage programme, tax-financed free universal healthcare launched in 2002, found that in addition to contributing to reducing national infant mortality rates, the differences between rich and poor provinces practically disappeared.

Achieving universal health coverage is also the most effective way to improve national health security which would protect the Tanzanian population against the potentially devastating impact of epidemic infectious diseases such as Ebola.

Health policymakers can, therefore, be confident that implementing UHC reforms is likely to result in significant improvements in the health of their populations and reduce disparities between population groups as well.

C3: Economic

While worldwide approximately 100 million people are still being pushed into “extreme poverty” (living on 1.90 USD (1) or less a day) because
of catastrophic out of pocket health expenses, families who benefit from UHC are healthier in financial terms. A central concern of UHC is equity, and thus it is important to consider who is who is not protected against the financial hardship imposed by OOP payments. This directly supports the President’s agenda of an industrialized economy. For example, China achieved universal health insurance coverage in 2011, by deliberately increasing public health spending as a means to reduce levels of unproductive households saving, this represents the largest expansion of insurance coverage in history. By 2011, government subsidies accounted for 75 and 85 percent of the premiums of New Rural Cooperative Medical Scheme (NRCMS) and Urban Resident Basic Medical Insurance (URBMI) respectively, making these insurance programs very attractive investment options. The heavy subsidies are critical for coverage expansion. For example, although Chinese governments attempted to establish the NRCMS in 1996, the NRCMS coverage stayed at very low level until the subsidies were announced in 2003. Within five years of the announcement, the subsidies increased fourfold, and along with the increased subsidies, the NRCMS enrolment rose to 800 million people.

If China with population of 1.38 Billion was able to do that, Tanzania with a population of less than 60 Million can do that. Similarly, Thailand launched ambitious UHC reforms in 2002, and an independent 10-year evaluation of this programme found that the incidence of people falling below the poverty line due to health costs had been reduced by two thirds.

The broad economic benefits of UHC are two-fold and relate to the impact that healthier populations have on economic growth and benefits associated with improved financial protection for households. Progress towards UHC will result in a more productive society which is able to actively engage in industrial production and across other sectors. Also, population’s purchasing power will be higher compared to
a less healthy population. Henceforth, Tanzania will join other countries especially the Asian Tigers (Korea, Malaysia, Thailand etc.) in harnessing demographic dividends.

There is now an extensive evidence base showing that the economic rates of return on public investments in health systems are extremely high. In 2001, the Commission on Macroeconomics and Health\textsuperscript{vii} demonstrated that the global economic benefits of universal access to effective health care would be in the order of $360 billion per year. Building on these findings, a recent Lancet Commission “Investing in Health” showed that reductions in mortality accounted for about 11 percent of recent economic growth in low-income and middle-income countries, or even 24 percent of growth if the value of added life years is used to calculate a country’s full income. More recently, in 2015, 267 eminent economists from 44 countries signed The Economists’ Declaration on Universal Health Coverage which concluded that the economic returns on investing in UHC were more than ten times the costs.

To summarize, UHC systems can:
- generate and support significant employment in the health and life sciences sectors and be a very effective way to create employment opportunities for women – particularly in rural areas.
- UHC’s ability to provide financial protection can be an effective policy to reduce inequalities and poverty levels.

D: Where is Tanzania on the Road to UHC?

Under previous administrations, Tanzania’s progress towards UHC has been unsatisfactory. This is shown by only modest progress against health outcome and service coverage indicators and levels of financial protection. However, there has been various attempts through parallel efforts to expand access to health care to the last mile. At different times, the government issued policy statements and directives\textsuperscript{2} in good
faith for UHC. Most part of these are well articulated in the final draft of Tanzania Health Financing Strategy.

**D1: Health outcome indicators and service coverage indicators**

Figure 02 below summarizes the trend of Maternal mortality rates\(^3\) across Eastern Africa. In general, all countries have seen a steady decrease in MMR at different rates, except Tanzania from the year 2010 to 2015 there was an increase of MMR. According to these estimates, Tanzania has the highest Maternal Mortality in East Africa. A model for Rwanda is to be emulated, in the 1990s it had the highest maternal mortality 1,300 per 100,000 and in 2015 has the lowest MMR across these countries.

The four Antenatal attendance rates among pregnant mothers have not steadily increased, but the impressive story is that health facility deliveries increased from 2010 from 51 percent to 64 percent. Comparing East African countries on UHC coverage Index (SGD 3.8.1), Tanzania ranks least at 39 percent, with Kenya ranked first at 57 percent followed by Rwanda at 53 percent \(^ix\).

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\(^2\) URT, MoHSW: Health Services Development Programme (PHSDP) 2007 – 2017: One Health facility per village, CHF/TIKA insurance schemes and up-grading health facilities

\(^3\) The *maternal mortality ratio* is the annual number of maternal deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy, childbirth, or within 42 days of termination of pregnancy, per 100,000 live births per year.
The low health coverage levels are related to inadequate availability and low quality of vital health systems and inputs such as HR, essential medicines, infrastructure, and IT systems which in turn is due to insufficient levels of public financing for health. As depicted in figure 4; Over the last fifteen years, both facility delivery and assisted delivery have improved, but 4+ ANC attendances have not been impressive. In 2004/5 it was 62 percent then declined to 43 percent in 2010 and increased to 51 percent (still below levels of 2005).
A qualitative study by Ashley Sheffel in 2017 indicated that the experience of care was equally important to clients and providers as the availability of physical and human resources and the content of the care delivered. In addition, clients and providers perceived that a positive patient care experience – marked by good communication, active listening, keeping confidentiality, and being spoken to politely – increased utilization of maternal health services and improved maternal health outcomes. As part of strengthening health system for MCH, these factors will have to be evaluated.

**D2: Financial Protection Indicators**

Tanzania has developed a National Health Financing Strategy (Draft since 2015) that is intended to address the issues of poor people who fall into poverty and fail to access health services. Tanzania envisages establishing a Social Health Protection (SHP) system with the aim of reaching Universal Health Coverage (UHC). The Financing Strategy aims to establish a mandatory Single National Health Insurance (SNHI) under which the entire population of Tanzania will have access to a standard minimum health care benefits package.

According to World Bank data, in Tanzania out of pocket expenditure as a share of total health expenditure decreased from 43.2 percent in 2002 to 24.1 percent in 2012 before it began to increase and has remained at 26.1 percent since 2014. WHO country data shows that about 10 percent of the population incur more than 10 percent of their income on health expenditure; this is almost twice that of Kenya at 5.8 percent.

![Figure 05: Comparison of Financial protection across East African Countries (SGD 3.8.2)](image-url)
Furthermore, WHO country data on financial protection as per figure 5 above, shows that Rwanda has the highest financial protection for catastrophic health spending, followed by Kenya and then Tanzania. In Tanzania, about 9.9 percent of the population spends more than 10 percent of their annual income on health, as compared to Kenya 5.8 percent and Rwanda 4.6 percent.

The Tanzania Service Provision Assessment Report (MoH 2015), shows that a critical barrier to improved quality and access is the lack of effectiveness and efficiency in health financing. It is recognised that health financing architecture is fragmented, which means that individual health insurance schemes are covering different population segments rather than combining them. The report notes that only 26.2 percent of Tanzanians accessed health services without fees. This means that more than seven in ten people had to pay direct user fees which in many cases would have led to indebtedness and impoverishment. Exemptions and waivers established in 1994 are meant to provide free treatment for chronic or epidemic diseases, pregnancy, and children under-five, and vulnerable people involved in accidents or emergencies. However, it is questionable whether these exemptions are being implemented effectively. An assessment by SIKIKA in two districts of Kinondoni (Urban) and Kilolo (Rural) show that overall health facilities received very little or no compensatory payments for treating eligible patients. The five sampled health facilities in the rural district of Kilolo received an average amount of 311 TSH ($0.14) per OPD attendance for the treatment of the elderly from the council’s own sources while one in five health facilities in Kinondoni received a lump sum amount of 798 TSH ($0.35) per eligible patient xiii.

Figure 6 xiv below, shows that more than six in ten people do not have health insurance. National Health Insurance and Community Health Insurance combined covers only 33 percent of people.
Out of pocket expenditures shown in Figure 7 often constitute a major barrier to access needed health care. The percentage of out of pocket expenditure has not shown a steady decrease; the highest was in 2002 when it was 43.2 percent then decreased to 26 percent in 2006.

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4 Out-of-pocket payments (OOPs) are defined as direct payments made by individuals to health care providers at the time of service use.
Public financing for health in Tanzania has not increased enough to address the health challenges previously mentioned. Figure 8 summarizes the trend of public health financing in Tanzania which peaked in FY2015/16 most likely due to a loan from The World Bank (IDA) under Global Financing Mechanism, the reduction in the health budget share below 10 percent in 2016/17 represents a political choice to deprioritise health relative to other sectors.

According to data from World Health Organization on Health spending as a percentage of GDP, Tanzania highest domestic investment in health was in year 2006 (2.4% of GDP). Figure 9 shows that domestic spending for health as percentage of GDP declined up to 1.2% in 2012 to 2014 and started to increase in year 2015.

Source: http://apps.who.int/nha/database/Select/Indicators/en
As depicted in figure 9 above the fifth government stared increasing its domestic spending to health and reached 1.7% in year 2016. This is still lower compared to world average of 5.85% and off course the recommended 4-5% and recommended 4-5% of GDP. In East Africa, Rwanda is leading at 2.3% followed by 1.7% then Kenya at 1.6% and Uganda at 1%. See more details on Annex H1 and H2. The Government of Tanzania needs to increase its public health spending to reach 4 or 5% of its GDP.

E: How can Tanzania reach UHC?

As proved beneficial in Rwanda and Ethiopia, reducing financial barriers for households will lead to increased demand for essential health services. The other important component of this strategy is to increase the availability and quality of public health services. This will involve fundamental health systems reforms, including, recruiting and training frontline health workers, increasing health worker salaries, ensuring that all facilities have guaranteed supplies of essential medicines and commodities, investing in thousands of community health workers and providing them with basic medicines and supplies.

In 2015, Tanzania demonstrated an intention to achieve UHC when it published an ambitious health financing strategy, but for many reasons, it has not been finalized and operationalized. The only way Tanzania can reach UHC is through increasing levels of public financing for health from current levels of around 1.7 percent GDP to at least 4 percent of GDP by 2023. It will also be Important to allocate these resources efficiently and equitably to strengthen vital health systems (HR, medicines, infrastructure, equipment, IT) and reducing the financial burden on households.

We recommend that Tanzania should achieve full population coverage through an essential package of health services focusing on cost-
effective PHC services, but also including vital hospital services for emergency and referred patients. This would achieve HSSPIV of reaching all households with quality health services and SGD agenda of leaving no one behind.

This goal could be accomplished by accelerating the scale-up of the integrated national health insurance scheme by offering free, or heavily subsidized, improved community health fund (ICHF) membership to all households in the informal sector who are not eligible for the NHIF scheme. As the country becomes richer and public budgets increase, the government can add services to the benefits package. This strategy has been adopted by all the middle-income countries seen as UHC success stories, including, Thailand, Sri Lanka, Malaysia, Costa Rica, Brazil, and Mexico, etc.

With the current levels of GDP (USD 52.09 billion in 2017), the annual health spending should be 4 percent of GDP meaning that Tanzania should spend USD 2.1 billion. Table 01 below presents projections of Tanzania GDP using the estimated lowest GDP growth rate of 2.6 percent which is the lowest rate.

**Table 1: Forecast of Tanzania GDP and proposed health allocation**

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<th>Year</th>
<th>Y2018</th>
<th>Y2019</th>
<th>Y2020</th>
<th>Y2021</th>
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<td>4.58</td>
<td>4.70</td>
<td>4.83</td>
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<td>5.08</td>
<td>5.21</td>
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Table 1 summarizes the GDP for Tanzania over the years using the lowest estimate of annual growth. We have outlined the proposed allocation for health based on the 4 percent GDP as recommended by WHO.
2019 to 2023 (five years) a total of USD 11.26 billion is recommended for allocation to health sector. This is equivalent to TZS 24.77 trillion at an exchange rate of USD1 = TZS 2200. More specifically, there are systems and legal changes that need to take place for Tanzania to reach UHC.

Below we present specific recommendations for action.

• Bring representative stakeholders (Government, Donors, Private Sector and CSOs) together to commit themselves to reach UHC in Tanzania
• Approve and implement a health financing strategy that will replace private voluntary health financing (especially out-of-pocket payments) with compulsory progressive public financing that will result in the healthy and wealthy subsidising the sick and the poor
• Undertake tax reforms to start pro-health taxation on items such as cigarettes, sugar and fossil fuels
• Enact and amend laws that govern the provision of health care and insurance to create Single National Health Insurance, with pooled funds that will subsidize the poor and vulnerable
• Allocate and disburse resources for health care, aiming to reach government health expenditure of 4 percent of GDP by 2023; an estimated USD 11.64 billion (TZS 24.77) trillion for five years from 2019/2023
• Bring together and align all funding schemes in Tanzania including GFATM, GAVI, PEPFAR/PEPFAR for each to contribute to UHC

**E1: What will be the impact of this strategy in the short to medium term**

Universal Health Coverage will have short term, medium and long term effects. In the short term, three benefits will be acquired:

(a) The population covered by essential health services will increase,
(b) Improved health services will lead to higher levels of client satisfaction
(c) There will be a reduction in the burden of cost-sharing fees

As a result, the poorest people who are denied health services would decrease significantly, individual, household and community satisfaction
will increase which will lead to political bonuses in the short and medium term.

In the long term, spending on health is an investment. The country will have a healthy population, a healthy workforce, and increased productivity. This was a strategic development decision made by the UK in 1948 universal health entitlement, Japan 1961 with the national wide universal coverage reforms, Thailand’s universal coverage scheme 2001, and Ghana’s health insurance for all pregnant women. The figure below summarizes what UHC will accomplish in the scheme of health care services.
G: Conclusions
For a president already providing free education, there is no better way to demonstrate his commitment to caring for the poor and vulnerable than ensuring that all people (especially the most vulnerable) access the health services they need without financial barrier. For this to be sustainable, the president must build a publicly financed UHC system to ensure every poor and vulnerable person has access to quality health services. This will not only command respect to Tanzania globally but to the president too.

To help household that are unable to pay for health services, the government can use its experience in establishing special levy, this time directed to provision of insurance subsidies as was done in China.
H: Annexes

H1: Graph showing UHC spending indicators for East Africa countries

H2: Table showing Domestic Expenditure on Health as % of GDP

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I: End Note References

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