United Republic of Tanzania
Ministry of Health of Health and Social Welfare

Draft report

Health sector PER update 2007

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Tanzania

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Acronyms
<<to be reviewed for completeness>>

ACT	Artemesinin Combination Therapy (for malaria)
AGO	Accountant General's Office
AJHSR	Annual Joint Health Sector Review
AIDS	acquired immuno-deficiency syndrome
ARVs	Anti-Retrovirals
Bn	billion
CCHP	Comprehensive Council Health Plan
CFS	Consolidated Fund Services
CHF	Community Health Fund
DPP	Department of Policy and Planning
DRF	Drug Revolving Fund
ESRF	Economic and Social Research Foundation
FY	financial year
GOT	Government of Tanzania
HIV	human immunodeficiency virus
HQ	headquarters
HRH	human resources for health
HSF	Health Service Fund
IFMS	Integrated Financial Management System
LGA	Local Government Authority
LGDP	Local Government Development Programme
LOGIN	Local Government Information
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania [National Strategy for Growth and Poverty Reduction]
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NHIF	National Health Insurance Fund
OC	other charges
PE	personal emoluments
PER	Public Expenditure Review
PHC	Primary Health Care
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PRS	Poverty Reduction Strategy
SBAS	Strategic Budget Allocation System
SWAp	Sector-Wide Approach
TFIR	Technical and Financial Implementation Report
TSh	Tanzania shillings
WHO	World Health Organisation

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Thanks are due to the various officials of the MOH who contributed data for this exercise, and also to colleagues in the Ministry of Finance and the President's Office – Regional Administration and Local Government. Ms Anna Nswilla contributed to the development of the instrument for the local government sub-study, while Mr Muhume, Chief Pharmacist MOHSW, provided useful and timely information on drugs and medical supplies. Mr Nduhiye provided information on the Community Health Fund revenues, and Mariam Ally provided information on MTEF projections. Ms Jacqueline Mahon of SDC provided essential input and support up to the time of her departure from Tanzania. Dr Jamie Boex, a consultant working on the revision of the allocation formula for pharmaceuticals provided useful information on local government financing. Thanks also go to Daniel Fujiwara and colleagues in the External Finance Department of the Ministry of Finance for updated information from their database.

Welcome comments and feedback were received from members of the Technical Sub-Committee of the Ministry of Health. *<<to be updated once any comments received>>*

Errors in interpretation or calculation remain those of the authors.

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CAVEAT

This year's PER update has proven the most challenging to date, due to the multitude of inconsistent data sources. While recognising that new systems are under development, and acknowledging the step forward which the new databases represent in simplifying access to budget data, many gaps and questions remain, and the analysis presented here should be treated with caution.

Information on off-budget sources of funding to the health sector in particular was more difficult to obtain than in previous years. Serious gaps remain in this section, particularly relating to complementary sources of financing, thereby limiting the value of the PER.

If the PER is to serve its purpose in pulling together information on all sources of funding for the public health sector, it is imperative that these limitations be addressed and a comprehensive picture be available for review, debate and to guide future allocation decisions.

Executive Summary

Introduction

The 2007 health sector Public Expenditure Review (PER) update took the form of an initial presentation at the Annual Joint Health Sector Review in September 2007, followed by preparation of a more in-depth report. A number of challenges hampered completion of the original Terms of Reference and this report is less detailed than previous years as a result.

Previous PER findings

Review of the previous year's PER findings found that progress had been made in the establishment of the high level committee on health financing, with the first meeting being held in November 2007, a focal person for complementary financing had been identified within the Ministry of Health and Social Welfare, more external funding was being captured within the MTEF, and that some work on assignment of items procured at headquarters to their beneficiary levels had been undertaken through the Drug Tracking Study. Unfortunately, progress in improving the completeness of national level reporting on off-budget sources of funding, both domestic and external, was very limited.

On-budget health spending: key findings

Health as % overall GOT spending	• No information was obtained on total GOT spending in FY2005/06 or 2006/07 so comparison was made using budget only. • The health sector share of budget increased in 2006/07 from 9.6% to 10.8%, but then fell back to 9.8% for 2007/08 (including Consolidated Fund Services). • Corresponding figures excluding CFS were a rise from 10.9% to 11.4%, followed by a fall to 10.8% • Sector share continues to fall short of Abuja target of 15%
The level of spending on Health	• There was a continued rise in the nominal budget, from TSh426bn in 2005/06 to TSh 521bn in FY2006/07 (ie 38%) and to TSh 648bn (ie 22%) in FY2007/08. Although less than budget, nominal expenditure also rose by 23% between FY2005/06 and FY2006/07. • In contrast to FY2006/07 when the rise in budget was driven by the PE component of the recurrent budget, in FY2007/08 the increase was largely due to a 77% increase in the development budget. • The real value of sector spending has also risen in recent years. Actual expenditure rose by 9% between 2005/06 and 2006/07, while the 2007/08 budget was 28% higher in real terms than 2006/07 expenditure.
Per capita spending	• The FY2007/08 budget shows a per capita US figure of US$14.08, up from actual expenditure of US$10.71 in FY2006/07, and almost doubling over the four year period. • The FY2006/07 figure itself indicated an increase of US$1.60 from actual spending of US$9.11 in FY2005/06. • While a long way from international estimates of required funding, this shows that on-budget spending continues to move in the right direction.

Sub-sectoral spending: key findings

Recurrent and development spending	• Relative shares of recurrent and development spending have fluctuated over the period, but budgeted development is 5% higher in FY 2007/08 than in previous years. • The share is influenced by how central level basket funding is considered in any particular year.
Allocation by level of the health system	• The crude allocation of the budget by level of the health system indicates that the central level share fell steadily over the period, with both Regional and LGA levels gaining in FY2006/07. • LGA share increased slightly from 35% in FY2006/07 to 36% in FY2007/08. • Work remains to fully assign items within the central level budget to the appropriate beneficiary level, and to extend this analysis to actual expenditures.

Allocation by MKUKUTA objective	• Ten stated MKUKUTA objectives accounted for 95% of the FY2006/07 budget, but only 90% of actual expenditure, despite overall expenditure being lower than budgeted. This implies reallocation away from MKUKUTA objectives.

Expenditure in relation to budget: key findings

Aggregate on-budget total	• Overall budget performance improved slightly, from 90% in FY2005/06 to 91% in FY2006/07 • Development budget performance worsened from 98% to 84%, while recurrent budget performance improved from 89% to 94%.
MOHSW headquarters	• Recurrent budget performance varies according to which of two values of Approved Estimates are used. Both improved between FY2005/06 and FY2006/07 however. • Dept of Curative Services was over-spent by 2%, while expenditure in other departments was 6 – 44% under-budget. • On the development side, Preventive services achieved the highest level of budget execution at 91%. • 66% of actual development expenditures were for the National AIDS Control Programme. • External grant funding performed better than GOT development funding, though this may be related to the focus of GOT on infrastructure and resultant contractual commitments and delays.
Regions and LGAs	• Data obtained on regional spending is questionable, but indicates that budgets were fully expended in both FY2005/06 and FY2006/07. • At the LGA level, data is taken from www.logintanzania.net which still has some queries. Data show FY2006/07 budget out-turn for PEs of 83% and for OCs of 87%, but it is not clear whether this reflects block grant funding alone. • Subventions (believed to represent basket funding) performance according to www.logintanzania.net was 110%.
NHIF	• Available data on the allocation to NHIF from Vote 23 Accountant General's Office indicates that 56% of budgeted funds were spent in FY2005/06 but that this had improved to 100% in FY2006/07.

Off-budget spending: key findings

Complementary financing	• Data constraints prevent the drawing of any meaningful conclusions regarding revenues or expenditures on the Health Service Fund or Community Health Fund revenues and expenditures, or of National Health Insurance Fund claims in FY2006/07. • Health Service Fund, believed to be for FY2005/06, indicates that expenditures were 22% higher than receipts, suggesting some drawing down of balances.
External funding	• The External Financing database has a number of queries which we were unable to resolve and it is again not possible to conclude anything more than the need for a review of this instrument.

LGA desk review: key findings

Level and composition of spending	• The mean per capita CCHP budget across 10 selected LGAs was just over TSh 5000, with a range from TSh 2,500 to TSh 17,000. • Although data concerns prevent firm conclusions, for most, the block grant continues to represent the major funding source.
Allocation issues	• Deviation from the mean per capita CCHP budget and block grant broadly follows the direction of the 2004 resource allocation formula, though the variance is much higher. • Within councils, allocation of the block grant between sub-votes appears, unsurprisingly, driven by facility distribution. • PEs accounted for between 61% and 89% of the recurrent block grant.
Receipts in comparison with budget	• On average, 93% of budgeted block grant and 100% of basket funds were reported in the Technical and Financial Implementation Reports as received. • Cost-sharing revenues varied widely compared to projections, ranging from 59% of the projected figure to 249%.

Timing of OC releases	• Although virtually 100% of OC funding was released during the financial year, for most of the selected councils, around 25% was released in the last month, potentially impacting negatively on absorption.
Expenditure analysis	• There was considerable variation in expenditure against budget, from 66% in Temeke MC to 42% over-budget in Kibondo. • In part this reflects inconsistencies between councils in reporting different sources of funds in the budget and expenditure sections. • Budget performance was generally higher at Council Health Department and Hospital levels than for front line health facilities. Community initiatives were consistently underspent.

Summary of recommendations

Recommendation	Responsible	Time frame
Lobby MOF for earlier and consistent data on total government expenditure at the end of the financial year; and seek agreement between GOT and DPs on which is the definitive version of such data	DPPs	By August 2008
Agree on which definition of Estimates should be used as the comparator (preferably original approved estimates, with presentation of any revised budget together with explanations)	DPP and DPs	By August 2008
Update the analysis of the sector share of actual expenditures, and lobby accordingly for at least a return to the FY2006/07 share of budget in FY2008/09, and preferably an increase.	DPP	Prior to and as part of current budget round
Further work to analyse all on-budget spending according to beneficiary level	DPP	Prior to next PER update
Include specific targets for budget and spending by level of the health system in the new Health Sector Strategic Plan to enable annual monitoring towards those targets.	DPP	As per new HSSP
Monitor quarterly spending against objectives, and should provide written justification of deviations	DPP	Starting 2008/09
Incorporate and expand the analysis of spending against MKUKUTA objectives in future PER updates.	DPP	From next PER update
Review the completeness and usefulness of the External Finance Database (either directly or through a small commissioned study) in advance of the next PER update • Specifically, to seek clarification on the various columns and sources of data; to compare with in-house data; and to resolve queries with figures as indicated in this report; • Review off-budget external finance for consistency with policy goals (as last year)	DPP	Prior to next PER update
Compare findings of current NHA exercise with estimates of external funding from the relevant PER update	DPP	Prior to next PER update
Continue to improve capture of external funding within MTEF	DPP/Programmes	2008/09 budget round
Clarify the position with HSF data for FY2006/07 in order to update the table in Annex B	DPP/Accounts	immediate
Provide consolidated picture of CHF membership, income (separating membership premia and user fee revenues), and expenditure on an annual basis	Focal person for complementary financing	Starting July 2008
Require NHIF to provide timely annual report showing clearly the distribution of claims on a geographic basis (ie by council) and by level (primary facilities, district hospitals, regional hospitals, referral hospitals, national and special hospitals)	Principal Secretary	Immediate, by financial year
Commission nationally representative tracking study of LGA spending during the course of FY2008/09, whether as part of the PER or as a stand-alone exercise.	DPP/District Health Services	Aug/Sept 2008

Recommendation	Responsible	Time frame
Review the role and timing of the health sector PER update, the Task Team, and the appropriate body to serve as a Steering Group	MOHSW/DPs	Immediate
Collate the necessary data prior to engagement of any consultant team	PER MOHSW Task Team	Prior to next PER update
Consider a return to a fixed, full-time exercise, and to ensure that the necessary incentives are in place to permit MOHSW and other government officials to play their role.	MOHSW/DPs	Prior to next PER update

1 Introduction

Presentation of the Public Expenditure Review (PER) update is traditionally one of the standing items at the Annual Joint Health Sector Review (AJHSR) of the Ministry of Health and Social Welfare (MOHSW), and continues to provide sector-specific information in advance of preparation of the cluster PERs as defined within the Poverty Reduction Strategy. A brief update on the previous year's recommendations and presentation of major trends was given at the 2007 AJHSR, and this document expands on that presentation. Terms of reference (TORs) for the PER update are reproduced in Annex A.

It was not possible to meet the TORs in their entirety due to a number of challenges both within and external to the team. As indicated in the Caveat on page vi, accessing complete and consistent information was more difficult than in previous years. In some cases this appears to have been due to such data not being available, in others to the need to clarify sources and inconsistencies between sources, while in yet others the effective reliance on a single individual within the MOHSW rather than the stated Task Team limited what could be achieved within the timeframe. There was also an unforeseen change in the circumstances of the external consultant which affected the timeframe to some extent.

Two items in particular could not be completed. Firstly, it has not been possible to estimate resource requirements for the Budget Guidelines, due to constraints in data on future external financing and potential revenues generated in the sector[1]. Secondly, time constraints arising from the challenges of obtaining and clarifying the routine data on sector spending meant that no attempt was made to assess the impact of the switch to high cost technologies in the sector.

The document is organised as follows.

Section 2 reviews the recommendations and follow-up actions from the PER update for FY2005/06.

Sections 3 and 4 provide a review of budget and expenditure trends at the sectoral and sub-sectoral level respectively, looking at the share of Health in overall on-budget spending, nominal and real levels of spending, and the per capita allocation to the sector. Sub-sectoral analyses include a crude breakdown by administrative level and by MKUKUTA objective.

Section 5 reviews budget performance, both at the overall sectoral level and for selected sub-sectoral components of the budget: MOHSW by Department – recurrent and development, Regions, LGA block grant; and the National Health Insurance Fund.

Section 6 presents the available data on off-budget financing of the sector, both domestic and external, while Section 7 presents the findings of a limited desk review of local government spending.

Section 8 discussed the findings of the earlier sections, and presents some recommendations for consideration by the sector during the coming budget cycle for FY2008/09.

[1] And failure to source the LG budget guidelines for 2007/08 – 2009/10 to provide input to the on-budget projections <<though this could potentially still be done>>.

2 Review of PER FY06 recommendations and actions

The main recommendations of the PER FY06, together with actions planned and/or taken during FY07, are presented in Table 1 below. Implications for the sector are discussed briefly below.

Table 2-1 Summary of action taken on PER FY06 recommendations

Recommendation	Action taken
Ensure that the High Level Committee on health financing is functional, ie meeting regularly with visible outputs	The Committee has been constituted and approved by the Sector-Wide Approach (SWAp) Technical Committee, Terms of Reference have been drafted, letters of appointment circulated, and the first meeting was held in late November 2007.
Follow-up with Ministry of Finance re apparent failure to compensate Health forward budget for lack of World Bank funds (to be channelled through General Budget Support)	No progress.
Creation of a specific Unit within the Department of Policy and Planning to handle complementary financing, ideally with focal persons for each separate financing scheme (eg Health Service Fund (HSF), Community Health Fund (CHF), National Health Insurance Fund (NHIF), and Drug Revolving Fund (DRF) as a means of improving information in this area	No specific Unit has been created but a Focal Person has been appointed to deal with all financing schemes.
Annual report to be provided by NHIF showing clearly the distribution of claims on a geographic basis (ie by council) and by level (primary facilities, district hospitals, regional hospitals, referral hospitals, national and special hospitals)	No action has been taken.
Incorporate reports on CHF, DRF and NHIF into the Appropriation Accounts as with HSF	Funds collected from these schemes are deposited in Account No 6 and/or Sub-Treasury and are reported in the Councils reports. However, this remains incomplete and inconsistent, and a consolidated annual report on each would be useful.
Separation of each financing source within the Technical and Financial Implementation Report (TFIR) at council level in order to permit aggregated reporting by individual financing mechanism at national level	This relates to the cost-sharing schemes mentioned above, and is currently variable in actual practice. Clearer adherence to the guidelines would be welcomed.
Further work to analyse all on-budget spending according to beneficiary level	Partly done by the drug tracking study which shed some light on drug expenditure by health facility.
Preparation of a comprehensive MTEF, as has been the intention, to incorporate all external funding, on and off-budget	Some programme funds have been incorporated into MTEF, for instance Global Fund. Further progress is required.
High Level Committee on health financing to review full sector MTEF (ie not MOHSW alone) and determine desired shares for central, regional and local government by end of period	Not yet done <<or was this discussed in the November meeting?>>.
Review and analysis of the MOF External Finance database for the Health sector for completeness and accuracy, and to determine the extent to which off-budget spending is in line with Millennium Development Goals (MDGs) and MKUKUTA goals	Not done.
Initiate annual analysis of council level spending patterns both for budgets (ie using Comprehensive Council Health Plans (CCHPs) and for expenditure (ie using fourth quarter TFIRs)	District Health Services section analyses CCHPs and financial reports on quarterly basis. However, no consolidated analysis of council budgets and spending is currently performed. Data on some sources can now be obtained from www.logintanzania.info although some inconsistencies remain.
Analysis of CCHPs and MTEF to enable a consistent comparison of Economic and Social Research Foundation (ESRF) costing with actual budgets	Not done.
Review timing and process of the PER to fit with agreed changes in the planning and monitoring cycle	Attempted for 2007 update, but problems remain in accessing data on time.

Recommendation	Action taken
On basis of decision on PER timing, initiate process for FY07 update (ensuring linkage with National Health Accounts (NHA)	Final report of PER was expected in December 2007; NHA process was expected to report in January 2008. No linkage has been forged between the two exercises.

3 Overview of on-budget spending, FY2004/05 – FY2007/08

Total nominal on-budget spending in the period FY2004/05 – FY2007/08 is shown in Table 3-1 below, together with the year on year growth rates for both budget and expenditure. The data refer to on-budget health sector public spending only, with presentation of off-budget spending in Section 6. The detailed figures on which these graphs are based are shown in Annex B.

Table 3-1 Summary of on-budget health spending (current prices)

	FY2004/05		FY2005/06		FY2006/07		FY2007/08
	App Est	Actual	App Est	Actual	App Est	Actual	Estimates
Recurrent	232.41	230.59	307.44	268.91	398.85	368.89	432.22
Development	75.86	58.40	118.33	115.73	122.23	103.26	215.95
Total	**308.28**	**288.99**	**425.77**	**384.64**	**521.07**	**472.15**	**648.17**
Annual growth - budget			*38%*		*22%*		*24%*
Annual growth - actual				*33%*		*23%*	

The following sub-sections attempt to present the performance of the health sector budget and expenditure over a four year period, and according to three different measures:

- The sectoral share of total government budget/expenditure;
- Absolute levels of spending, both nominal and real;
- In per capita US dollar terms.

In addition, there remain some inconsistencies which we have been unable to clarify. Main data sources are listed in Annex C.

3.1 Health as a share of overall government spending

Figure 3-1 below shows the trend in terms of the sectoral share of total government budget/expenditure, both including and excluding Consolidated Fund Services (CFS), ie largely public debt. As it only proved possible to get hold of budgeted total GOT spending, the later three years present health sector budget data for consistency. Ideally, this graph would present actual expenditure shares for the three earlier years.

Figure 3-1 Health sector spending as a share of GOT budget/expenditure, FY2004/05 – FY2007/08

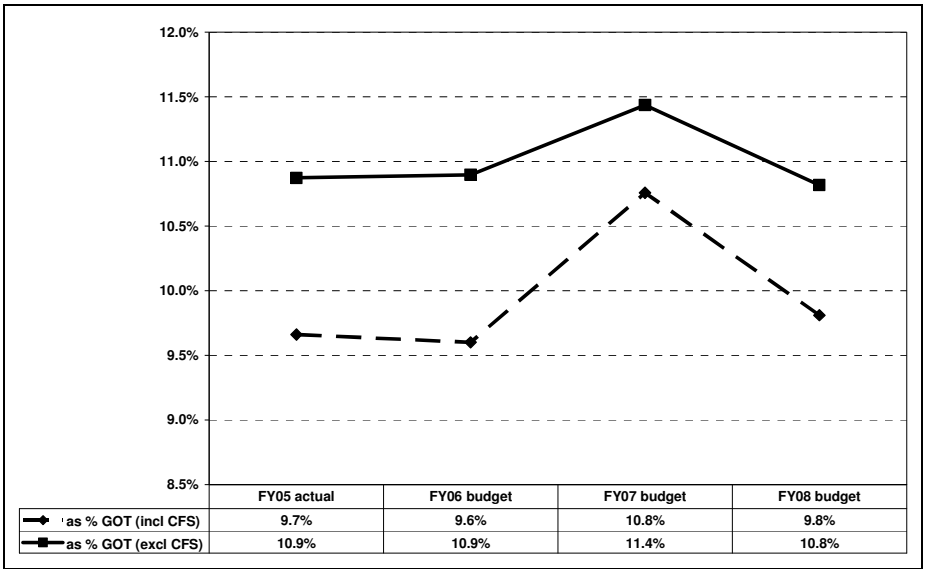


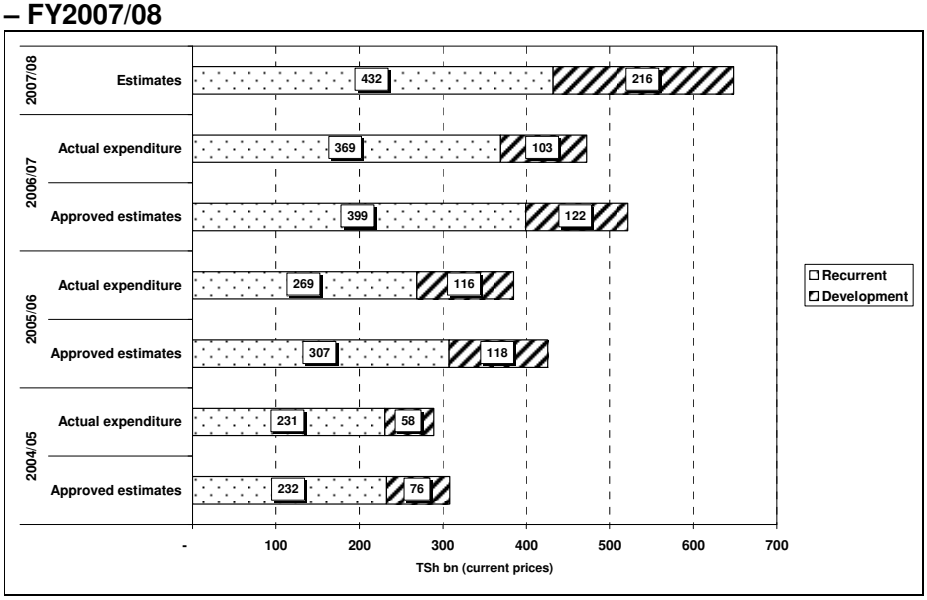
Figure 3-1 shows that the FY08 budget for the sector has fallen as a share of the total government budget from its three year high in FY2006/07. This fall is sharper as a share of the total including CFS, dropping a full percentage point. The fact that it falls is of concern given the well-publicised constraints in the sector, and due to the government's commitment to reaching the Abuja target of a 15% allocation to the health sector. However, this is likely to be due to the stated priority in the FY2007/08 budget to productive rather than social sectors.

It should be borne in mind that the actual effective share for FY2006/07 is not known due to the absence of figures for total GOT expenditures.

3.2 Absolute levels of spending, nominal and real

Figure 3-2 below shows the absolute level of health sector spending in nominal terms, both budgeted and actual, since FY2004/05. While clearly showing an increase in the nominal value of the budget each year, it also shows the shortfall of expenditure against budget.

Figure 3-2 Nominal on-budget health spending, recurrent and development, FY2004/05 – FY2007/08



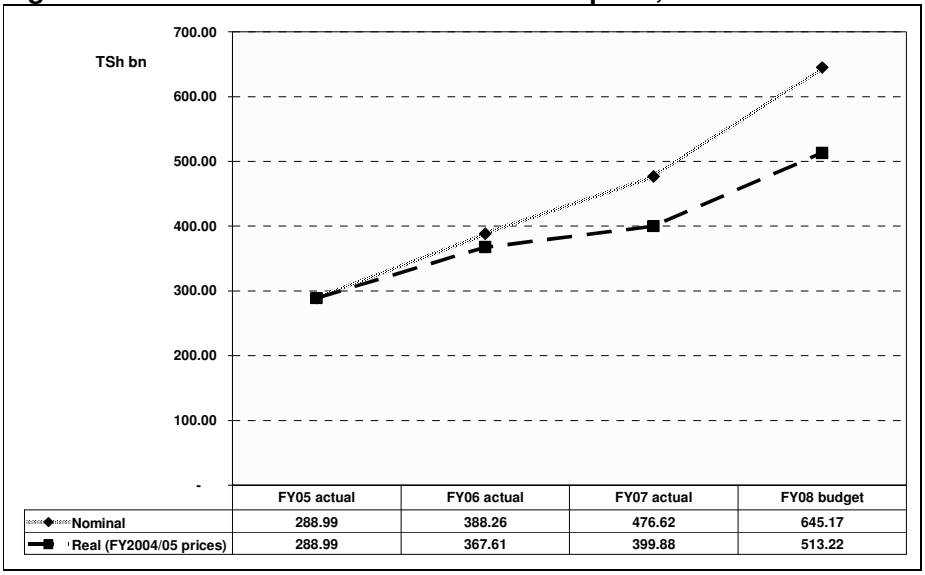
In contrast to FY2005/06 when the increase in the nominal allocation to the sector was driven by a large increase in the recurrent budget, largely the PE component, in FY2007/08 the increase was almost completely due to a 77% increase in the Development budget, as other commentators have noted[2]. <<implications in discussion>>

Figure 3-3 shows the trends in absolute spending, both in nominal and real terms, the latter in FY2004/05 prices[3].

[2] See for example the analyses undertaken for Care International (Smithson 2007) and for the Development Partners Group (Do 2008)

[3] Table x in Annex y gives the CPI data on which these figures are based.

Figure 3-3 Trend in nominal and real health spend, FY2004/05 – FY2007/08



The figure shows that both nominal and real spending have been on a steady upward trend over the four year period under review. In real terms, the FY2007/08 budget represents a 28% increase over actual spending the previous year, and a 78% increase over the period.

3.3 Per capita spending

The final measure of health spending presented in this section is the nominal value in per capita US dollars. This is shown in order to provide a crude comparison with spending in other countries[4], and to show the trend in relation to the various international costings developed over the years. Table 3-2 gives both the annual estimates, and the data used to produce them[5].

Table 3-2 Spending trend in per capita US dollars, FY2004/05 – FY2007/08

	FY05 actual	FY06 actual	FY07 actual	FY08 budget
in per capita US dollars	7.32	9.19	10.81	14.01
Nominal spend	*288,989,428,769*	*388,255,199,495*	*476,624,170,111*	*645,169,039,500*
Population projections	*36,576,738*	*37,704,872*	*38,867,802*	*40,066,599*
Exchange rate	*1,080*	*1,120*	*1,134*	*1,149*

Again, the trend in per capita US dollar terms has been steadily upwards over the period under review, virtually doubling from $7.32 to US$14.01. While still far short of the 2001 WHO Commission on Macroeconomics and Health estimates of US$ 34, it should be borne in mind that external funding is unlikely to be fully reflected within the budget.

[4] Ideally we would present this in terms of purchasing power parities. <<FK to work on this>>
[5] The difference in the figure for FY05 actual and that given in the PER FY06 update is due to both a change in the exchange rate used, and a different measurement of the NHIF contribution.

4 Sub-sectoral spending

This section presents information on selected sub-sectoral allocations of on-budget resources.

4.1 Recurrent and development funding

The relative shares of recurrent and development funding in the health sector in recent years have fluctuated, both by year, and according to whether budgeted or actual spending is considered. This is shown in Table 4-1 below.

Table 4-1 Relative shares of Recurrent and Development budget, 2004/05 – 2007/08

	Budget				Actual		
	2004/05	2005/06	2006/07	2007/08	2004/05	2005/06	2006/07
Recurrent	75%	72%	76%	67%	80%	70%	78%
Development	25%	28%	24%	33%	20%	30%	22%

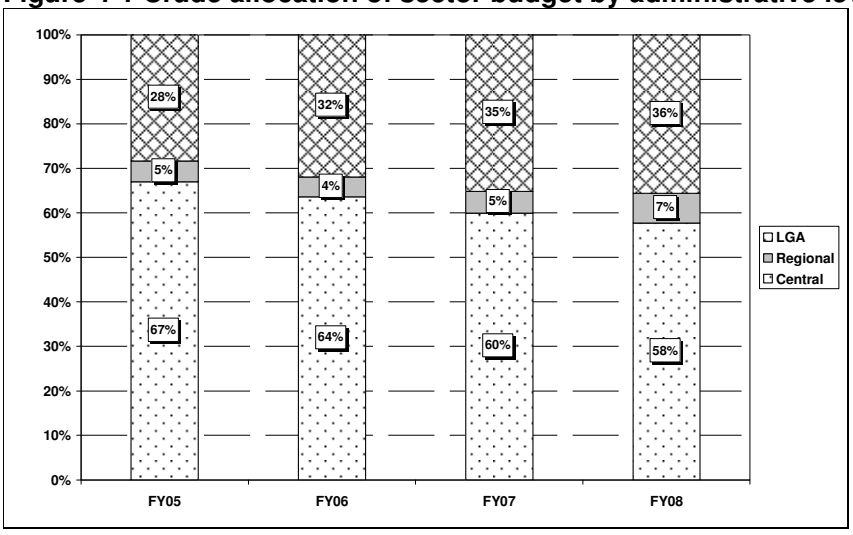
The split partly reflects how the basket funding is treated in a particular year. While district level basket funding has been included consistently as recurrent funding in the PER, up until FY2005/06 the central basket allocations were split between recurrent and development - both in the official budget and subsequently in the PER - according to the nature of the items they were funding. In FY2005/06 and for FY2007/08, they have been fully reflected in the Vote 52 development budget, despite a significant proportion of funds being allocated to recurrent cost items such as family planning commodities, anti-retroviral drugs, supervision of the CHF and matching grants. This "mis-assignment" of recurrent items based on their source of funding is a perennial issue, and not specific to Tanzania.

Budgeted development spending in FY2007/08 is higher than in any of the three previous years. In contrast, the final share of the Development budget in FY2006/07 was relatively low, and smaller than had been budgeted. This reflects relatively poor budget performance of the development sub-component, as is shown in Figure 5-1 in the following section.

4.2 Allocation by level of the health system

The allocation of the health budget between the three levels of government is shown in Figure 4-1.

Figure 4-1 Crude allocation of sector budget by administrative level, FY05 – FY08



The Budget Guidelines for 2007/08 specified a number of items which should be more fully devolved, but at present the main change is in the allocation of the Block Grant directly to LGAs, rather than via Prime Minister's Office, Regional Administration and Local Government (PMO-RALG) headquarters.

The figure is somewhat misleading as a significant proportion of the central level budget continues to reflect items intended for lower levels of the health system despite the increased emphasis on Decentralisation-by-Devolution (D-by-D) in the past year. The 2007/08 budget guidelines, for example, referred to a transfer of 30% of the essential drugs budget to LGAs, but this has not yet happened[6]. Notable examples of "mis-assigned" funding in the figure include the allocation to the NHIF which is captured here as a central level transfer from Accountant General's Office (AGO), while its intended beneficiaries are the health facilities themselves, together with the inclusion of various medical supplies and services which are account for a significant share of the MOHSW headquarters development budget. In the absence of more detailed data on their allocation from the technical programmes, the distortion in the picture continues, and further work in this area remains a recommendation[7].

Nevertheless, the distortion is consistent over the time period, and the data therefore show a steady downward trend in the share of the central level allocation over the period. The fall from 60% of FY2006/07 spending to 58% of the FY2007/08 budget reflects an increase in both the Regional share, up by 2% to 7%, and the Local Government Authority share, up from 35% to 36%.

4.3 Allocation by MKUKUTA objective

Greater emphasis has been given this year to analysis of the extent to which MKUKUTA objectives are reflected in the budget. For the Health sector, although the MOHSW headquarters MTEF has been prepared according to these objectives for the past couple of years, using the Strategic Budget Allocation System (SBAS), this has not been the case for other agencies within the sector. In addition, the routinely available flash report of expenditures reports only according to sub-vote and to item code, and not automatically by strategic objective[8].

For the financial year FY2006/07, ten specific objectives were included in the MOHSW headquarter budget (ie Vote 52), as shown in Box 1 below. The allocation of budgeted and actual spending for each of these is shown in Table 4-1 below. Data include both recurrent and development spending, and show also funds disbursed.

[6] P61 of Ministry of Finance and Ministry of Planning and Economic Empowerment (2007). *Guidelines for the preparation of the Medium Term Plan and Budget Framework for 2007/08 –2009/10: Part 1*. Working Document. Dar es Salaam: Feb 2007

[7] It should be noted that the TORs for this year's PER included some analysis of the impact of large ticket items, such as antiretroviral drugs (ARVs), artemesinin combination therapy (ACT) for malaria, and vaccines. This was not possible due to time constraints arising from the delays in obtaining the basic data, and the local government sub-analysis.

[8] An attempt was made during the previous PER to relate spending by strategic objectives as given in the MTEF to an IFMS report which did provide such details. However, the lack of consistency meant that the exercise had to be abandoned.

Box 1 Strategic objectives for MOHSW in FY2006/07

52A	To improve services and reduce HIV/AIDS infections
52B	To reduce morbidity and mortality rates in vulnerable groups with special focus on infants, under five children, School age, Youth, people with disability, women of reproductive age and elderly
52C	To ensure availability of basic essential health care services backed up with an effective referral system, action oriented research, gender disaggregated health data and active participation and involvement of the community
52D	To monitor and control quality and safety of food, drugs, chemicals and cosmetics to safeguard health of the public and environment
52E	To prevent and control communicable and non-communicable diseases with special attention to HIV/AIDS, malaria, tuberculosis, nutritional disorders, environmental health and sanitation, occupational health, chemicals management and health promotion
52F	To plan, train and provide competent and adequate number of health staffs, with appropriate skill mix that is gender focused to manage health services at all levels
52G	To rationalize and rehabilitate the health infrastructure taking into consideration services for people with disability and provide a maintenance system for health facilities, equipment and instruments
52H	To review, develop, disseminate monitor and evaluate the National Health policy, policy guidelines, legislation, standards, processes, regulations, plans and budgets that ensure delivery of quality health services with a gender perspective
52I	To improve the wellbeing of vulnerable groups through support, care, protection, promotion and access to social welfare services
52J	To create a conducive and gender responsive environment for efficient and effective delivery of supportive services

Table 4-2 MOHSW spending against objectives, FY2006/07

	TSh m			*% total budget*			*Actual as % Approved*
	Approved	Disbursed	Actual	Approved	Disbursed	Actual	
52A	12,691	12,567	12,536	4.6%	4.6%	5.1%	99%
52B	15,938	14,100	13,018	5.7%	5.1%	5.2%	82%
52C	114,857	114,027	112,519	41.4%	41.5%	45.3%	98%
52D	677	501	501	0.2%	0.2%	0.2%	74%
52E	9,534	7,497	6,780	3.4%	2.7%	2.7%	71%
52F	7,238	3,929	3,825	2.6%	1.4%	1.5%	53%
52G	83,550	81,921	63,883	30.1%	29.8%	25.7%	76%
52H	8,955	7,932	5,282	3.2%	2.9%	2.1%	59%
52I	2,504	1,555	1,281	0.9%	0.6%	0.5%	51%
52J	7,500	5,748	4,547	2.7%	2.1%	1.8%	61%
Other	14,060	24,664	24,020	5.1%	9.0%	9.7%	171%
Total MOHSW	**277,505**	**274,441**	**248,192**				**89%**

Source: MOF database \2006_07_budget_outturnsvr3

Table 4-2 indicates that although the overall total spending was under-budget by 11%, there was also an apparent reallocation away from the ten strategic objectives. Although objectives 52A to 52J accounted for around 95% of the original MOHSW budget, their share of total expenditure fell to just over 90%, while "Other spending" was 71% over budget. Only two of the ten objectives achieved expenditure rates close to 100%, ie 52A and 52C. <<Any explanation for this?>>

The new set of strategic objectives for FY2007/08 is shown in Box 2 in Annex D. While accepting that objectives are likely to change over time, and indeed should if the funding is having its desired effect, this makes tracking spending against objectives difficult over a multi-year period, either prospective or retrospectively.

5 Expenditure in relation to budget

5.1 Aggregate on-budget sector total

Actual expenditure as a percentage of Approved estimates for the past three financial years is shown in Figure 5-1 below, both for the total budget, and separately for the recurrent and development budgets.

Figure 5-1 Health sector budget performance, FY05 – FY07

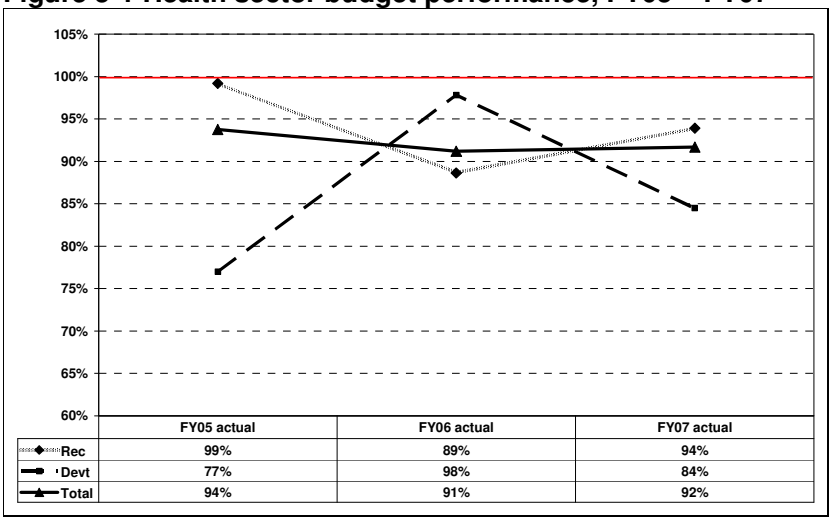


Figure 5-1 shows that there has been a slight increase in overall budget performance, 90% in FY2005/06 to 91% in FY2006/07. Recurrent budget performance was 94% which, although lower than it had been in FY2004/05, represented an improvement on FY2005/06, while there was a significant fall in the execution of the development budget over the year, from 98% to 84%.

5.2 Ministry of Health headquarters

Recurrent budget performance of MOHSW headquarters was undertaken using data from the MOF database on outturns for the financial year 2006/07 (MOHSW recurrent (i) in Table 5-1). It should be noted that this data gives a lower figure for the Approved Estimates than that in the official Budget estimate book (MOHSW recurrent (ii), and is therefore inconsistent with the data in Annex B, and in sub-section 5.1 above. The overall total budget performance is given for both values. Table 5-1 shows how the individual departments or sub-votes at MOHSW headquarters performed. Overall MOHSW recurrent budget performance is given for both values (ie i and ii).

Table 5-1 MOHSW headquarters recurrent budget performance, FY2006/07

Sub-vote	Approved Estimates (a)	Allocated funds (b)	Actual expenditure ©	b/a	c/b	a/c
1001 Administration and General	2,943,540,221	2,884,187,150	2,540,455,950	98%	88%	86%
1002 Finance and Accounts	719,299,400	705,872,468	640,528,158	98%	91%	89%
1002 Policy and Planning	1,796,472,900	1,521,893,650	1,001,255,404	85%	66%	56%
2001 Curative Services	106,213,038,763	109,061,472,266	108,032,884,644	103%	99%	102%
2003 Chief Medical Officer	2,938,389,574	2,900,037,324	2,758,726,488	99%	95%	94%
3001 Preventive Services	48,933,464,548	46,777,606,159	43,854,542,418	96%	94%	90%
4001 Tanzania Food and Drug Admin.	2,517,617,400	1,800,198,672	1,800,198,672	72%	100%	72%
4002 Social Welfare	3,735,571,042	3,431,861,680	3,157,480,478	92%	92%	85%
5001 Human Resource Development	11,410,157,900	10,659,273,684	10,561,791,214	93%	99%	93%
Overall MOHSW recurrent (i)	**181,207,551,748**	**179,742,403,054**	**174,347,863,427**	**99%**	**97%**	**96%**
Overall MOHSW recurrent (ii)	*197,185,021,000*					*88%*

Note: MOHSW recurrent (i) is as reflected in the MOF database; MOHSW recurrent (ii) is taken from the Estimate Books.

According to the MOF database, 99% of planned funds were allocated to the MOHSW, 97% of which were spent, resulting in an overall budget execution figure of 96%. This compares favourably with the figure of 88% if the original budget estimates are taken. Even this, however, is an improvement on the figure for FY2005/06 which was 82%, as shown in Annex Table 9-1.

As usual there is significant variation in budget performance between the different sub-votes. Curative Services was over-spent by 2%, while other departments were between 6% and 44% under-budget. Policy and Planning again fared worse than other departments, arguably pointing again to capacity constraints in implementing planned activities. Also of concern are the shortfalls in Preventive Services, Social Welfare and the Human Resource Department, all of whom have a critical role to perform in improving the health and welfare of the nation. <<add in recommendation to discussion section, based on MOHSW/Richard's explanation of poor performing sub-votes>>

Table 5-2 below presents the performance of the development budget, again using data from the MOF database.

Table 5-2 MOHSW development budget performance, FY2006/07

Sub-vote	Approved Estimates (a)	Allocated funds (b)	Actual expenditure ©	b/a	c/b	a/c
1002 Policy and Planning	7,568,845,100	7,568,845,100	6,701,998,117	100%	89%	89%
2001 Curative Services	15,419,180,178	14,242,959,900	4,206,642,914	92%	30%	27%
3001 Preventive Services	67,205,398,322	67,100,820,418	60,985,838,292	100%	91%	91%
4001 Tanzania Food and Drug Admin.	1,000,000,000	980,000,000	841,676,709	98%	86%	84%
4002 Social Welfare	1,303,200,000	1,007,200,000	250,000,000	77%	25%	19%
5001 Human Resource Development	3,801,190,300	3,798,690,300	858,015,071	100%	23%	23%
Overall MOHSW recurrent (i)	**96,297,813,900**	**94,698,515,718**	**73,844,171,104**	**98%**	**78%**	**77%**

Here the findings are somewhat reversed, with the Preventive Services department achieving the highest level of budget execution, at 91%, with Policy and Planning also spending close to 90% of their budgeted funds. Review of the disaggregated figures shows that in general, external (grant) funding performed better than GOT funding, both in terms of budget performance (99% of PG funding was released compared with 86% of PT), and to absorption of those funds (79% of PG releases were spent compared with 61% of PT releases).

Explanation for the differing performance relates to the specific projects. Funding for the National AIDS Control Project alone accounted for slightly over half (51%) of budgeted (and released) development funding and a staggering two-thirds (66%) of actual expenditure. Although the unhelpful classification of all spending under this project (and the programme generally) being lumped together under a single item code (240608) does not permit identification of the specific items in either the MTEF or the MOF database, much of this was for anti-retroviral drugs.

The majority of GOT development funding (84%) was allocated to infrastructural development, either as counterpart funding to the ADB-funded project, or for Strengthening of referral hospitals. While releases were reasonably high (86%), expenditure was only 58% of the released funding. However, there may have been contractual commitments or procurement delays with the works which account for this apparent failure to absorb the released funds. MOHSW/Richard needs to comment on this further.

Details by individual project are given in Annex Table 9-2.

5.3 Regions – recurrent

In contrast to previous years, no disaggregated data were obtained for the Regional level, either for PE : OC or for Preventive: Curative. In addition, sources differ for estimates and expenditures and therefore the comparison may be questioned. Such data as were available indicates that budgets were fully executed in both FY2005/06 and FY2006/07, as presented in Table 5-3 below.

Table 5-3 Regional budget performance, recurrent, FY2005/06 and FY2006/07

	Approved estimates	Actual expd	Expd/Est
FY 2005/06	11.52	11.53	100%
FY 2006/07	19.12	19.21	100%

5.4 Local Government Authorities – recurrent

Data on the LGA recurrent budget performance were taken from comparative reports of Budget Plan and Cumulative Budget Outturns from www.logintanzania.net. While seemingly the best current source of data on LGA budgets and spending, there are still some gaps and inconsistencies in the data, which should be treated with caution. The data show PE and OC, but these should not necessarily be equated with the block grant as the total figures are not consistent with the figures given for block grant in a separate report, and it is therefore assumed that they reflect spending from different sources.

Table 5-4 LGA budget performance, recurrent, FY2006/07

	Budget	Out-turn	Budget performance
PE	85,053.5	70,605.0	83%
OC	33,025.8	28,780.8	87%
Total Recurrent	**118,079.3**	**99,385.8**	**84%**
Block grant	*114,778.5*	*96,811.2*	84%
Subventions	*22,737.6*	*24,980.9*	110%

Source: www.logintanzania.net

The data provided by the summary indicates a significant shortfall in both PE and OC spending against budget. It is not clear whether the shortfall of 17% for PE reflects a failure by the central level to release the necessary funds, or of the LGA to recruit staff as planned, but both are of concern in an environment where staff shortages critically constrain health service delivery.

The shortfall in OC funding is slightly lower, at 13%, but is still sizeable given the overall resource constraints which the sector faces, and further exploration of the reasons for the shortfall is necessary. Prior to this, further verification of the figures is advisable however.

When looking at the respective performance of the block grant and basket funding, again assuming that the data are substantially correct, it is clear that the main shortfall has been in domestic funding. This is of concern given the stated commitment, emphasised in the FY2007/08 budget guidelines, to Decentralisation by Devolution. This is most likely due to the shortfall in PE allocations as noted above.

More information on selected LGAs is given in Section 7 below.

5.5 National Health Insurance Fund

In the previous PER update, NHIF expenditure was reported as the value of the claims which actually reached health facilities, rather than the disbursement from the Accountant-General's Office (Vote 23) and others to the NHIF on behalf of public servants. This was felt to be a more accurate reflection of the contribution of this particular item to the available resource envelope for providing health services. However, the team were unable to obtain updated information from NHIF despite a number of attempts. Table 5-5 below therefore presents data on the allocation from Vote 23 from the MOF databases for FY2005/06 and FY2006/07.

Table 5-5 NHIF budget performance, FY2005/06 and FY2006/07

	Approved estimates	Actual expd	Expd/Est
FY 2005/06	20.46	13.53	56%
FY 2006/07	24.05	23.95	100%

The data indicate that although funds were released almost in full from the Accountant General's Office in FY2006/07, this contrasted with a serious shortfall of 44% in the previous financial year. <<any reasons for this? Can we verify it from another source, pref NHIF figures themselves?>>

6 Off-budget spending

The PER has typically included a section on off-budget spending, albeit with the caveat that the data is incomplete and any discussion based on various assumptions and extrapolations. As already mentioned, the data problems were greater than usual for this update, and the sections below should be seen as an indication of how much work is required in this area if analysis is to be of use.

6.1 Complementary financing sources

6.1.1 Health Service Fund

The PER usually includes a summary of internally generated funds at government hospitals, as reported in the MOHSW Appropriation Accounts. We were able to obtain two files containing rather incomplete data on these funds which apparently related to FY205/06 and FY2006/07. However, some numbers are the same in both files, and one file has two separate sets of data both of which claim to be for the same year. At the time of writing we had been unable to clarify these issues. Available data are summarised in Table 6-1 below.

Table 6-1 HSF data, ?FY2005/06

	Tsh m
Balance BF	2,101
Receipts	2,242
Payments	2,738
Balance CF	1,606
Expd as % of Receipts	*122%*
Balance CF as % Receipts	*72%*

For whichever year the data refer to, receipts were TSh 2.2bn while payments were TSh 2.7bn, indicating some drawing down of balances which is to be encouraged as the balances carried forward appear to have been more or less equivalent to a year's income.

6.1.2 Community Health Fund

A three day workshop was held in early 2007 to review progress and challenges with the CHF, with participation from a range of stakeholders. At that time it was indicated that sensitisation on the CHF had been carried out in ninety-two of ninety-eight district councils, while sixty-nine councils were actively implementing the CHF. It was reported that a total of TSh 800m had been raised in membership premia over the previous two years, the value of which had been doubled through the matching grant which is currently funded through the Basket[9].

For the PER, we were able to obtain data on fifteen or sixteen councils, and this is presented in Table 6-2 below, together with some manipulations thereof[10].

[9] MOHSW (2007). *Community Health Fund best practices: workshop report*. February 2007

[10] The number is fifteen or sixteen depending on whether both Kigoma entries are for the same council (ie urban or district). Data are presented as obtained, ie for different periods spanning more than one financial year.

Table 6-2 Summary information on CHF

Council	Membership fees	CHF members	CHF fees / member	User fees (UF)	UF as % CHF premia	*Period covered*
Rungwe	77,940,000	5,562	14,013	34,733,214	45%	*Apr 06-May 07*
Rungwe	59,358,000	5,745	10,332	20,820,430	35%	*Jan 06-Aug 06*
Mwanga	21,020,000	3,981	5,280	7,366,000	35%	*Jan 06-May 06*
Kahama	22,960,000	2,296	10,000	13,856,650	60%	*Apr 06-May 07*
Geita	96,870,000	9,687	10,000	0	0%	*Feb 06-May 07*
Iringa	21,175,000	3,220	6,576	24,923,000	118%	*Jan 06-May 07*
Kasulu	13,037,500	2,609	4,997	6,047,000	46%	*Jan 06-Dec 07*
Igunga	32,280,000	4,128	7,820	5,647,500	17%	*Jan 06-Apr 07*
Kigoma	42,785,000	18,159	2,356	0	0%	*Jan 04-Nov 06*
Sumbawanga	22,415,000	4,483	5,000	37,648,189	168%	*Oct 04-Oct 06*
Rombo	87,160,500	6,115	14,254	3,691,000	4%	*Mar 05-Feb 06*
Muheza	9,648,112	1,322	7,298	14,322,250	148%	*Jan 05-May 06*
Singida	4,060,000	812	5,000	2,204,000	54%	*Jan 06-May 06*
Shinyanga	34,860,000	6,972	5,000	14,097,000	40%	*Oct 05-May 06*
Mbulu	42,118,000	7,424	5,673	10,535,203	25%	*2004/05*
Kigoma	42,593,000	8,002	5,323	4,679,000	11%	*Jul 05-May 06*
Sengerema	6,020,000	602	10,000	18,435,000	306%	
Total	**636,300,112**	**91,119**		**219,005,436**		
Mean			***6,983***		***34%***	

Comparison of the total reported membership fees over a mixed period generally not exceeding two years casts some doubt on the earlier mentioned figure of TSh 800m. The calculations undertaken on premium per member and on the ratio of user fee revenues to CHF membership premia raise as many questions than they answer, and unfortunately the team were unable to obtain clarification on either gaps or queries.

6.1.3 National Health Insurance Fund

As with the other two sources of complementary funding, we failed to obtain updated information on NHIF claims, despite efforts through the MOHSW and directly with NHIF. Significant work has been undertaken with NHIF since the previous PER update to improve the status of claims processing for health facilities, as reported elsewhere[11].

The absence of a readily available report on funding into, and from, the NHIF as an input to this PER is regrettable, given the size of the allocation from Vote 23, and the potential importance as a source of funding to front line facilities. Such a report would also facilitate analysis of the efficiency and equity of this source of funding.

6.2 Off-budget external financing of the sector

As in previous years, the latest version of the database maintained by the External Finance department of the Ministry of Finance was obtained for the purpose of providing some commentary on off-budget external financing. The database records various information regarding external financing agreements, whether on or off-budget, and is potentially an extremely useful data source for public financial management. However, it remains unclear to what extent it is a) complete and b) consistent with the on-budget information. It appears likely that the information is not correct, given that there also entries relating to Forestry, and Sustainable cities (Danida), Coffee/cotton markets (CFC), and support to Bank of Tanzania (Canada) currently categorised as Health, to name but a few. It is also not particularly easy to interpret, as it includes a number of columns, the differences in which are not immediately

[11] Find ref of the final report from the Danida/GTZ-funded work with NHIF (Enemark, Minja et al)

obvious, particularly given data gaps and inconsistent figures, and different measures for the same financial year are not presented contiguously within the database.

Notwithstanding, a brief review was made of those entries in the database which appeared to be health-related, over the period FY2004/05 to FY2006/7, the findings of which are shown in Table 6-3 below. Only those entries with positive values for Total Disbursement (the only column which was common to all three years) were included, and those specifying implementation on Zanzibar were also excluded.

Table 6-3 Health sector external finance disbursements as per MOF database, FY2004/05 – FY2006/07

	2004/05	2005/06	2006/07
ADF	11,896,437,940,094	141,471,791,864	4,925,377,890
Australia	-	-	-
BADEA	546,216,437	616,454,356	2,755,008,717
Belgium	3,035,970,943	319,935,977	451,555,266
Canada	217,982,485	2,771,188,033	47,846,991
Denmark	1,717,426,534,833	-	14,111,572,732
DFID	-	-	-
Germany	-	-	-
Global Fund	1,963,895,771,575	37,075,916,649	-
IDA	4,869,968,576,453	12,526,258,246	-
Ireland	15,753,310,481	-	9,643,198,500
Italy	-	-	-
Japan	3,952,657,252	745,958,891	1,189,836,070
Netherlands	537,431,899,855	6,064,284,573	8,495,205,531
Norway	-	1,574,936,440	-
OPEC	-	-	-
SDC	263,611,605,530	67,672,350	14,344,826,227
UNFPA	61,428,376,639	-	-
Unicef	-	-	292,874,042
USAID	-	-	-
WHO	-	-	-
Total disbursement	**21,333,706,842,578**	**203,234,397,378**	**56,257,301,966**

Clearly, there are some significant gaps in the database, as several major partners appear not to have disbursed any funds over the three year period (eg Germany, USAID and WHO). In addition, the figures appear excessively high for FY2004/05 in particular, in the trillions[12]. It was therefore decided that further analysis based on this data was not warranted, thereby resulting in a gap in the information on external off-budget funding in this PER update.

The external finance database, at least far as it pertains to the health sector, is an area which has been recommended for review in several previous health sector PERs, and this brief review confirms this point yet again. This is particularly important given the increased emphasis currently being given to the level and nature of support specifically targeted at MKUKUTA priorities as the volume of off-budget external spending remains significant.

[12] Having failed to obtain clarification from MOF, eventual further review of the database found that this appeared to be due to errors in applications of a number of exchange rates, the most serious being of which seemed to relate to use of the price of Gold rather than the exchange rate for ADB Special Drawing Rights. Time constraints prevented correction of this error. However, the fact that it had not been noted within MOF suggests that the database is not much used.

7 Local government spending sub-study

Although PER updates have been undertaken in the health sector for the past few years, there has always been a significant degree of dissatisfaction over the quality of the LGA component of the review, not least as expenditure data has not been forthcoming. Given the importance of the council level in terms of actual health service delivery, and the increased focus on "Decentralisation by Devolution", it was therefore agreed that for the 2007 update, more efforts should be expended to get a picture of the actual spending position at that level, rather than relying on central level data on budgets and releases.

In addition, while acknowledging that the block grant and basket funds are the major sources of financing for council health activities in most places, LGAs have access to an increasing range of financing options, for example through direct donor support or cost-sharing mechanisms. All of these are expected to be reflected in their Comprehensive Council Health Plans (CCHPs) and also in their Technical and Financial implementation Reports (TFIR). It has been noted in several PERs that much more could be made of the data which these documents contain.

At the same time, significant developments have been made in local government financial information systems, at least at central level, with the emergence of www.logintanzania.net, which aims to provide an easily accessible database of budgeted and disbursed funds, together with actual expenditures, both in total, and disaggregated by sector and sources of funds. It is not yet comprehensive, and some gaps and inconsistencies remain, but it represents a significant improvement on the timeliness and quality of data on local government expenditures before now.

Twelve councils were selected by the team for inclusion in the review. Although the original intention had been to undertake this as a field review, delays in the process resulted in a change to a desk review approach. Following both a search of the available reports in MOHSW and a subsequent trip to Dodoma to the PMO-RALG headquarters, it was discovered that, for a number of the selected districts, either the CCHP and/or the 4th quarter report was not available in either location. Although www.logintanzania.net data were available for all councils, this meant that for Kondoa, Mafia, Pangani and Ruangwa, some analyses could not be done.

The various documents were reviewed for the selected districts in order to obtain a picture of the following:

- The level of funding – ie budget, receipts, and expenditures - and comparison between these;
- Composition of budgets and expenditures by source;
- Allocation by sub-vote or level of the health system, and between PE and OC.

7.1 The level and composition of council budgets

7.1.1 Health budgets

The budget in the CCHPs of the selected councils were reviewed and compared with population figures to determine the range of per capita allocations. For those councils for which CCHPs were available, the figures are presented in Table 7-1 below.

Table 7-1 Council CCHP budgets FY2006/07 (TSh)

Council	CCHP total	Population	Per capita	as % of mean
Biharamulo DC	1,183,899,594	458,984	2,579	49%
Kibondo DC	1,721,529,120	463,905	3,711	71%
Kyela DC	1,359,911,882	194,888	6,978	134%
Mwanza CC	2,423,691,932	532,184	4,554	87%
Pangani DC	839,980,000	49,242	17,058	326%
Ruangwa DC	744,386,000	139,032	5,354	102%
Same DC	2,434,195,237	237,388	10,254	196%
Songea TC	853,248,936	146,713	5,816	111%
Tabora TC	958,070,601	210,780	4,545	87%
Temeke MC	4,700,193,705	861,544	5,456	104%
Total selection		**3,294,660**	**5,226**	

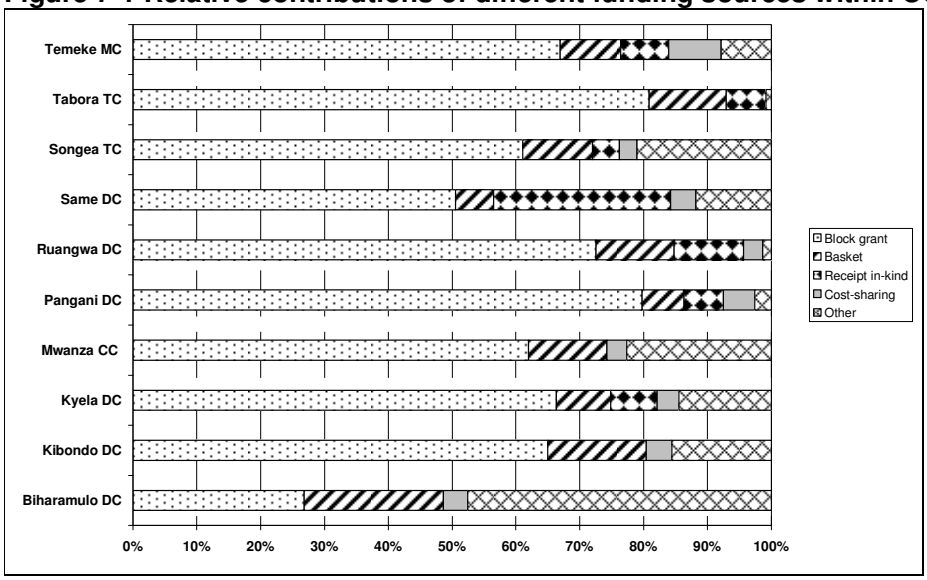
Note: population figures taken from www.logintanzania.net

The figures ranged from a low of TSh 2,579 in Biharamulo DC to TSh 17,058 in Pangani DC, ie more than a five-fold difference. The mean for the selected councils was just over TSh 5,000. While there are wide differentials in the share of MOH and basket funding within the total (see 7.1.2 below), and also in eventual budget out-turn, this indicates a) that the general level of per capita funding at the LGA level is very low, and b) in terms of what councils actually control (ie OC and basket plus any cost-sharing revenues), the figure is even lower.

7.1.2 Composition of the resource envelope

The CCHP is expected to reflect all sources of funding available to the council during the financial year, in an attempt to capture both the geographical distribution of known project funding and off-budget sources not known to the central level. In addition, they include budgeted and realised cost-sharing revenues. The FY2006/07 CCHP budgets were reviewed to determine the contribution of the various different sources, the findings of which are shown in Figure 7-1 below.

Figure 7-1 Relative contributions of different funding sources within CCHPs



It should be borne in mind that this data provides a crude picture only, as there are errors and inconsistencies within the CCHPs, not least that some only include OCs rather than the full block grant (eg Biharamulo DC), and others exclude receipts-in-kind, ie the drug budget (eg Biharamulo DC, Kibondo DC, and Mwanza CC). As disbursement of different sources

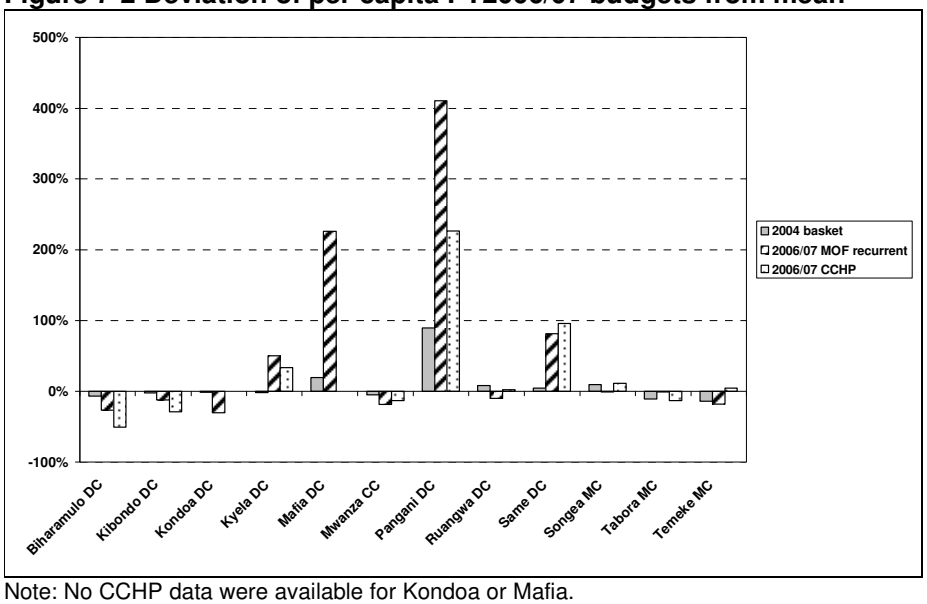
varies considerably, ideally the CCHP budget should be compared with disbursements or expenditures over some years to determine how realistic it is.

At face value, it is clear that for most, the major source remains the block grant from GOT. However, it is likely that the capture of other sources varies considerably, and it would be useful to undertake a mapping at central level of where at least that proportion of on-budget external funding actually goes, in order both to review the equity of the de facto resource allocation in the sector, and to cross-check with CCHP data.

7.1.3 Inter-council resource allocation

It was not possible to undertaken an in-depth review of council budgets or expenditures to determine the extent to which they bore out the intentions of the resource allocation formula. However, a quick and dirty comparison of the FY2006/07 MOF data on recurrent budgets, and the resource envelopes as shown in the CCHPs, shows that in general any deviation from the mean per capita allocation was in the same direction as was the case with the 2004 resource allocation formula[13]. However, the scale of such deviations was much greater, as shown in Figure 7-2 below.

Figure 7-2 Deviation of per capita FY2006/07 budgets from mean



Note: No CCHP data were available for Kondoa or Mafia.

7.1.4 Intra-council resource allocation

- Allocation by level or sub-vote

Information on inter-governmental transfers for the sector (ie the recurrent block grant and any development grant), is disaggregated by four sub-votes in the LGA budget as per GOT official estimates. The sub-votes are:

- 5010 Health services (largely curative, includes any Council district hospital)
- 5011 Preventive (believed to include the Council Health Management Team)
- 5012 Health centers
- 5013 Dispensaries.

[13] The latest available to the team.

Table 7-2 shows the allocation of recurrent block grant funding by sub-vote in the selected councils. There is a clear pattern on allocations to health services for councils that have a district hospital. Further, except for Songea TC, dispensaries have been allocated more funds compared to health centres. This is likely to reflect the higher number of dispensaries in the various councils, although further exploration would be needed to confirm this.

Table 7-2 Allocations of recurrent block grant per sub-vote

District/Subvote	5010	5011	5012	5013
1. Biharamulo DC	0%	16%	27%	57%
2. Kibondo DC	52%	5%	19%	24%
3. Kondoa DC	35%	17%	22%	26%
4. Kyela DC	46%	18%	16%	21%
5. Mafia DC	57%	8%	0%	35%
6. Mwanza CC	8%	16%	16%	61%
7. Pangani DC	48%	14%	16%	21%
8. Ruangwa DC	22%	5%	35%	38%
9. Same DC	53%	8%	16%	23%
10. Songea TC	7%	20%	42%	31%
11. Tabora TC	18%	42%	0%	40%
12. Temeke MC	52%	12%	17%	19%

There was no spending under the Health services sub-vote in FY2005/06 for Biharamulo, while the majority of spending (57%) was allocated to the dispensary level. This is most probably due to lack of a district hospital. Tabora TC has no allocation for sub-vote 5012 (health centres). In Mwanza CC, the health services sub-vote receives the least, presumably due to the fact that hospital services are provided by the Regional hospital.

Development grants were allocated to three sub-votes (Table 7-3). No development spending was recorded for Same DC, Ruangwa DC, and Mafia DC and, again, follow-up would be required to determine why this is the case.

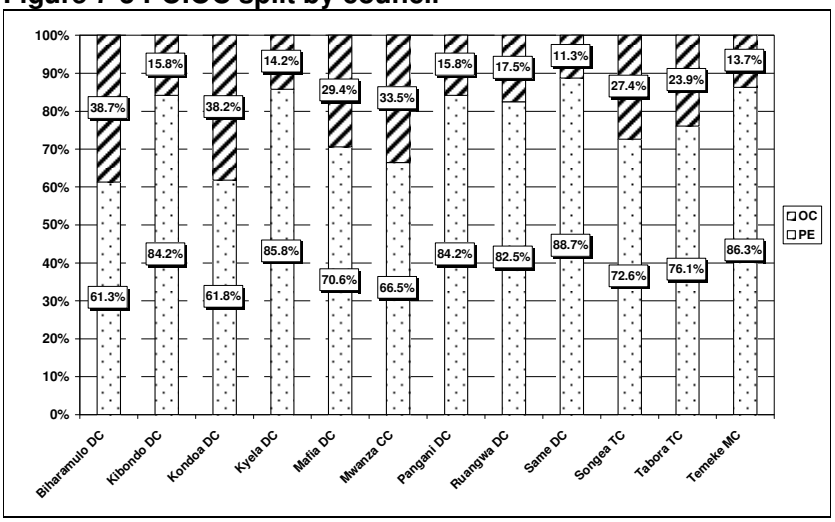
Table 7-3 Allocation of Development grant by sub-vote (TSh m)

	Sub-vote		
Council	**5010**	**5012**	**5013**
Biharamulo DC	-	20.00	-
Kibondo DC	-	-	22.00
Kondoa DC	-	-	-
Kyela DC	23.00	-	-
Mwanza CC	-	-	22.19
Same DC	-	-	-
Songea TC	-	12.00	-
Tabora TC	18.10	7.30	-
Temeke MC	44.00	-	-

- Allocations of Personal Emoluments (PE) and Other Charges (OC)

The split between PE and OC within the recurrent block grant is shown for the twelve selected councils in Figure 7-3 below. Personal Emoluments range from 61% in Biharamulo DC to 89% in Same DC. Although these figures appear high, in the context of significant other recurrent OC funding through the district basket, it is difficult to comment on how efficient or otherwise such allocations might be.

Figure 7-3 PC:OC split by council



The database shows no OC spending under the Preventive sub-vote in FY2005/06 for Kibondo DC while there was in both FY2004/05 and FY2006/07. Further investigation would be needed to determine whether this is merely a reflection of incomplete information.

In some councils, data showed PE allocations without a corresponding OC allocation for some sub-votes. For example, while the absence of PE spending under 5010 Health services for Tabora TC is probably due to the council being in the regional centre, with the hospital catered for under the Regional vote rather than the LGA, it would be good to have an explanation for the OC allocation. Similarly, the existence of a PE allocation for 5011 Preventive without a corresponding OC allocation needs to be clarified. The same findings are found for Songea TC, ie no PE allocation under sub-vote 5010 health services but an OC allocation; no OC allocation for 5011 preventive but a PE allocation. For Ruangwa DC and Mafia DC, there is no OC under sub-vote 5011 but there is PE.

7.2 Receipts in comparison with Budget

The detail of what has been budgeted and what has been received is normally presented in the councils' annual Technical and Financial Implementation Reports (TFIR). The data show that, on average, 93% of the budgeted block grants and 100% of budgeted basket funds were received, as shown in Table 7-4. In some cases, councils reported receiving more than was budgeted, eg Kondoa DC (block grant and basket funds) and Biharamulo DC (basket funds). Conversely, Temeke MC reported only receiving 56% of their block grant.

Table 7-4 Budget compared with funds received

	Receipts as % Budget			
Council	**Block Grants**	**Basket Fund**	**Cost Sharing**	**Receipt in Kind**
Tabora MC	98%	100%	99%	
Mwanza CC	100%	100%	100%	
Songea TC	95%	115%	98%	105%
Same DC	96%	100%	77%	100%
Kyela DC	98%	100%	102%	110%
Kondoa DC	104%	113%	249%	67%
Kibondo DC	100%	100%		
Biharamulo DC	90%	150%	59%	180%
Temeke MC	56%	100%	73%	74%
Mean	**93%**	**109%**	**107%**	**106%**

Source: Fourth quarter/ Annual Technical and Financial reports

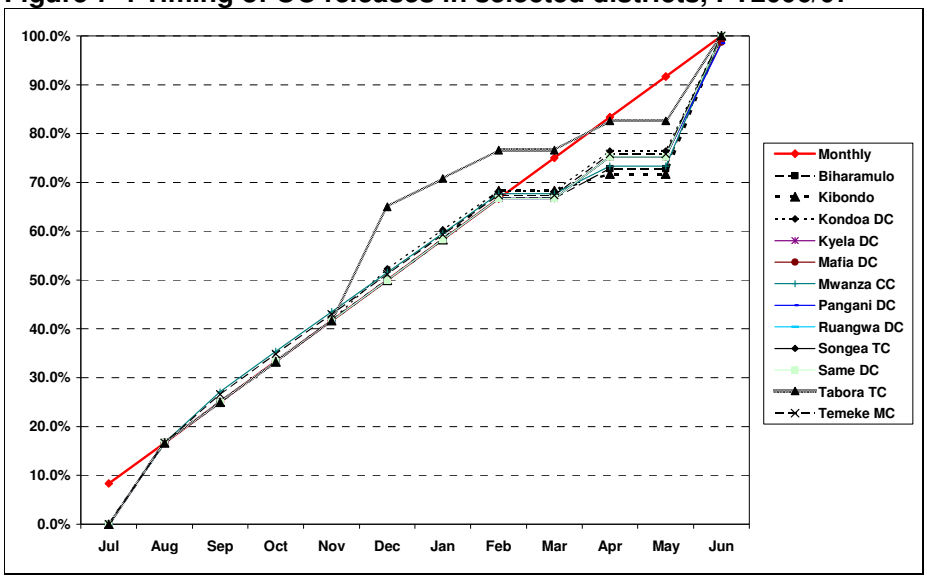
Cost-sharing receipts varied wildly between councils compared with budgets. Although the average for the eight councils reporting funding was 106%, figures ranged from a low of 59% in Biharamulo DC to a high of 249% in Kondoa DC.

However, as noted with the budget data, there is considerable inconsistency in reporting on receipts between what has been budgeted and what has been received between the different sources. For many of the other sources included in the CCHP, there is generally no information on funds received or expenditures.

7.3 Timing of OC releases

Data on release of funding during the course of the financial year was again obtained from www.logintanzania.net, in the form of the monthly releases of block grant funding for OC and PE for each council (Report 5a). It had originally been intended to get Council Health Officials to verify this data, but time constraints prevented this. Figure 7-4 shows the timing of releases of funds for the selected districts. Although it may be difficult to see the individual councils, the general pattern is clear.

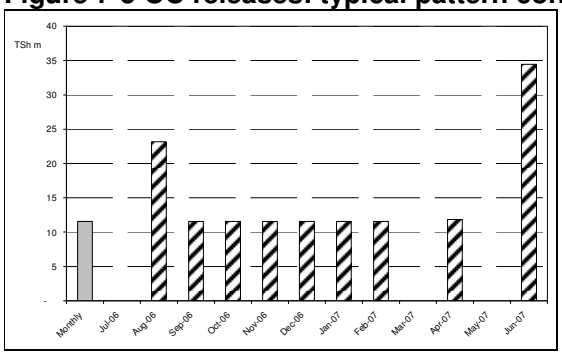
Figure 7-4 Timing of OC releases in selected districts, FY2006/07

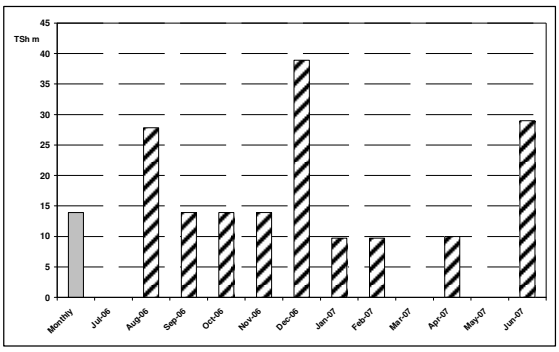


Although virtually 100% of OC funding was released during the financial year, the data show that for most councils around 25% of the budgeted funds were released in the last month. Although we cannot see on what date it was released, this pattern clearly has implications for absorption capacity as it may be impossible to undertake the planned activities within the timeframe and therefore spend the monies. **This is therefore an area where more probing is needed from the CHMT and District Treasurer.**

The graph shows the deviation from the monthly expected release, on the assumption that funds are released evenly throughout the course of the financial year. It shows that cumulative releases were on the expected level for 7 months of the year for the majority of councils, with the shortfall being made up in the final month, thereby putting pressure on the council to be able to absorb the funds efficiently. The typical pattern is demonstrated more clearly for Kyela DC in Figure 7-5 below. This is contrasted with Tabora TC, which was the only council to receive its OC funding significantly ahead of schedule, though it then experienced cuts in the last quarter. These trends remain to be explained.

Figure 7-5 OC releases: typical pattern contrasted with Tabora TC





7.4 Analysis of reported expenditures

7.4.1 Overall budget performance

The 4th quarter report should also enable analysis of actual expenditure, and comparison with stated budgetary allocations. Table 7-5 below presents total expenditures and total budget, as reported in the 4th quarter TFIRs, for the selected districts.

Table 7-5 Comparison of budget and expenditure, TSh m

Councils	Budget	Expenditure	Expd/ Bgt
Tabora MC	814.53	823.66	101%
Mwanza CC	2,952.67	2,858.46	97%
Songea TC	773.80	651.23	84%
Same DC	2,437.57	2,207.92	91%
Kyela DC	1,055.12	1,049.34	99%
Kondoa DC	1,938.15	1,447.40	75%
Kibondo DC	1,274.42	1,804.37	142%
Biharamulo DC	1,435.22	1,017.47	71%
Temeke MC	4,700.19	3,095.06	66%

The table shows that there is considerable variation between councils, with reported expenditure ranging from a low 66% of budget in Temeke MC to more than 40% over-budget in Kibondo DC. In the former case, this is likely to be related to the relatively low receipt of funds noted above.

However, it should be recalled that inconsistencies in the reporting of budgets between and within different sources mean that this data should be treated very cautiously. For example, while the data for Kibondo DC above suggest that expenditure was 42% over-budget, in fact this is due to an error of omission, whereby it appears that only block grant funds were included in the "budget" data despite both the CCHP and 4th quarter report showing a total budget in excess of TSh 1.7bn. There are also addition errors in the detailed report by level.

7.4.2 Spending by level of the health system

Although the allocation by sub-vote reported in Section 7.1.4 cannot be followed through to expenditures, due to slightly different reporting in the CCHPs (eg including community initiatives and voluntary agency facilities), further analysis of the 4th quarter reports showed that, on average for the selected councils the dispensary level accounted for the highest proportion of expenditures at 31%, followed by the council health department level (25%). For all nine councils, community initiatives accounted for the smallest share of spending, averaging 1% of total expenditure, as shown in Table 7-6.

Table 7-6 Expenditure share by sub-vote (%)

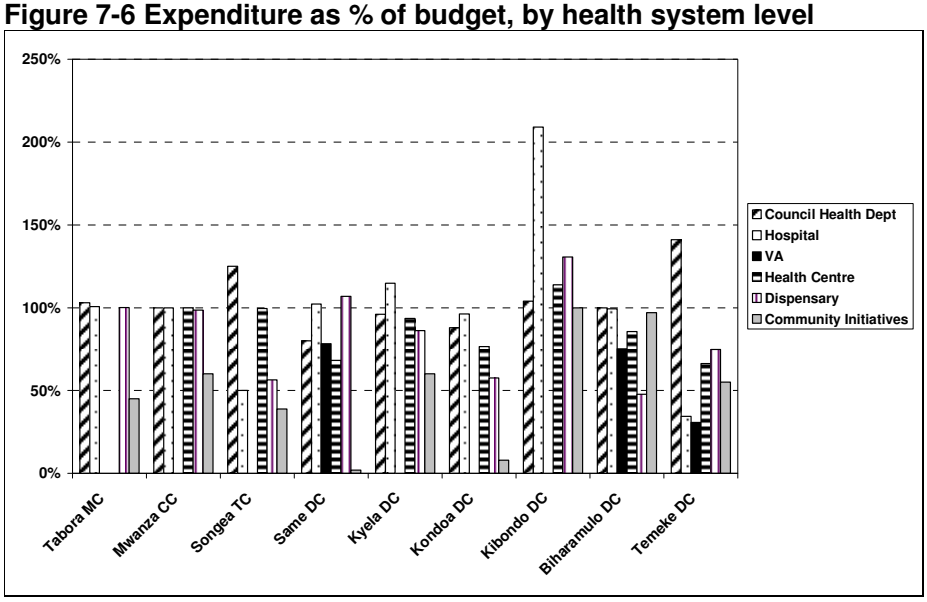
Councils	Council Health Dept	Hospital	VA	Health Centre	Dispensary	Community Initiatives
Tabora MC	55%	5%			39%	0%
Mwanza CC	38%	12%		10%	36%	4%
Songea TC	31%	2%		38%	28%	1%
Same DC	9%	31%	6%	15%	39%	0%
Kyela DC	10%	48%		13%	28%	2%
Kondoa DC	11%	47%		18%	23%	1%
Kibondo DC	10%	36%		22%	32%	0%
Biharamulo DC	22%	8%	10%	28%	30%	2%
Temeke DC	39%	24%	1%	13%	23%	1%
Mean	**25%**	**24%**	**6%**	**20%**	**31%**	**1%**

The relatively high levels of Council Health Dept spending in Tabora and Mwanza are most likely due to provision of hospital services by the Regional Hospital, and absence of health centres in the former. This does not however explain the high proportion spent in Temeke MC, and further exploration of these figures with the councils would be beneficial.

7.4.3 Budget performance by level of the health system

Figure 7-6 below shows the comparison of actual expenditures compared with the budgeted allocation by level of the health system, from the TFIRs.

Figure 7-6 Expenditure as % of budget, by health system level



The data show better budget performance at Council Health Department and Hospital levels (104% and 101% respectively on average), while Community Initiatives consistently under-perform across councils.

Again, there is need for caution in interpreting the data as like is not always being compared with like in the documents. For example, although it appears that the Kibondo council hospital budget was overspent by more than 100%, review of the data suggests that this may be due to failure to incorporate other sources of funding in the initial budget estimates. Although the CCHPs and TFIRs are intended to be comprehensive, it remains the case that emphasis in some areas is still only placed on block grant and basket funding, with the summaries by level or by item not including all funding sources.

8 Discussion and recommendations

8.1 The level and share of health sector spending

While the development of databases of budget and expenditure within MOF have simplified some aspects of the PER, the lack of clarity about precise sources of information, and the existence of different values for key figures considerably hampered what should be a fairly straightforward piece of work to review the level of on-budget sector spending. For example, it has been unclear whether the original estimates approved by the National Assembly in June should be used as the "budget" figures, or the final approved estimates following re-allocations during the financial year. This is particularly important in a year with a significant budget cut to the sector, as in FY2006/07.

In addition, inability of the team to obtain clear overall government expenditure data (with and without CFS) meant that the health sector share could not be calculated, and comment therefore was restricted to budget data. With the known shortfalls in the level of sector spending against budget, it is important that actual expenditure shares are monitored and compared with budgeted shares.

The above notwithstanding, the continued rise in the nominal budget for the health sector is encouraging, particularly as it translated both to a rise in the real value of the budget, and to an increase in the per capita level. However, the fact that this was driven by a large increase in the development budget makes it more important that actual expenditures are monitored given the variation in budget performance of development spending in recent years (as seen in Figure 5.1, for example).

The fall in the share of the sector is perhaps not surprising, given emphasis in on productive sectors, but moves the country further away from the Abuja commitment of 15%.

Recommendations:

- Lobby MOF for earlier and consistent data on total government expenditure at the end of the financial year; and seek agreement between GOT and DPs on which is the definitive version of such data;
- Agree on which definition of Estimates should be used as the comparator (preferably original approved estimates, with presentation of any revised budget together with explanations);
- Update the analysis of the sector share of actual expenditures, and lobby accordingly for at least a return to the FY2006/07 share of budget in FY2008/09, and preferably an increase.

8.2 Spending in line with priorities: D by D

Section 4.2 shows a small increase in the share of the sector budget directly allocated to LGAs. Information on the assignment of centrally procured items is still poor. The 30% allocation of the drug budget referred to in the Budget Guidelines did not take place. Section 7.1 indicates the low per capita level of flexible monies effectively in the hands of Council Health Management Teams. Together, these facts and figures suggest that D-by-D has some way to go, but that the movement is in the right direction.

Given recent discussions regarding limited funding to the Regional level when compared with their increased role in supervision and coordination of the LGA activities, the slight increase in the budgeted share at this level in Figure 4-1 is encouraging.

Recommendations:
- As in previous PERs, efforts should be made to unpack central level and externally funded spending to facilitate better analysis of the allocation by beneficiary level (ie LGA or health facility type), both for budget and actual expenditure values. This is not a small task, and arguably it should be undertaken separately from the PER.
- Include specific targets for budget and spending by level of the health system in the new Health Sector Strategic Plan to enable annual monitoring towards those targets.

8.3 Spending in line with priorities: MKUKUTA objectives

The MKUKUTA indicates that the Health Sector Strategic Plan will be implemented in full. This is clearly not possible given well-publicised constraints in both financial and human resources. Priorities for resource allocation are also outlined in successive Budget Guidelines, and through the strategic objectives according to which the budget is organised. Although it has not proved possible in the past to follow these stated priorities through from budget to expenditure documents, the current format of the MOF/DP database on budget out-turns is a welcome step forward. Monitoring of MKUKUTA spending is an area which has received more attention generally this financial year, although delays in basic data collection precluded a full analysis for the Health sector. It is hoped that for the next sectoral PER update efforts will be possible to present a more substantive analysis of expenditures in line with these stated priorities.

The limited analysis in Section 4.3 shows that in FY2006/07 there was an effective reallocation away from MKUKUTA objectives and towards other spending, due both to a shortfall in releases against budget lines for those objectives, and over-spending on other budget lines. The reasons for this are not yet clear <<any explanation from MOHSW?>>. However, wherever budget execution deviates from the original stated objectives, this reduces the credibility of the budget as a financial management instrument and is a matter for concern. Explanations should incorporated in the TFIR and PER.

Recommendations:
- At central level, MOHSW should monitor quarterly spending against objectives, and should provide written justification of deviations;
- Incorporate and expand the analysis of spending against MKUKUTA objectives in future PER updates.

8.4 Off-budget external funding

Efforts have been made within the sector to capture an increasing proportion of external funding within the MTEF document, particularly in the development budget. Information on actual expenditures is more easily accessed with the MOF databases. However, for those funds which are not captured, the External Finance database has been used in the past to estimate the extent of off-budget spending. The PER has in successive years proposed a reconciliation exercise be undertaken to compare information in the database with information held by MOHSW, but this has yet to happen. Given the major concerns with the data in the External Finance database this year, it has not been possible to use it even to provide a crude estimate, yet this is necessary to get a more complete picture of available funding to the sector in order to facilitate discussion of the extent to which such funding contributes to sector objectives, MDGs and MKUKUTA and is therefore “filling a gap”. It would be interesting to see the findings of the current round of National Health Accounts on total external funding for comparison.

Recommendations:
- DPP staff to review the completeness and usefulness of the External Finance Database (either directly or through a small commissioned study) in advance of the next PER update
  - Specifically, to seek clarification on the various columns and sources of data; to compare with in-house data; and to resolve queries with figures as indicated in this report
  - To review off-budget external financing for consistency with policy goals (as last year);
- Findings of current NHA exercise to be compared with the estimates of external funding from the relevant PER update.
- Continue to improve capture of external funding in MTEF in order to reduce volume of off-budget spending.

8.5 Information on complementary financing

While recognising that the councils are the actual implementors of the Community Health Fund, and that information is contained in the CCHPs and in the Fourth quarter TFIRs, it is not consistently reported, and there is still a quite astounding lack of aggregated or national level information at central level. This has not improved over the past five years.

Similarly, it remains problematic to obtain timely and complete data on the value and distribution of claims from the National Heath Insurance Fund, despite the significant proportion of the sector recurrent budget which is allocated to that institution.

These two sources of income and expenditure for the sector are viewed as critical in the longer term evolution of sector financing, and while it is encouraging to note that a focal person has been appointed to oversee activities in the area of complementary financing, it is questionable whether one person can maintain a sufficiently detailed overview of the different mechanisms (which also include the Drug Revolving Fund and the Health Service Fund). The continued poor data remain a major gap in the PER.

Recommendations:
- DPP or Accounts to clarify the position with HSF data for FY2006/07 in order to update the table in Annex B.
- The focal person in the MOHSW should provide a consolidated picture of CHF membership, income (separating membership premia and user fee revenues), and expenditure on an annual basis for incorporation in the MOHSW Appropriation Accounts. In part this can be drawn from the Fourth quarter TFIR although care should be taken to ensure that the data is consistent. Other data should be solicited from the MOHSW team responsible for overseeing CHF implementation, from the Tanzania Network of CHFs, or by annual return of a simple monitoring form by all councils.
- NHIF should be required to provide a standardised annual report on incomes, and claims, disaggregated by council and type of facility (public/private, primary/hospital) to enable analysis of the geographical distribution of benefits, and the efficiency of service use (ie use of the referral system).

8.6 Spending at the LGA level

8.6.1 Consistency of data

One major hurdle in analysing LGA spending, either budget or actual expenditure, lies in the inconsistency between various sources of data. Table 8-1 records the different figures found during the desk review for recurrent block grant funding. In addition to the data varying by source, it is perhaps striking that there is no consistency in this variation.

Figure 8-1 Variation in Recurrent block grant estimates by source

	MOF database		Logintanzania		CCHPs		
Councils	PE	OC	PE	OC	PE	OC	**TFIR**
Biharamulo DC	685.4	433.0	722.2	433.0		317.7	1,118.4
Kibondo DC	1,145.3	215.0	805.8	143.6	731.2	387.5	1,269.2
Kondoa DC	690.3	427.0	368.8	474.8	-	-	906.9
Kyela DC	837.0	139.0	776.0	164.3	755.1	146.4	940.3
Mafia DC	349.0	145.0	349.0	145.0	-	-	-
Mwanza CC	943.2	476.0	943.2	476.0		1,502.0	1,763.2
Pangani DC	705.5	132.0	705.5	132.0		670.0	-
Ruangwa DC	344.5	73.0	344.5	73.0	376.7	163.3	-
Same DC	1,275.5	162.0	969.9	162.0		1,131.9	1,230.5
Songea TC	353.0	133.0	353.0	133.0	386.8	134.3	521.1
Tabora TC	531.5	167.0	531.5	167.0		774.4	698.5
Temeke MC	2,024.1	322.0	2,822.2	303.2	2,822.2	322.0	3,144.2

Some variation must be expected due to the documents being produced at different times of the budget cycle, and therefore reflecting the changing budget position during the financial year. Consistency in presentation and clarity regarding sources would be useful however., and clarity , however, eg for all CCHPs to reflect both expected PE and OC allocations, as would reference to earlier figures where appropriate, eg for the 4th quarter TFIR to refer back to the CCHP and note any changes within year. For logintanzania, it would be useful to know the source of their data.

Recommendations:

- A nationally representative tracking study of LGA spending should be done during the course of FY2008/09, whether as part of the PER or as a stand-alone exercise. This should be organised in two parts, the first as a desk review of CCHPs and TFIRs to obtain a picture of budgets and reported spending, and the second part to follow up in the field to get more detail, and also to verify some the reports. Further detail on the timing of releases and receipts, and of expenditures would also help identify bottlenecks in spending in the field. The draft instrument that had been developed during the PER, but which was not used for this exercise due to budgetary and time constraints, is appended at Annex F.

8.7 Health sector PER process and timing

The PER was a standing item at the Annual Joint Health Sector Review when it took place in April. With the move to a September Review, it is possible only to provide a tentative review of the previous year's spending, as Appropriation Accounts are often not available until October. Without MOHSW providing up-front information on the expected resources, and early (and agreed) analysis of past trends, the likelihood of the PER being able to feed into the Budget Guidelines by December is also quite limited.

It had been proposed that the PER should be presented at a smaller meeting in March/April, together with the draft MTEF but no such meeting took place in 2007, and it is not clear

whether this suggestion will be taken up by MOHSW. As such, the timing needs to be reviewed, as a PER which completes in December/January, but is not presented until September, risks being out of date.

The input of MOHSW and other government officials to the health sector PER process appears to have reduced steadily over the past few years, and currently relies heavily on just one or two already over-burdened individuals. Although the same recommendations are made each year about early data collection, this never happens, and even basic information, eg on expected future resources, has not been forthcoming. No effective Steering Group exists to a) keep the process on schedule and b) respond to queries arising as the analysis proceeds, and inability to progress results in consultants pursuing other activities, thereby further delaying the process.

Recommendations:

- MOHSW and DPs to review the role and timing of the health sector PER update, the Task Team, and the appropriate body to serve as a Steering Group;
- MOHSW to commit to collating the necessary data prior to engagement of any consultant team;
- MOHSW and DPs should consider a return to a fixed, full-time exercise, and to ensure that the necessary incentives are in place to permit MOHSW and other government officials to play their role.

9 Annexes

Annex A Scope of Work for the FY07 health sector PER update

Phase I

a) Review the PER Health FY06 findings and actions taken by the Sector in response to those findings, indicating unaccomplished/pending actions and reasons as well as implications and the way forward. Identify follow-up actions planned in FY08. This needs to be undertaken in conjunction with the MoHSW Taskteam.

b) Analyse the recurrent and development budget performance for the past three-years (aggregate actuals vs budget) but with a particular focus for the presentation at the JAHSR on the most recent year (FY06/07).

Phase II

a) Establish trends of government allocation and expenditures to the health sector at sectoral and sub-sectoral level, including the central-local government split and specific health care interventions. This should include doing an analysis of the core/priority areas/items of expenditure as highlighted in the HSSP and MKUKUTA
   - Assess whether and how far these trends reflect policy objectives with practical suggestions for improvement;
   - Review deviations in overall budget performance (budgeted, release vs actual expenditure) indicating clear justifications for such deviations and factors constraining the allocations of resources

b) Determine the extent of off budget spending and suggest way to improve coverage of this kind of spending within the budget.

c) Provide estimates to feed in to budget guidelines for 2008/09 including:
   - Estimated resource envelope (all sources of financing on/off-budget, including revenues collected & retained in the health sector), high and medium scenarios
   - Compare the financial requirements for meeting MKUKUTA targets to projected resource availability for the sector (see f(i) above) and present options for restructuring expenditure to meet the targets. This should also take account of the "residual" required to cover normal running costs. Spell out the implications of these options and recommendations (e.g. scaling back targets, improving efficiency, mobilization of additional resources etc).

d) Assess the impact on the adoption of more expensive technologies for existing activities in the Health Sector (e.g., the change in malaria treatment to a drug which costs 5 time more due to resistance, the adoption of new vaccines that may be more cost effective, but which are more expensive) many of which are supported by external financing and the long-term implications on the domestic budget.

e) Undertake a detailed analysis of health income and expenditure at the council level which should provide a good overview on financial flows and how the resources are being allocated in the assessed councils.

Annex B Disaggregated data as at 31 March 2008

	2004/05		2005/06		2006/07		2007/08
	Approved estimates	**Actual expenditure**	**Approved estimates**	**Actual expenditure**	**Approved estimates**	**Actual expenditure**	**Estimates**
Recurrent							
Accountant General's Office							
National Health Insurance Fund	10,116,000,000	16,534,000,000	20,456,910,000	13,534,102,301	24,049,990,000	23,949,990,000	30,177,323,200
Ministry of Health							
Government funds	105,083,684,200	104,162,371,573	180,305,853,900	152,007,748,994	195,981,343,000	178,822,082,213	188,468,188,100
Donor basket fund	24,799,646,900	24,178,465,404			20,388,755,000	31,481,963,794	
Regional Administration							
Government funds	10,130,000,000	10,547,394,253	11,521,571,851	11,532,000,000	19,115,000,000	19,209,000,000	28,760,878,000
Local Government Authorities							
Government funds	63,587,000,000	68,800,402,413	75,081,381,900	75,314,000,000	114,778,500,000	96,811,200,000	137,899,729,000
Donor basket fund	18,697,480,120	18,697,480,120	20,074,739,000	20,136,805,400	23,330,863,000	23,093,863,000	43,911,514,500
Total recurrent	**232,413,811,220**	**230,590,737,028**	**307,440,456,651**	**272,524,656,695**	**397,644,451,000**	**373,368,099,007**	**429,217,632,800**
Development							
Ministry of Health							
Government funds	3,552,448,200	3,090,224,254	5,000,000,000	5,000,000,000	7,123,005,000	4,392,633,900	6,774,000,000
Donor basket fund	62,863,658,500	44,441,467,487	28,485,806,000	28,766,646,000	34,766,425,900	42,665,587,855	104,302,958,500
Foreign (non-basket)			57,376,942,400	57,096,102,400	48,969,143,800	26,785,949,349	70,859,041,900
PMO-RALG							
Government funds	20,000,000	20,000,000	100,000,000	100,000,000	70,000,000	70,000,000	56,600,000
Donor basket fund	2,569,490,000	4,460,000,000	19,737,959,000	19,737,959,000	21,424,480,000	17,963,600,000	450,000,000
Foreign (non-basket)							2,435,000,000
Regions							
Government funds	1,159,000,000	1,134,000,000	1,169,269,600	2,945,000,000	3,852,000,000	5,463,000,000	9,926,320,800
Foreign (non-basket)	3,290,000,000	2,896,000,000	3,880,004,200				
Local Government Authorities							
Government funds	2,409,000,000	2,357,000,000	2,579,453,200	2,084,835,400	6,021,200,000.00	5,915,300,000	21,147,485,500
Total development	**75,863,596,700**	**58,398,691,741**	**118,329,434,400**	**115,730,542,800**	**122,226,254,700**	**103,256,071,104**	**215,951,406,700**
Total on budget	**308,277,407,920**	**288,989,428,769**	**425,769,891,051**	**388,255,199,495**	**519,870,705,700**	**476,624,170,111**	**645,169,039,500**
Off budget expenditure							
Cost sharing							
Health Services Fund – Hospital	2,725,582,152	2,697,528,653	2,697,528,653	2,737,746,834	2,737,746,834		
Community Health Fund – PHC	4,751,767,889	8,012,153,333	8,012,153,333				
Other foreign funds	97,423,057,035	122,912,095,705	94,483,467,268				
Total off budget	**104,900,407,076**	**133,621,777,691**	**105,193,149,254**	2,737,746,834	2,737,746,834	-	-
Grand total	**413,177,814,996**	**422,611,206,460**	**530,963,040,305**	**390,992,946,328**	**522,608,452,534**	**476,624,170,111**	**645,169,039,500**

Notes: Light shaded areas indicate figures where queries remain; bright shaded areas represent outstanding gaps.

Annex C Main data sources and notes <<to be completed>>

No changes have been made to data from FY05 since the last PER update. Sources of (on-budget) data for FY06 – FY08 are indicated in the table below, presented in the order in which the different components of the sector appear in the table in Annex B. Comments and outstanding queries are also included in the table.

Data	Year(s)	Source	Comments
Recurrent funding			
Accountant General's Office – National Health Insurance Fund	FY2005/06 budget	Estimates book FY2005/06 (approved by National Assembly)	
	FY2005/06 actual	MOF database \budget outturn 05 – estimates 06	Note: funds disbursed to NHIF under AGO Vote, NOT claims paid so not comparable with last year's PER
	FY2006/07 budget and actual	MOF database \2006_07_ budget_outturnsv3r3	
	FY2007/08 budget	MOF database \Estimates _07_08	
MOHSW – government funds	FY2005/06 budget	Estimates book FY2005/06 (Approved by National Assembly)	
	FY2005/06 actual, FY2007/08 budget and actual	MOHSW Appropriation Accounts FY2006/07	
	FY2007/08 budget	MOF database \Estimates _07_08	
MOHSW – donor basket fund	FY2006/07 budget and actual	MOHSW document: Agenda 4 Joint Disbursement Systems spreadsheet for Qtr ending 30-06-07	
Regions – government funds	FY2005/06 budget	Sum of entries in	
	FY2005/06 actual		
Local Government Authorities – government funds			
LGA – donor basket fund			
MOHSW – local			
MOHSW – foreign			
PMO-RALG – local			
PMO-RALG – foreign			
Regions - local			
Regions – foreign			
LGAs – local			

Specific notes, queries and assumptions made

Annex D Additional tables and figures

Box 2 Strategic objectives in the FY2007/08 MOHSW budget

52A	To improve services and reduce HIV/AIDS infections
52B	Equitable and gender sensitive health and social welfare service ensured women of reproductive age and elderly
52C	Quality essential health and social welfare services provided
52D	Burden of disease reduced
52E	Research, training and continuous professional development for improved performance enhanced
52F	Institutional capacity and organisation of the Ministry to implement its core functions improved
52G	Policies, legislations, regulations and guidelines for efficient and effective service delivery improved
52H	An efficient and effective governance system for the delivery of services in place
52I	Financing gap reduced
52J	To create a conducive and gender responsive environment for efficient and effective delivery of supportive services

Table 9-1 Budget performance, FY2005/06

Sub-vote	Estimates	Actual expenditure (b)	b/a
1001 Administration and General	2,760,850,100	2,090,105,515	76%
1002 Finance and Accounts	661,409,200	654,106,629	99%
1002 Policy and Planning	1,420,226,600	378,044,500	27%
2001 Curative Services	99,519,488,300	91,168,006,242	92%
2002 Chief Govt Chemist Laboratory	1,512,410,200		
2003 Chief Medical Officer	784,834,500	516,901,188	66%
3001 Preventive Services	63,397,611,700	44,736,415,319	71%
4001 Tanzania Food and Drug Administration	1,014,056,200	652,846,821	64%
4002 Social Welfare		719,668,203	
5001 Human Resource Development	9,234,967,100	6,238,307,210	68%
Overall MOHSW recurrent	**180,305,853,900**	**147,154,401,627**	**82%**

Source: Original estimates as approved by National Assembly and used in PER update FY06 ; Actual expenditure from MOF database \Budget outturns 05-Estimate 06-voll2and4

Table 9-2 Budget performance of individual projects, MOHSW FY2006/07

			Vol IV		MOF database					
Subvote	Project Code		DPs	Estimates	Approved estimates (a)	Funds allocated (b)	Actual expd ©	b/a	c/b	c/a
1003 Policy and Planning	PT	5416	GOT	260,005,000	260,005,000	260,005,000	25,024,000	100%	10%	10%
	PG	5416	BF, Danida	7,202,462,000	633,962,000	633,962,000	52,112,000	100%	8%	8%
	PG	5486	BF	650,000,000	6,674,878,100	6,574,878,100	6,524,862,117	99%	99%	98%
2001 Curative Services	PL	5409	ADB	7,000,000,000	176,170,278	-	-	0%	0%	0%
	PT	5409	GOT	1,450,000,000	1,450,000,000	950,000,000	950,000,000	66%	100%	66%
	PG	5411	BF	3,205,888,000	7,525,209,900	7,525,159,900	347,246,819	100%	5%	5%
	PT	5411	GOT	4,519,800,000	4,519,800,000	4,019,800,000	1,950,000,000	89%	49%	43%
	PG	5412	BF	420,000,000	420,000,000	420,000,000	330,000,000	100%	79%	79%
	PG	5487	BF	728,000,000	728,000,000	728,000,000	366,494,612	100%	50%	50%
	PG	5494	BF	600,000,000	600,000,000	600,000,000	262,901,483	100%	44%	44%
3001 Preventive services	PG	2208	BF	360,000,000	360,000,000	360,000,000	211,580,898	100%	59%	59%
	PT	2208	GOT	50,000,000	50,000,000	50,000,000	50,000,000	100%	100%	100%
	PG	5406	Mixed	10,541,170,900	11,033,414,300	11,033,414,300	8,096,340,284	100%	73%	73%
	PG	5485	BF	6,306,536,000	6,705,588,000	5,856,205,085	3,263,748,955	87%	56%	49%
	PG	5492	Mixed	41,241,143,800	48,637,217,322	48,637,092,508	48,631,295,708	100%	100%	100%
	PG	5496	BF	419,178,700	419,178,700	384,157,133	165,262,547	92%	43%	39%
4001 TFDA	PG	5493	BF	460,000,000	460,000,000	440,000,000	341,676,709	96%	78%	74%
	PT	5493	GOT	540,000,000	540,000,000	540,000,000	500,000,000	100%	93%	93%
4002 Social Welfare	PG	5451	BF	1,000,000,000	1,000,000,000	704,000,000	-	70%	0%	0%
	PT	5451	GOT	303,200,000	303,200,000	303,200,000	250,000,000	100%	82%	82%
5001 Human Resource Dev	PG	2204	BF	3,601,190,300	3,801,190,300	3,798,690,300	858,015,071	100%	23%	23%
Total MOHSW Development				**90,858,574,700**	**96,297,813,900**	**93,818,564,326**	**73,176,561,204**	**97%**	**78%**	**76%**

Table 9-2 shows the variation in performance between the different projects in the Vote 52 Development budget. It also shows the difference between the original Estimates as passed by the National Assembly, and those which are reflected in the final accounts in the MOF database. The two largest projects, Control of Communicable Diseases and support to the HIV/AIDS Control Programme are funded both through the Basket Fund and other partners, and it has not been possible to separate these two sources.

Table 9-3 Council FY2006/07 CCHP budgets, by source (TSh m)

Council	Block grant	Basket	Receipt in-kind	Cost-sharing	Other	CCHP total
Biharamulo DC	318	258		45	563	1,184
Kibondo DC	1,119	266		69	268	1,722
Kyela DC	901	116	99	46	197	1,360
Mwanza CC	1,502	297		76	549	2,424
Pangani DC	670	55	52	41	22	840
Ruangwa DC	540	91	81	23	10	744
Same DC	1,230	145	675	97	287	2,434
Songea TC	521	93	36	23	701	1,374
Tabora TC	774	116	60		8	958
Temeke MC	3,144	447	353	385	371	4,700

Annex E Selection of councils for inclusion in LGA desk review

Time and financial constraints precluded a statistical and nationally representative exercise, and it was agreed that identification of a few councils for a case study should be based on the analysis undertaken by the MOHSW of the draft Council Comprehensive Health Plans for FY2007/08 and the Financial reports for the 3rd quarter of FY2006/07, as reported in MOHSW (2007)[14]. This analysis ranks the councils according to the combined scores received in the analysis of the two documents.

It was agreed that the sample would cover four of the best performing councils, four of the worst, and four from the middle of the range. The selection excluded new districts on the grounds that they had no financial report for FY2006/07 and the ranking was therefore incomplete. In addition, the best performing urban council was identified, as the highest ranked councils in the MOHSW analysis were all rural. Temeke MC was also included in the sample.

Following an initial shortlist, the poverty status of the selected councils was also reviewed, to determine whether a sufficient range was covered. This was felt to be acceptable. The selected councils and their scores etc are shown in Table 9-4 below.

Table 9-4 Selection of councils for tracking study

	Region	Council	Score	U/D	Poverty
Well-performing	Dodoma	Kondoa DC	75.8	D	0.36
	Kilimanjaro	Same DC	74.3	D	0.32
	Coast	Mafia DC	74.3	D	0.48
	Ruvuma	Songea MC	72.8	U	0.29
Median	Dar es Salaam	Temeke MC	70.5	U	0.18
	Mbeya	Kyela DC	67.5	D	0.23
	Lindi	Ruangwa DC	67.5	D	0.57
	Kigoma	Kibondo DC	67.5	D	0.39
Poorly-performing	Kagera	Biharamulo DC	57.0	D	0.29
	Tanga	Pangani DC	56.0	D	0.38
	Tabora	Tabora MC	55.5	U	0.17
	Mwanza	Mwanza CC	55.5	U	0.46

Note: Poverty data taken from the 2004 MOH Resource Allocation formula spreadsheet, and assumed to reflect Household Budget Survey data.

[14] MOHSW (2007). Detailed statistical analysis of evaluation report both 132 CCHP 2007/08 and 121 financial progress reports Jan-March 2007. Annex 6 to the report by MOHSW/PMO-RALG (2007). *Agenda 6 & 7 report on evaluation of Comprehensive Council Health Plans (CCHPs) 2007/08 from 132 and Third quarter financial progress reports (January – March 2007) from 121 councils*. 14 July 2007

Annex F Draft instrument for LGA field tracking study

"Undertake a detailed analysis of health income and expenditure at the council level which should provide a good overview on financial flows and how the resources are being allocated in the assessed councils."

Step 1: Select districts, agree on programme for visits, and develop instruments for district assessment (using secondary data if possible)

Step 2: Pre-test instruments, in or close to Dar es Salaam

Step 3: Desk review of existing secondary data on these districts (CCHP, 4th quarter technical and financial reports, data from logintanzania.net)

Step 4: Communicate queries and gaps to council directors of health in advance of travel, together with proposed date of visits

Scope of review: 2006/07 and 2007/08

Instruments:
1. Guide for discussion with District officials
2. Format for capturing data from the council records (both in advance, and during the field visit)

Guide for discussion with key informant: preferably the District Medical Officer.

Note: It may be necessary to meet also with the District Treasurer for confirmation, and possibly even the District Executive Director. It will be clearer after the pre-test. Without knowing in advance the precise process of accessing funds – whether they flow automatically (which I think is the case for both block grant and basket) or whether they need to be requested,

1. Following approval of the CCHP and the overall government budget, please describe the process for obtaining funds from
a) the block grant; and
b) the basket fund?
<<if we can get this established in advance, we probably don't need it>>

2. If this is done by written request, please provide details of each request made for each source of funds - the amounts and the dates on which funds were requested

If funds were released automatically from Treasury/MOHSW/PMO-RALG *(and we need to be clear which it was for Basket funds last year)*, please provide details (dates and amounts) of all deposits into Account no 6 (for OC and basket funds) and into the Miscellaneous holding account for health sector PEs (ie for sub-votes 5010, 5011, 5012, and 5013). *<<Are we likely to be able to get this directly from cash books or bank statements?>>*

All steps from any initial request for funds to the final issue of a cheque by DMO should be detailed (ie dates and amounts, so that we can identify and quantify delays in the system)

Proposed format – to be finalized after clarification on the precise process

Source of funds	**Budgeted amount**	**Date and amount of request**	**Date and amount received in Account**	**Date of first expenditure by CHMT**
Block grant Q1 OC				
Block grant Q2 OC				
Block grant Q3 OC				
Block grant Q4 OC				
Total block grant OC		*<<total requested in total, if applicable>>*	*<<Total received>>*	*<<Total reported spending from this source>>*
Basket fund Q1				
Etc etc				

Did you experience any delays in the receipt of funds during FY2006/07? (Please indicate specific instances.)

What was the cause of these delays? *(propose no prompting, but examples might include late release, failure to provide complete or timely accounts etc) – need justification for the response*

What was the impact of the delays?

What about the process for other key sources of funding to the council, eg project support from development partners or NGOs, cost-sharing revenues? *How detailed do we want this? Can use similar formats – eg agreed annual budget, date of request, date of receipt, date of expenditure, reasons for delays etc*

Cost-sharing *<<if we go into this>>*

Need to separate out the different components of cost-sharing – CHF, Health Service Fund, National Health Insurance, Drug Revolving Fund – check how reported in CCHP and Q4 FR and try to get details of expenditure.