Ministry of Health and Social Welfare

Health Sector PER Update 2008

Prepared by;
Directorate of Policy and Planning
Ministry of Heath and Social Welfare
Dar es Salaam

30th September 2009

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

The Health Sector PER update for 2008 was undertaken by a three person team comprising Dr Flora Kessy of the Ifakara Health Institute (IHI), Dar es Salaam, Mr Prosper Charle, an Economic Development Consultant, and Mr Benson Obonyo an International Economic Development Consultant from Nairobi Kenya. The team was supported by Ms Mariam Ally and Mr Richard Mkumbo from the Department of Policy and Planning in the Ministry of Health and Social Welfare (MoHSW). Financial support was provided by the Swiss Agency for Development and Cooperation (SDC), the World Health Organisation (WHO) and Ministry of Health and Social Welfare (MoHSW).

Thanks are due to the various officials of the MoHSW who contributed data for this exercise, and also to colleagues in the Ministry of Finance and Economic Affairs (MoFEA), and the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG).

Thanks also go to Mr Charles Kibaja (MoFEA) for providing all requisite budget and expenditure data, Mr Maximillian Mapunda (WHO) for providing clarity on financial data from several sources, Dr Jamie Boex (consultant assisting PMO-RALG with the maintenance of the LOGIN website) for providing useful information on the current status of the LOGIN website, and Dr Dominic Haazen (World Bank), Ms Rose Aiko (SDC) and PER Technical Working Group for providing constructive comments on the first draft of this PER.

Errors in interpretations or calculations remain those of the authors.

LIST OF ACRONYMS

ARV	Anti-Retro Viral
BEmOC	Basic Emergency Obstetric Care
CC	City Council
CCHP	Comprehensive Council Health Plan
CFS	Consolidated Fund Services
CHF	Community Health Fund
CHSB	Council Health Services Board
CHMT	Council Health Management Team
DC	District Council
DDH	District Designated Hospital
DPs	Development Partners
DPP	Department of Policy and Planning
DRF	Drug Revolving Fund
EmOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
ESRF	Economic and Social Research Foundation
FANC	Focused Antenatal Care
FY	Financial Year
GBS	General Budget Support
GFS	Government Finance Statistics
GoT	Government of Tanzania
HR	Human Resource
HRD	Human Resource Development
HRH	Human Resource for Health
HSF	Health Service Fund
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses (IMCI),
LGA	Local Government Authority
LOGIN	Local Government Information
MC	Municipal Council
MDGs	Millennium Development Goals
MKUKUTA	*Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania* [National Strategy for Growth and Reduction of Poverty]
MMAM	*Mpango wa Maendeleo wa Afya ya Msingi* [Primary Health Services Development Program]
MNCH	Maternal, Newborn and Child Health
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NHIF	National Health Insurance Fund
OC	Other Charges

PAC	Post Abortion Care
PAF	Performance Assessment Framework
PE	Personal Emoluments
PER	Public Expenditure Review
PLWA	People Living with HIV and AIDS
PMO-RALG	Prime Minister's Office - Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
PRS	Poverty Reduction Strategy
RHMT	Regional Health Management Team
TASAF	Tanzania Social Action Fund
TB	Tuberculosis
TC	Town Council
TFDA	Tanzania Food and Drugs Authority
TFIR	Technical and Financial Implementation Report
ToR	Terms of Reference
TZS	Tanzania Shillings
WHO	World Health Organisation

EXECUTIVE SUMMARY

(i) Objectives

The 2008 Health Sector Public Expenditure Review (PER) set out to analyse allocation and use of resources in the health sector, with particular focus on the following key areas:

- A review of the previous Health Sector PER FY07 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions for FY08;
- Analysis of recurrent and development budget performance for the past three years;
- Analysis of expenditure trends at sectoral and sub-sectoral levels including the central-local government split;
- Analysis of the core/priority areas/items of expenditure as highlighted in the HSSP II and the National Strategy for Growth and Reduction of Poverty (NSGRP)/(MKUKUTA;
- Analysis of the contribution of cost sharing funds in health financing and in enhancing equity and efficiency in health care financing; and
- Analysis of health income and expenditure at the Council level to provide a good overview on financial flows and how the resources are being allocated in the assessed Councils.

In addition, this year's PER conducted an analysis of Reproductive and Child Health (RCH) and Human Resource for Health (HRH) spending. In this respect, in addition to the standard PER format, this year's review has attempted a review of the composition and trends in spending on RCH and HRH as key areas for achieving the targets of the Health Sector Strategic Plan III, and health related MKUKUTA objectives.

(ii) The 2008 PER Highlights

Allocations and expenditures in health have increased, but the share of health in government budget remains below 15% recommended in Abuja Declaration.

The review has shown an upward trend of expenditures and allocation of available resources, which is a reflection of the commitment by the government and development partners to increase health spending and to ensure the expenditures are allocated to support the primary health care approach to health sector development. The review indicates that the allocation of budget resources for health grew by 18% in 2007/08 and by 19% in 2008/09. Also, actual health expenditure grew by 41% in 2005/06, then by 20% in 2006/07 and by 12% in 2007/08. The budget allocations are lower than the HSSP III predicted annual growth rates of 24% on on-budget allocations on account of parallel increases in recurrent and development budget

allocations of 21% and 31% respectively. Also, the findings of this review indicate that although health budget has increased, its share in total government budget has not improved much because the allocations for health have increased at a slower pace than the 20% average increase in total government budget. Foreign funding for health (both basket and non-basket) has grown at an average annual rate of 36%. In total, however, the share of health sector budget in the total government budget has averaged around 11% over the review period, which is well below the 15% recommended in the Abuja Declaration.

Composition of financing sources for the health sector has remained unchanged, though the share of foreign financing has increased during the review period.

The expenditures from the main sources of public spending: government, donors, and user fees have increased over the years, and despite the government remaining the largest source of public spending, external resources by bilateral and multilateral agencies have become significant, accounting for up to 37% of the total expenditures. User fee revenues have also increased reaching well over US$5 million in 2007/08, and despite being small compared with government and donor contributions, user fees constitute an important source of expenditures in the facilities where it is collected and spent. In total, the off-budget financing component (mainly in form of Health Services Fund—HSF) accounts for an average of about 1% of the entire health sector financing.

Per capita health spending is still low, and falls significantly short of WHO recommended target of US$ 34 to address health challenges, and is well below the HSSP III projections of US$ 15.75 per capita spending by 2009/10.

Per capita health spending is still low, at an average of about TZS 14,215 in nominal terms, while in real terms (2001 constant prices), is still below TZS 10,000. In Dollar terms, the average per capita health spending is about US$ 11.29 in 20078/08 and grew to 13.46 in year 2008/09, with health sector claiming about 10 -11% of the government budget, reaching the WHO's estimated per capita spending of US$34 in order to adequately address health challenges, remains an uphill task. Also, the level of spending is still far short of HSSP III projection of achieving US$15.75 per capita spending by 2009/10.

Budget performance has been satisfactory; but difficulties related to procurement and procedures for works and contract management continue to affect the performance of development budget.

Generally, budget performance has been good, with actual total expenditures reaching 99% of the approved estimates in 2006/07, but declining to 93% of the estimates for 2007/08. Budget performance was much lower in 2007/08 compared to 2006/07, with recurrent budget performance declining from 98.5% in 2006/07 to 91.2 in 2007/08, while development budget performance slipped down to 95.4% in 2007/08 from 99.7% in 2006/07. While issues related to failure to release funds for budget execution, late disbursement of the funds, and reallocation of the funds to other

activities were the major reasons for failure to fully execute the recurrent budget , the major reason for failure to fully execute the development budget is cumbersome procurement procedures (delays in tendering and awarding processes), and failure to get funding from other sources which the disbursement is beyond the capacity of the Ministry of Health and Social Welfare (MoHSW).

The share of development health spending has increased throughout the review period

The share of recurrent expenditure in total health expenditure declined from about 80% of actual expenditure in 2004/05 to 55% of the estimates in 2008/09. At the same time, the share of development expenditure has increased from about 19% of the actual expenditure in 2004/05 to about 36% of the actual expenditure in 2007/08 and about 45% of the estimates in 2008/09. These trends in recurrent and development budget indicate a significant boom in financing for development projects in the health sector, largely by the Development Partners.

Shares of resources managed centrally (by MoHSW) and locally (by LGAs) have changed just modestly, indicating a slow pace in decentralization of health sector financing

In FY2005/06, about 61% of total health spending was centrally managed (by MoHSW), while 39% of health expenditures were managed locally. The situation improved even further in FY 2007/08, with the share of actual health spending managed centrally (by MoHSW) declining to 58%, while the share managed locally increased to about 42% of the total actual health spending. So far, the share of health sector financing managed centrally over the period 2004/05-2008/09 has averaged around 60%, with the Councils and Regions managing just about 40% of the resources. However, this separation does not take into account expenditures by the MoHSW on drugs and supplies which eventually go to the LGAs. Also, if it is assumed that the health related financing that is channeled through PMO-RALG eventually go down to the Local Government Authorities, then the share of locally managed resources could increase.

Expenditure on human resources has increased, but still remains too low to meet the human resource needs as identified in the Human Resource for Health Strategic Plan.

The review findings indicate increase in the overall spending on personnel, including training, and that, much of the spending on human resources are recurrent expenditures. But despite such increases in recurrent expenditure, the overall expenditure for HR Development still remains very low, and the HRH resources gap based on the HSSP-III costing figures still remains wide. The findings of this review indicate that, if HR needs as identified in the HR Strategic Plan are to be met, about 20% of the MoHSW budget should be allocated to HR Development. However, only 6% of the MoHSW budget has been allocated to HR development in 2008/09 which is

approximately 31% of total resource requirements for human resource development in 2008/09.

Complementary health financing is becoming increasingly important in health sector financing, but there is significant amount of unused funds both at the National Health Insurance Fund (NHIF), and Health Services Fund (HSF).

Total receipts for HSF almost doubled between 2006/07 and 2007/08, and about 89% of the receipts were used for health service delivery in 2007/08. NHIF contributions have also grown significantly from TZS 45.5 billion in 2006/07 to TZS 55.5 billion in 2007/08. Despite such increase, significant amount of resources are unused both at the NHIF and HSF. This review has found that less than 15% of NHIF annual income is utilized by health facilities. Also, although cost sharing collections are perceived to be insignificant, the LGA sub-study has found that cost sharing funds exceed Other Charges (OC) allocations in some specific LGAs. But, in total, HSF was approximately 2% of OC allocations to the LGAs in 2006/07, and increased to about 4% of the OC allocations to the LGAs in 2007/08.

Despite the difficulties in disaggregating Reproductive and Child Health (RCH) budget and expenditure data, a quick analysis of the existing information reveals that allocations for RCH are still far below the HSSP-III projections.

While complete data required for analysis of budget and expenditure on RCH was not available, limited information was obtained from the MoHSW Annual Performance Report for 2007/08. The data showed expenditures related to RCH on reducing maternal mortality and infant and child mortality, nutrition and prevention of stunting, wasting and underweight in children. Actual expenditure on these areas of RCH claimed a share of about 7% in the total actual expenditure for the MoHSW. Because this item was not covered in the previous reviews, it is not possible to make comparisons with previous years. Further, since the budget and expenditure for RCH services are linked to other health interventions it becomes difficult to separate expenditures specifically linked to RCH.

Release of funds for health sector activities to the Local Government Authorities is satisfactory, but LGAs control very little portion of resources going to the health sector.

Information from the sampled 12 Councils indicates that releases of finances (OC and basket funds) are satisfactory, with some receiving 100% of funds with little or no delays. However, the share of resources controlled by the LGAs for health sector activities is very small compared to the share controlled centrally. Also, the major sources of financing for Council health activities still remain block grant and basket fund, but some of the Councils have huge off-budget financing, which is not captured centrally.

(iii) Limitations

Due to data limitations, it was not possible to address all of the objectives spelt out in the Terms of Reference as outlined above. For instance, the study team could not undertake an analysis of the Community Health Fund (CHF) due to unavailability of information on the spending on it, yet it is an important component of the overall health financing reforms in Tanzania. The problem of incomplete information also affected the quality of analysis on expenditures of LGAs, human resource development, and Reproductive and Child Health interventions. In the case of human resources development, information available could not allow sufficient disaggregation to provide a clear picture of trends or offer a clear indication about the adequacy or not of the spending compared to resource requirements. As such the PER's findings with respect to spending on HR development cannot offer strong guidance on future budget formulation to address HR needs. Expenditure tracking on RCH suffered from the challenge of isolating RCH specific spending in the context of integration of services and interventions as well as funding flows.

Another limitation encountered was due to the late start of the PER, which meant that while it is expected to feed into the budget preparation, the two coincided with each other. This limited the quality of interaction of the PER team and staff of MoHSW and MoFEA. As a result, insights and qualitative information available with the relevant officers are lacking.

(iv) Recommendations

Drawing on the findings and limitations above, our recommendations are in two main areas: improving expenditure management and management of PER.

Expenditure Management

1. Capturing of off-funding spending;
    a. The MoHSW should strive to make sure that information on CHF collection and expenditures is made available for future PER analyses.
    b. The Department of Policy and Planning with collaboration with MoFEA should devise a system of capturing off-budget funds from the external finance database.
    c. Conducting a trend analysis of the off-budget finances (Council Own Fund, Other Sources of Fund and CHF) at the LGA level is important in the determination of resource envelope for the sector.

2. In order to improve NHIF claiming and reimbursement procedure, the recommendations as presented in URT (2009) should be implemented. In particular, the following recommendations have to be implemented in the short run.

a. DMO and RMO's should facilitate the preparation and implementation of a roll out plan of the training to lower lever facilities in order to improve claiming systems and financial management.
b. All health Facility Governing Committees in all Government health facilities should be activated and empowered for the purpose of their effective participation in financial planning and supervision in their respective areas.
c. Accountants at the District Council/DMO should prepare breakdowns of income and expenditure of all facilities and this report should be availed to Council, Regional and National level authorities.
d. Breakdowns of income and expenditure of all health facilities should be regularly provided to each health facility by the DMO in order to enable them to make facility level plans and to utilise their funds.
e. The MoHSW should consider providing additional support for the Councils which did not make a provision in their budget.

3. In order to improve the performance of the development budget, there is a need to initiate a national discussion on public procurement system in order to tease out measures to simply procurement procedure is imperative.

4. Since integration of services is accepted as a policy direction for the sector, attempts are needed to isolate and report spending on selected programs of special interest e.g. RCH, and human resource development. This could be strengthened by undertaking rigorous monitoring and measurement of performance so that results and outputs of the interventions can be used to gauge the effectiveness of spending.

5. In order to review the costing figures in the HRD Strategic Plan, a thorough national study to examine expenditures on HRD by central, LGAs and private institutions ought to be commissioned by MoHSW.

6. In order to establish trends over time for the sources of funds and in particular other sources of funds (DRF, CHF, NHIF, and user fees etc), we propose a resource tracking study that will not only look on one year data but establish a trend over time. The study could be organised in two parts: a desk review of CCHPs, TFIRs, and www.logintanzania.net to obtain a picture of budgets and reported spending on the one hand, and field study to get more detail, and also to verify some of the reports.

7. The next public expenditure reviews should include a thorough analysis of the expenditures by MoHSW on drugs and other supplies going down to the local level (both at LGA and Regional level). This will give a much clearer picture of the resources that go to the local level.

8. Financing from other sources to the LGAs should be part and parcel of health sector public expenditure review. The LGA sub-study carried out in this review has found this category of financing to be quite significant in some LGAs, for instance, in Biharamulo District Council, it accounted for about 40% of financing.

9. In the face of low reimbursements by the National Health Insurance Fund (NHIF), measures should be taken to expedite 'training for claiming', which has already started. But also, there should be concerted efforts to minimize delays in re-imbursements.

10. Cumbersome procedures have been found to contribute significantly to the low rates of reimbursements at NHIF. Efforts should be made to make the procedures amicable in order to increase the rate of reimbursement.

11. Status of complementary financing should be known clearly in every facility. This should be part of integrated planning, which will clearly indicate resources from all sources. This has to appear in the Comprehensive Council Health Plan in all districts. This will be an essential component for the transparency of the budget.

12. Decentralization should be expedited to allow the LGAs use the resources effectively. With the current procedures, even if more resources were to be sent to the LGAs, there would still be 'left-overs' because procurement rules prohibit them from using the resources.

Management of PER

1. Timing of PER process needs to be fixed and observed to feed into, rather than conflict with budget preparation.

2. Where preparatory studies are necessary, it would help if they are identified and conducted early enough and their findings endorsed by all stakeholders, including the MoFEA before adoption for PER purposes. Including several sub-studies under PER has proved to be challenging due to different data requirements.

3. Data gaps have persisted largely because of weaknesses in record keeping, particularly at the local levels. Therefore, measures should be taken to improve record keeping at all levels in order to better inform decision making.

1.0 INTRODUCTION

In recent years, governments of the developing countries have taken policy decisions to move away from the traditional focus on input-oriented budgeting – i.e. managing inputs such as staff and supplies to increased emphasis on how budget allocations can help achieve/promote national goals. The strategic approach to expenditure planning has been supported by the adoption of Poverty Reduction Strategy (PRS), which defines the government's overall poverty reduction objectives. This approach has been reinforced by the adoption of Medium Term Expenditure Framework (MTEF) as a means to foster a closer link between spending and policy objectives, and to anchor public expenditures on a sound macroeconomic framework of the country.

In Tanzania, the National Strategy for Growth and Reduction of Poverty (MKUKUTA) is the government's blueprint for poverty reduction and economic growh and provides the framework for planning and spending priorities in all sectors. Health features as one of the pillars for realising growth and poverty reduction, with the priorities pursued by health sector aimed at promoting the attainment of improved livelihoods. The Health Sector Strategic Plan (HSSP III) for the period 2009–2015 adopts a health systems approach to improve the performance of the health sector by focusing on priorities related to: infrastructure expansion and improvement; strengthening referral services; increasing the number and quality of human resources; improving management capacity at Council level, and increasing and broadening mechanisms of health financing. These interventions are expected to reverse the poor health status indicators, contribute towards poverty reduction and attainment of growth objectives of the country and the realization of the Millennium Development Goals (MDGs). Thus, they provide the framework for planning, budgeting and allocation of resources in the health sector.

The need to achieve country specific targets for poverty reduction and development, and MDG related ones has created pressure to generate more resources and to ensure efficient use of scarce national resources. For the health sector, the range of financing mechanisms have increased and alternative systems including Community Health Fund (CHF), National Health Insurance Fund (NHIF) and cost sharing arrangements have been established. All these aim to provide additional discretionary funding at local levels to facilitate quality service delivery. In addition, the government in partnership with donors has improved the coordination of external resource flows to enhance the predictability and utilization of these resources.

In addition, to ensure value for money, and as a result of the policy taken to shift in spending towards output-oriented rather than input approach to budgeting, the government of Tanzania has adopted a performance-based budgeting emphasising target setting. This has been followed by annual assessment of performance against the targets and outputs identified at the planning and budgeting stages. In parallel to this, a budget classification –Government Finance Statistics (GFS) that allows easy analysis spending has been introduced by the Treasury to promote transparency of public expenditures.

Public Expenditure Review (PER) forms one of the tools for linking country economic and sector work, and analysing sector performance in the context of the overall economic and the broad country agenda. PER addresses itself to the issue of optimal allocation of public expenditures by answering the question: are the limited government resources allocated to areas that maximise economic growth and contribute to poverty reduction? In addressing this question, the health sector PER 2008 provides the following:

- A review of PER FY07 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions for FY08;
- Analysis of recurrent and development budget performance for the past three years;
- Analysis of expenditure trends at sectoral and sub-sectoral levels including the central-local government split;
- Analysis of the core/priority areas/items of expenditure as highlighted in the HSSP II and the National Strategy for Growth and Reduction of Poverty (NSGRP)/(MKUKUTA;
- Analysis of the contribution of cost sharing funds in health financing and in enhancing equity and efficiency in health care financing; and
- Analysis of health income and expenditure at the Council level to provide a good overview on financial flows and how the resources are being allocated in the assessed Councils.

In addition to adopting the standard PER format, this year's PER has chosen as its theme in-depth analysis of Reproductive and Child Health (RCH) and Human Resource for Health (HRH) spending. See Annex A for the Terms of Reference (ToRs).

After presentation of the introduction in section 1, section 2 presents a review of PER FY07 recommendations, actions taken, pending actions and the reasons. Section 3 summarises recent trends in overall public health spending, in relation to the overall Government of Tanzania (GoT) budget. Trends in the total public health budget and expenditures, and various sub-sectoral trends are reviewed, with a more detailed analysis of particular recurrent expenditure items and of the development budget.

Analysis of the contribution of complementary financing in enhancing equity and efficiency in health care financing is presented in Section 4. Section 5 provides a review of the composition and trends in spending on RCH and HRH and Section 6 gives an overview of financial flows and how the resources are being allocated in the assessed twelve Councils. Section 7 discusses the results and provides recommendations for the way forward.

2.0 REVIEW OF PER FY07 RECOMMENDATIONS AND ACTIONS TAKEN

The main recommendations of the PER FY07, together with actions planned and/or taken during FY08, are presented in Table 1 below.

Table 1: Summary of Actions Taken on PER FY07 Recommendations

Recommendation	Action Taken
1. Lobby Ministry of Finance and Economic Affairs (MoFEA) for earlier and consistent data on total government expenditure at the end of the financial year; and seek agreement between Government (GoT) and Development Partners (DPs) on which is the definitive version of such data	The discussion was done and agreed that the source of total GoT spending should be the consolidated public expenditure books (including) the reallocations as published by MoFEA.
2. 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)	Agreed to use approved estimates as passed by the Parliament with explanations whenever deviation occur.
3. Update the analysis of the sector share of actual expenditures, and lobby for a greater share of the budget in future years.	PER 08 has updated the sector shares (based on actual figures); The Government recognizes the importance of channelling more funds to the health sector. For instance, in the 2009/10 budget the sector ranked the third priority sector after education and infrastructure.
4. Further work to analyse all on-budget spending according to beneficiary level	This PER has done part of the analysis by levels e.g. Central, Regional and District. It further analysed the allocation within a sample of Councils. Nevertheless, a detailed beneficiary level analysis is a tracking exercise that the Ministry of Health and Social Welfare (MoHSW) needs to consider as a separate study in the future.
5. Include specific targets for budget and spending by level of the health system in the new Health Sector Strategic Plan (HSSP III) to enable annual monitoring towards those targets.	In HSSP III, three health financing indicators have been defined: 1) Proportion of national budget spent on health; 2). Total Government and Donor (Budget and Off-budget) allocation to health per capita; 3) Proportion of population enrolled in CHF/TIKA.[1] In PER FY08 information is presented on proportion of national budget spent on health. Further, per capital health spending has been calculated both at the central and local levels.

[1] TIKA is an abbreviation for a Swahili phrase "*Tiba kwa Kadi*"

Recommendation	Action Taken
6. Monitor quarterly spending against objectives, and should provide written justification of deviations	This is not feasible under the current arrangement since the implementation of the health sector budget is under different authorities. However, MoHSW reports to MoFEA quarterly, semi-annually, and annually. The reports indicate spending by MKUKUTA, Performance Assessment Framework (PAF), and Ruling Party Manifesto.
7. Incorporate and expand the analysis of spending against MKUKUTA objectives in future PER updates.	This has been done in the PER 08 based on the available MoHSW Annual Report.
8. 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 PER FY07; • Review off-budget external finance for consistency with policy goals (as last year)	This is not a mandate of MoHSW; however, a discussion is underway between MoHSW and MoFEA to address these issues.
9. Compare findings of National Health Accounts (NHA) exercise with estimates of external funding from the relevant PER update	The two are not comparable. This is because NHA includes the off budget from the donor survey and out of pocket expenditure from the households while PER captures only on budget and limited data on off-budget spending.
10. Continue to improve capture of external funding within MTEF	This is done continuously. For instance, Global Fund is now captured in the MTEF.
11. Clarify the position with Health Service Fund (HSF) data for FY2006/07 in order to update the table in Annex B of PER FY07.	The table has been updated using data from the 2005/06 and 2006/07 Appropriation Accounts.
12. Provide consolidated picture of Community Health Fund (CHF) membership, income (separating membership premia and user fee revenues), and expenditure on an annual basis	This has not been done because there is no updated information from the MoHSW.
13. Require National Health Insurance Fund (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)	NHIF reports are produced annually. Further, NHIF produces disaggregated information of claims by geographical basis and the level of health care.

Recommendation	Action Taken
14. 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.	A tracking study of twelve districts was done as part of PER FY2008.
15. Review the role and timing of the health sector PER update, the Task Team, and the appropriate body to serve as a Steering Group	The PER timing has been reviewed to start the round in July of each year. The composition of the Task Team has been updated. The PER technical Working Group has been revived and has been functional throughout the PER 2008 process.
16. 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.	Government officials committed their time in the PER process albeit time constraint caused by conflicting timetable between the PER and the budget processes.

3.0 TRENDS IN HEALTH SECTOR SPENDING

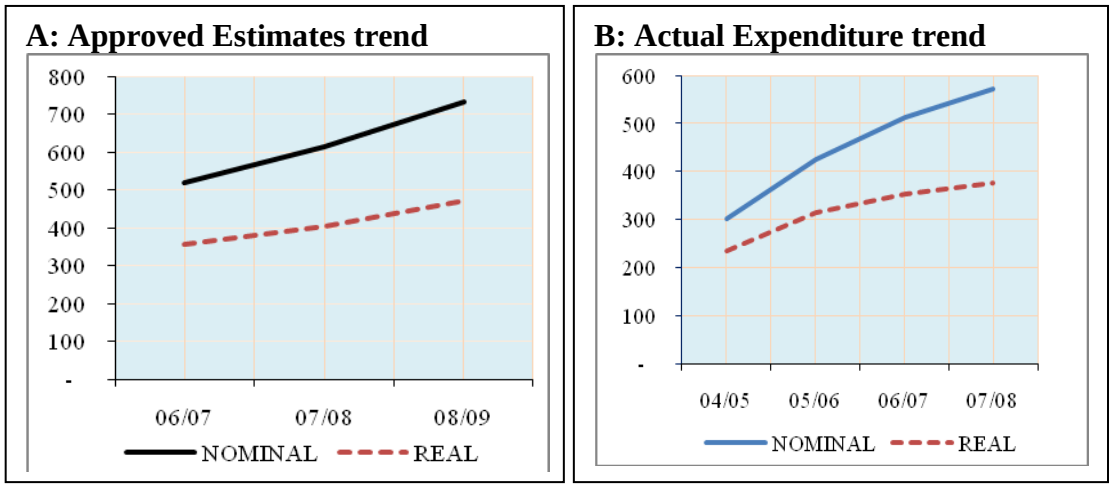
The 2008/9-2010/11 Budget Guidelines project increased expenditure in health in line with the implementation of the programs to combat Malaria, TB, Reproductive and Child Health and HIV and AIDS. The broad activities at the heart of health resource allocation according to the budget guidelines are: Prevention and treatment of malaria; Rehabilitation and rationalization of regional hospitals; Scaling up of provision of immunization services and other Reproductive and Child Health services; Scaling-up of proven non-Anti-Retro Viral (ARV) interventions, including Tuberculosis (TB) prevention and treatment of opportunistic infection in People Living with HIV and AIDS (PLWAs); Facilitating equitable, sustainable and cost effective access to ARV for all affected households with emphasis on ARV education; and Improving human resource capacity at all levels in terms of quality, skills mix and quantity.

Sufficient resources are needed to implement the identified interventional areas. This Section summarises recent trends in overall public health spending, in relation to the overall government of Tanzania budget. Trends in the total public health budget and expenditures, and various sub-sectoral trends are reviewed, with a more detailed analysis of particular recurrent expenditure items and of the development budget. The analysis presented in this Section is based on the data presented in Annex B.

3.1 Trends in Total Health Sector Spending

In line with the priorities identified in the planning and budget guidelines, the review indicates that the allocation of budget resources for health grew by 18% in 2007/08 and by 19% in 2008/09. Also, actual health expenditure grew by 41% in 2005/06, then by 20% in 2006/07 and by 12% in 2007/08. The actual spending for the health sector increased from TZS.516.5 billion in 2006/07 to TZS.576.8 billion in 2007/08, with the level of spending estimated to rise to TZS.733 billion in 2008/09 (Table 3).
Figure 1 below presents the general trend of total health expenditure, and budget (both in nominal and real terms) from 2004/05 to 2008/09.

Figure 1: Trend of Nominal and Real Expenditure in Health 2004/05 – 2008/09



3.2 Health in Relation to the Total Government Budget

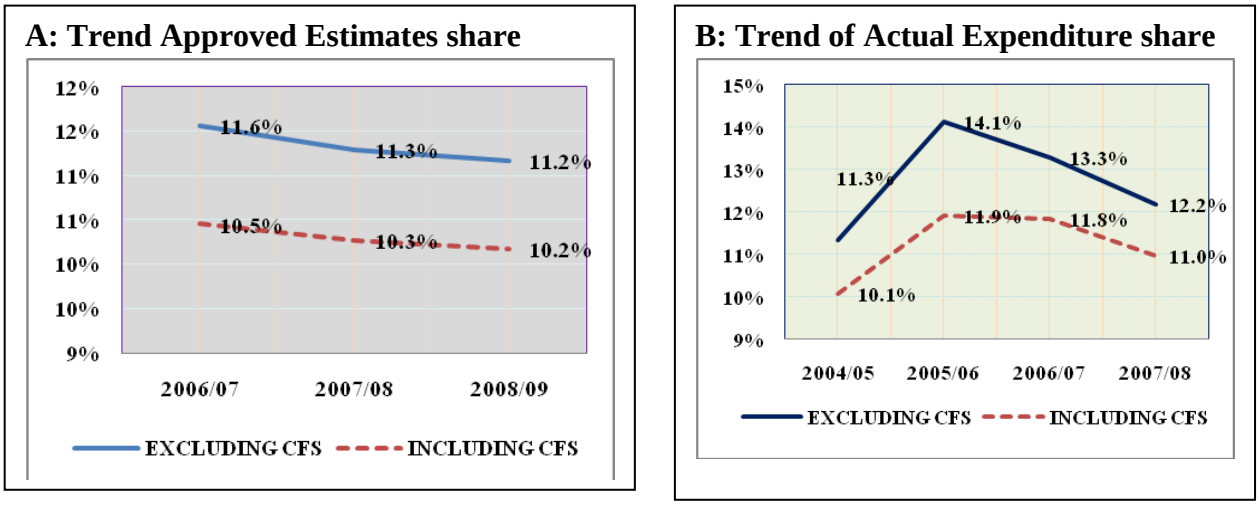
The increase in health spending observed above is taking place within an overall growth in total government expenditures to support the implementation of the National Strategy for Growth and Reduction o Poverty (NSGRP), which health is an integral part. Total government expenditures (both, including and excluding the Consolidated Fund Service – CFS) over the period 2004/05 – 2008/09 are summarized in the Table 2 below.

Table 2: Trend of Total Government Expenditure (TZS Mill)

	2004/05	2005/06	2006/07		2007/08		2008/09
	Actual expenditure	Actual Expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
TOTAL PUBLIC SPENDING EXCLUDING CFS	2,657,780	3,017,567	4,496,345	3,862,022	5,451,800	4,685,200	6,567,845
TOTAL PUBLIC SPENDING INCLUDING CFS	2,991,611	3,577,747	4,972,492	4,338,123	5,998,100	5,209,000	7,216,130
TOTAL HEALTH SPENDING	301,227	426,374	519,871	513,606	615,748	571,073	733,878
Health As % of Total Expenditure excluding CFS	11.3%	14.1%	11.6%	13.3%	11.3%	12.2%	11.2%
Health As % of Total Expenditure including CFS	10.1%	11.9%	10.5%	11.8%	10.3%	11.0%	10.2%

Figure 2 below plots total on-budget spending on health as a percentage of total government spending over the past four financial years, together with the budgeted amount for the current financial year -2008/09.

Figure 2: Share of Health Budget and Expenditure in Total Government Budget and Expenditure (2004/05 – 2008/09)



Note: CSF – Consolidated Fund Services, which is largely public debt

As Figure 2 portrays, the share of the health sector in total government budget and expenditures has remained well below the 15% target of Abuja Declaration. Allocation to the sector has been around 11% throughout the entire period of review, from 11.6% (2006/07), 11.3% (2007/08), 11.2% (2008/09). Actual health expenditure had increased from 10% of total government spending including CFS in 2004/05 to 12% in 2005/06, and this has so far been the peak for the entire review period. However, this was followed by a decline in actual health spending as a percent of total government spending to 11% in 2007/08. This decline in the share of health would happen because total government budget will increase slightly faster (20%) than the increase in budget allocations to the health sector (19%).

3.3 Trends in Overall Public Health Expenditure

3.3.1 Health Expenditure by Financing Sources

In total, the spending on health came from two broad streams: on-budget and off-budget resources comprising domestic and foreign sources. Expenditures by the government from tax revenues and the National Health Insurance Fund contributions together with general budget support and health sector basket constitute on-budget spending. On the other hand, user fees/Health Services Fund (HSF), CHF, Councils' own revenues, as well as foreign project funding form off-budget expenditure.

Table 3 below summarizes the overall health spending over the period 2004/05 – 2008/09. The Table shows increasing pattern in expenditures, with the total actual spending growing from TZS.304 billion to TZS.576 billion between 2004/05 and 2007/08 financial years. This trend reflects the growth in government and foreign funding to the sector. Off-budget funding mainly from HSF remains low as a share of the total spending. However, since the user fees collected are retained and spent at the points of collection, this revenue provides a significant source of expenditures at the health facility level.

Table 3: General Health Spending by Financing Sources (in Million TZS)

	2004/05	2005/06	2006/07		2007/08		2008/09
	Actual expenditure	Actual Expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
Government Funds	**206,554**	**296,819**	**370,991**	**348,890**	**413,258**	**378,113**	**459,496**
Foreign	**94,673**	**129,555**	**148,880**	**164,715**	**202,490**	**192,959**	**274,383**
Basket	91,777	68,299	99,911	103,204	80,956	80,956	97,629
Non Basket	2,896	61,257	48,969	61,512	121,534	112,003	176,753
Off-Budget[2]	**3,384**	**3,363**	**-**	**2,964**	**-**	**5,696**	**-**
Total	**304,612**	**429,738**	**519,871**	**516,570**	**615,748**	**576,769**	**733,878**

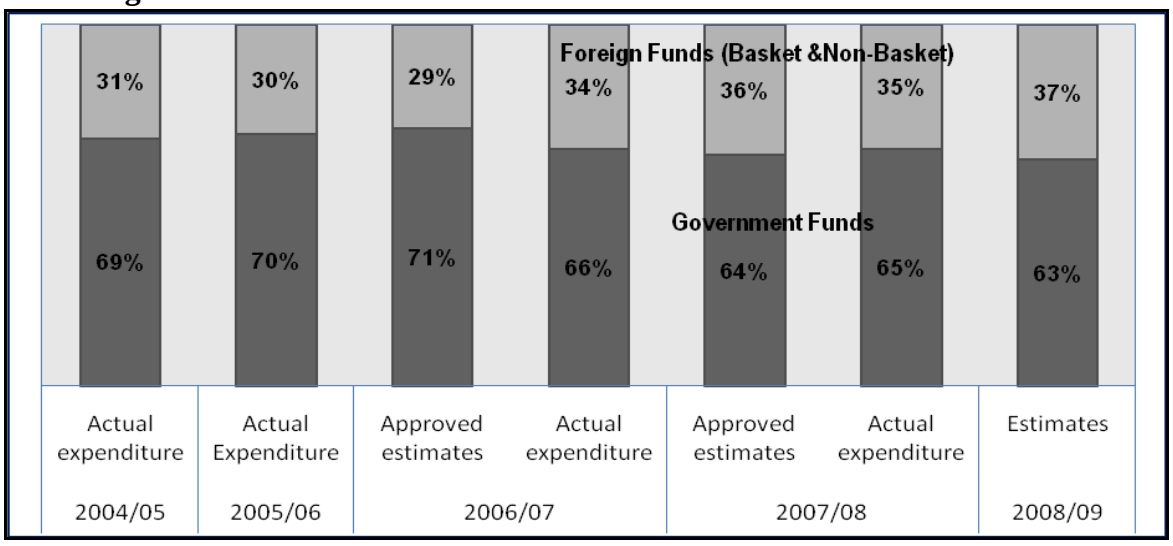
The off-budget component accounts for an average of about 1% of the overall health expenditure throughout the review period. Actual off-budget expenditure increased by

[2] The off-budget captured here is mainly the Health Services Fund (HSF)

92% from TZS 2.9 billion in 2006/07 to TZS 5.7 billion in 2007/08, but the share in total health expenditure remained the same around 1% because health expenditures by the other categories also increased. However, it is important to note that, the off-budget health financing is very much underestimated since only the Health Services Fund (HSF) has been captured. No data were available for other off-budget components, including external finance.

The review indicates that although the sector is still largely financed by government sources, the share of foreign funds (both basket and non-basket) has been increasing modestly over the past three financial years. The share of foreign funds has increased from 29% of the approved estimates for health spending in 2006/07 to 37% in 2008/09. Figure 3 shows the percentage shares of government and foreign contributions to health financing for the period 2004/05 to 2008/09 and it reveals that while the government funds remain higher, foreign funds have accounted for an average of 33% of resources between the two time periods. The increase in the share of foreign funds is due, in part, to the increase in the non-basket foreign financing, whose share in foreign health funds increased from 38% of approved foreign funds in 2006/07 to 58% of the estimates for foreign funds in 2008/09. Also, the share of basket funding in total foreign financing dropped to 42% in 2008/09 budget from 62% in 2006/07 due to the large injections of foreign non-basket support, in particular the Global Fund.

Figure 3: Shares of Government and Foreign Funds in Health Sector Financing



3.3.2 Recurrent and Development Spending

Since 2004/05, Tanzania improved the budget systems, with the extension of GFS coding to the Development Budget, thereby enabling disaggregation and analysis of the Recurrent and Capital elements of total (i.e foreign and local) on-budget spending. However, since 2007/08, the government has decided to treat all foreign assistance coming through General Budget Support (GBS) as public funds, and the funds are channelled to development projects as 'local financing for development.' Following

this decision, all recurrent expenditures are supposed to be financed by government funds. Table 4 presents a breakdown between recurrent and development expenditure since 2004/05. The analysis presented in Table 4 is based on the conventional distinction, looking at the amounts allocated and spent for recurrent and development components as recorded in the official Government Estimates, for the purpose of comparison with previous years.

Recurrent expenditure, which boasts the biggest share in government's health financing, is comprised of two main components, the Personal Emoluments (PE) and Other Charges (OC). Despite increase in allocation for personal emoluments by 30% and 16% in 2007/08 and 2008/09 respectively, the share of PE in the total health sector budget has increased slightly from around 6% in 2006/07, to about 10% in 2008/09. On the other hand, allocations for other charges increased by 5% both in 2007/08 and 2008/09, but the share of OC in the total health sector budget has declined from 58% in 2006/07 to 51% in 2007/08, and further to 45% in 2008/09.[3]

Table 4: Recurrent vs. Development Health Spending (in Million TZS)[4]

	2004/05	2005/06	2006/07		2007/08		2008/09
	Actual expenditure	Actual Expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
Recurrent	242,829	308,045	397,644	391,792	394,894	360,290	402,384
Development	58,399	118,329	122,226	121,814	220,854	210,782	331,494
Total on-budget	301,228	426,374	519,870	513,606	615,748	571,072	733,878

The decline in the share of OC in the recurrent budget has driven the share of recurrent budget down, while the share of development budget and expenditure has increased almost consistently since 2004/05. Figure 4 below presents the trend of recurrent and development expenditures for the period 2004/05-2008/09.

[3] PE allocations to the LGAs are computed as sum of allocations to Codes 250300 (Basic Salaries) and 250100 (Employment Allowances) for sub-votes 5010, 5011, 5012 and 5013 of the LGAs. However, the shares could be slightly underestimated because the PE and OC components at the regional level have not been captured.

[4] Note that some of the figures in Table 4 are different from the figures reported in the FY07 PER. This is because a thorough update was done base on the information from MoFEA and MoHSW. For instance, Government Funds to the LGAs were about TZS 2 billion less the amount reported in the budget books.

Figure 4: Trend of Recurrent Expenditure: 2004/05 – 2008/09

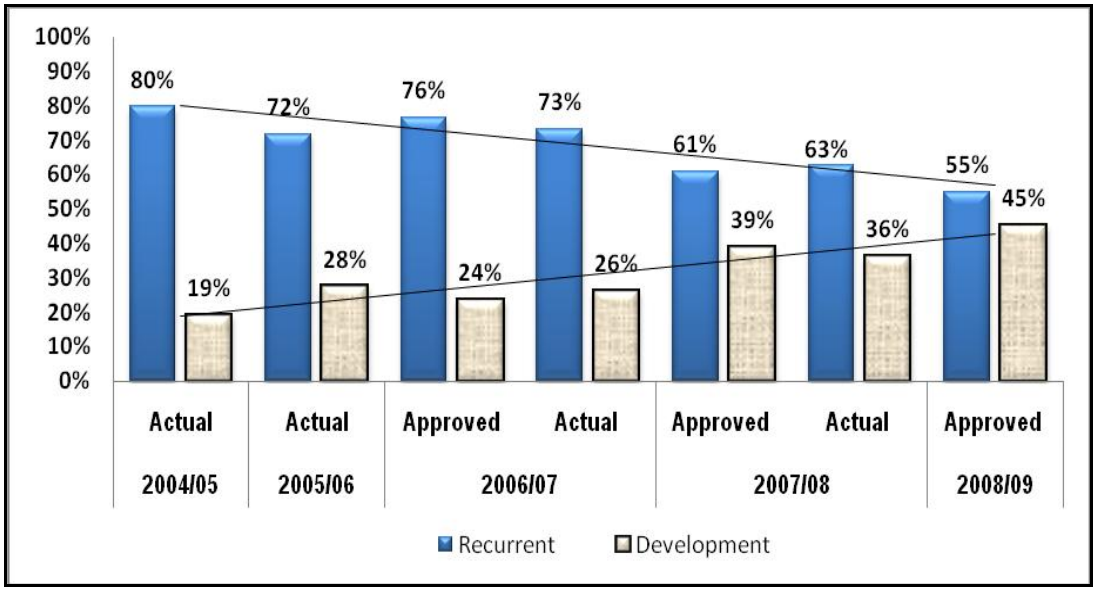


Figure 4 shows a declining share of recurrent expenditure in total health expenditure from about 80% of actual expenditure in 2004/05 to 55% of the estimates in 2008/09. At the same time, the share of development expenditure has increased from about 19% of the actual expenditure in 2004/05 to about 36% of the actual expenditure in 2007/08 and about 45% of the estimates in 2008/09.

3.3.3 Overall Budget Performance: Actual Expenditures against Estimates

Overall budget performance for the health sector has been good, with little mismatch between approved estimates and actual expenditures. Figure 5 presents the actual expenditures against the approved estimates for 2006/07 and 2007/08, and the approved estimates for 2008/09. The Figure gives a general picture of the overall budget performance but Table 5 below summarizes the budget performance for 2006/07 and 2007/08, for both recurrent and development budget. Generally, budget performance has been good, with actual total expenditures reaching 99% of the approved estimates in 2006/07, but declining to 92.7% of the estimates for 2007/08. The key factor responsible for lower performance of the development budget is procurement and procedures for works and contract management.

Figure 5: Approved vs. Actual Expenditure (in TZS Million)

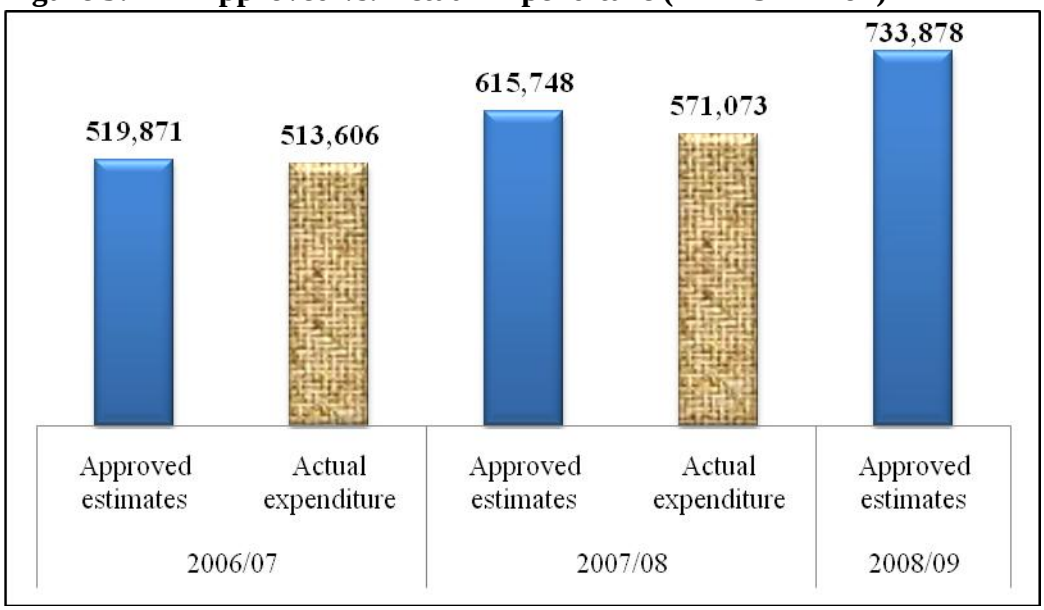


Table 5: Overall Budget Performance: 2006/07 and 2007/08

	2006/07	2007/08
Recurrent Budget Performance	98.5%	91.2%
Development Budget Performance	99.7%	95.4%
Total Budget Performance	98.8%	92.7%

If the performance is disaggregated between MoHSW and Regions and LGAs, it appears that the low budget performance in 2007/08 is largely under the MoHSW. Table 6 shows that MoHSW total budget performance was just around 90% in that year, and recurrent and development budget were 87.3% and 93.5% respectively. On the contrary, total budget performance at the level of Regions and LGAs was 96.3% , with development budget performance reaching 99.99%.

Table 6: Budget Performance Disaggregated by levels

Budget Performance by Levels	2006/2007	2007/2008
MoHSW (Total)	97.28%	90.08%
MoHSW -Recurrent	97.20%	87.30%
MoHSW -Development	97.47%	93.52%
Regions and LGAs	90.13%	96.30%
Regions and LGAs (Recurrent)	99.99%	94.91%
Regions and LGAs (Development)	61.05%	99.99%

Budget performance shown above is attributed to a number of factors, including:

- Better coordination of external resources through basket and budget support
- Adoption of performance based planning and budgeting by the government, where targets for measuring performance are evaluated through annual performance reviews
- Transparency in expenditures: Since 2004/05, Tanzania improved the budget systems, with the extension of GFS coding to the Development Budget, thereby enabling disaggregation and analysis of the Recurrent and Capital elements of total (i.e. foreign and local) on-budget spending.
- Inclusiveness of planning and budgeting cycle: the process is adequately inclusive, with respective sector ministries playing crucial roles in the preparation of budget guidelines, MTEF determination and subsequently issuance of resource ceilings.

While the major reason for failure to fully execute the recurrent budget is related to failure to release funds, late disbursement of the funds, and reallocation of the fund to other activities, the major reason for poor performance of the development budget is cumbersome procurement procedures (delays in tendering and awarding processes), and failure to get funding from other sources which the disbursement is beyond the capacity of the Ministry. For instance, the Ministry intended to undertake service delivery client satisfaction survey in monitoring quality of public services and disseminate the findings to stakeholders but only 58% of the target was executed because funds were not released.

3.3.4 Health Sector Spending by Levels

The review attempted an analysis of expenditures in the health sector based at different levels, from the MoHSW to the Local Government Level. Table 7 presents the health expenditure data based on the levels, with National Health Insurance Fund (under Accountant Generals' Department) and allocations and expenditures under Prime Minister's Office Regional Administration and Local Government (PMO-RALG) presented separately. This kind of distribution results in five different categories, the MoHSW, the Accountant General's Department (NHIF); PMO-RALG; Regions; and Local Government Authorities (Municipal, Town, or District Councils)

Table 7: Health Sector Spending by Levels

	2004/05 Actual expenditure	2005/06 Actual Expenditure	2006/07 Approved estimates	2006/07 Actual expenditure	2007/08 Approved estimates	2007/08 Actual expenditure	2008/09 Estimates
1: Ministry of Health and Social Welfare (MOHSW)							
Total MOHSW	**175,873**	**271,169**	**307,229**	**298,866**	**348,307**	**313,739**	**425,416**
Recurrent	128,341	180,306	216,370	210,304	192,875	168,379	196,378
Development	47,532	90,863	90,859	88,562	155,432	145,360	229,038
2: Prime Minister's Office, Regional Administration and Local Government							
PMO-RALG (Dev)	4,480	19,838	21,494	2,505	2,942	2,942	25,027
3: Accountant Generals Department							
NHIF	16,534	20,457	24,050	23,950	27,971	26,719	30,177
4: Regions							
Total Regions	**14,486**	**16,943**	**22,967**	**24,545**	**42,351**	**39,615**	**49,665**
Recurrent	10,456	11,893	19,115	19,052	28,761	26,024	30,927
Development	4,030	5,049	3,852	5,493	13,590	13,590	18,738
5: LGAs							
Total LGAs	**89,855**	**97,968**	**144,131**	**163,740**	**194,177**	**188,058**	**203,593**
Recurrent	87,498	95,389	138,109	138,486	145,286	139,168	144,902
Development	2,357	2,579	6,021	25,253	48,891	48,891	58,691
GRAND TOTAL	**301,227**	**426,374**	**519,871**	**513,606**	**615,748**	**571,073**	**733,878**

It is important to note that the information presented in Table 7 above does not give a clear indication of the resources going to the Local Government Authorities (LGAs). It is understood that, a significant portion of expenditure by the MoHSW ultimately go down to the local level in form of drugs and other essential supplies for the health facilities. Also, the health resources managed by the PMO-RALG eventually go down to the local level. A further disaggregation of resources at local level is attempted in Local Government sub-study, in section 6. Perhaps, the level of disaggregation that would provide a more proximate estimate of resources going to the local level would involve putting vaccines, drugs, and other spending which goes to LGA as a separate category.

3.3.5 Per Capita Health Spending

Per capita expenditures in health, as one of the key benchmarks used to assess the scope of health spending in a country has increased, though gradually over the two time periods. Per capita health spending increased modestly from about TZS 13,214 in 2006/07 to TZS 14,234 in 2007/08, and the estimates for 2008/09 could pull it up to TZS 17,768. Figure 6 shows the trend of both nominal and real per capita health spending for the review period, based on official exchange rates and population projection figures from the National Bureau of Statistics.

Figure 6: Trend of Per Capita Health Spending in USD

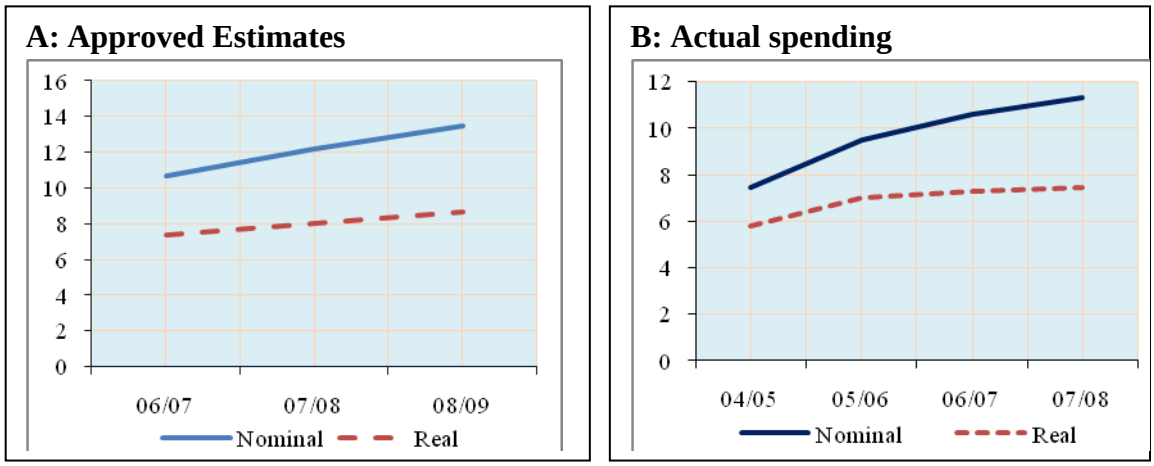


Table 8 below presents a summary of per capita health spending, both in local currency (TZS) and foreign currency (USD).

Table 8: Per Capita Health Spending

	2004/05	2005/06	2006/07		2007/08		2008/09
	Actual	**Actual**	**Approved**	**Actual**	**Approved**	**Actual**	**Estimates**
NOMINAL (TZS)	8,235	11,308	13,375	13,214	15,368	14,253	17,768
REAL (TZS)	6,412	8,321	9,177	9,067	10,120	9,386	11,400
NOMINAL USD	7.42	9.49	10.71	10.58	12.18	11.29	13.46
REAL USD	5.78	6.98	7.35	7.26	8.02	7.44	8.64
Deflator	*1.28*	*1.36*	*1.46*	*1.46*	*1.52*	*1.52*	*1.56*
Exchange Rate	*1,109*	*1,192*	*1,249*	*1,249*	*1,262*	*1,262*	*1,320*
Population	*36,576,738*	*37,704,872*	*38,867,802*	*38,867,802*	*40,066,599*	*40,066,599*	*41,302,370*

The trend of nominal per capita health spending in US dollar terms has shown a steady upward trend over the period under review, increasing by about 52% from $7.42 actual per capital spending in 2004/05 to US$11.29 in 2007/08. In real terms however (using the 2001 constant prices), per capita health spending remains well below US$ 9. 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 especially the off budget component.

3.4 Local Government Health Sector Spending

3.4.1 Overall Level and Share of Government Subventions to LGAs

In this review, attempt was made to aggregate all resources that go down to the Local Government Authorities, thus stratifying health sector resource allocation into two levels: The Central Level (Ministry of Health and Social Welfare) and Local Government Level. In this case, all the resources from PMO-RALG and those transferred to the Regions are assumed to be going to the local levels. With this aggregation, Figure 7 below shows the trend of distribution between the "central" and "local" for the period 2004/05-2008/09.

Figure 7: Trend of Distribution of Resources between Central and Local Govt

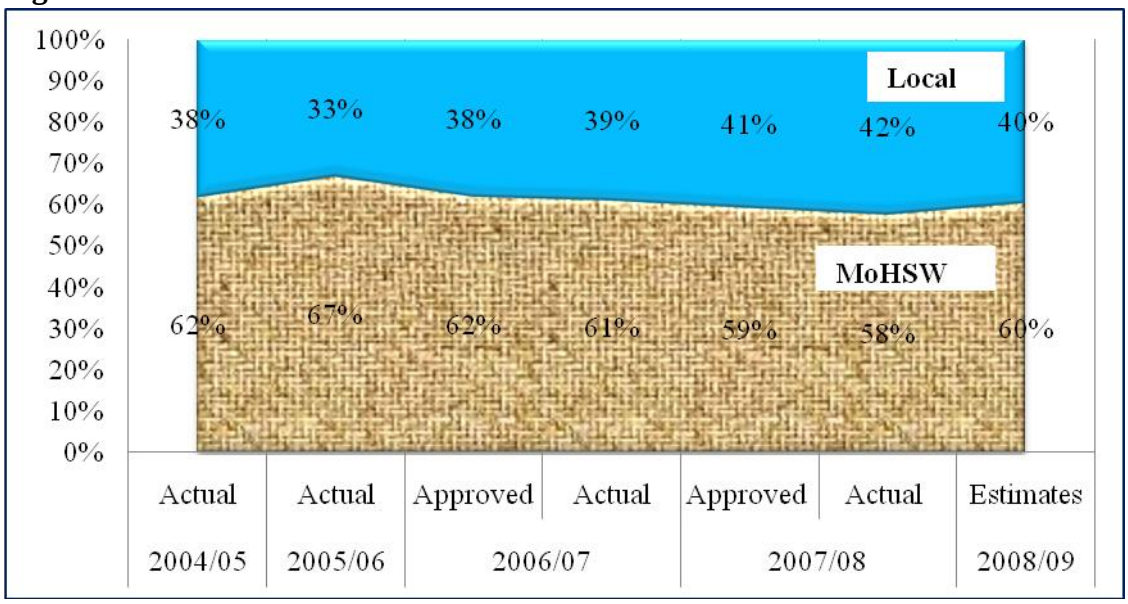


Figure 7 clearly indicates an almost stagnant share of the resources to the local level during the period under review. There was modest improvement in the share of resources to the local level from about 33% of actual expenditure in 2005/06 to about 42% of actual expenditure in 2007/08, but it slides back to about 40% of the 2008/09. If estimates and expenditures for PMO-RALG and Regions are removed from this categorization of 'local', the share to the Local Government Authorities becomes even smaller, with the share of the 'central' remaining unchanged, as indicated in Table 9.

Table 9: Share of Resources: Central and Local

	2004/05	2005/06	2006/07		2007/08		2008/09
Level	**Actual**	**Actual**	**Approved**	**Actual**	**Approved**	**Actual**	**Estimates**
Central	62%	67%	62%	61%	59%	58%	60%
PMO-RALG	2%	5%	4%	1%	1%	1%	4%
Regions	5%	4%	5%	5%	7%	7%	7%
LGAs	32%	24%	29%	33%	33%	35%	29%

The shares in Table 9 and Figure 7 indicate modest pace in decentralization. In FY2005/06, about 66% of total health spending was centrally managed (by MoHSW),

while LGAs managed only about 24% of the spending in health. The situation improved in FY 2007/08, with the share of health spending managed centrally (by MoHSW) declining to 58%, while the share managed by LGAs increased to about 35%. It can also be observed from Table 9 that the share of health spending that is managed by the Regions also increased from 4% in FY 2005/06 to 7% in 2007/08.

3.4.2 Health Spending at LGA Level by Sub-Votes

In the Government Budget Books, financial resources for health sector at the LGA level are categorized under four main sub-votes: Health Services [largely curative and includes any Council district hospital and District Designated Hospitals (DDHs), and allocations for Council Health Management Teams (CHMTs) and Council Health Services Boards (CHSBs)], Preventive Services, Health Centers, and Dispensaries. The estimates and expenditures for each of these sub-votes are summarized in Table 10 below.

Table 10: Health Spending at LGA Level by Sub-Votes (in Million TZS)[5]

	2006/07		2007/08		2008/09
	Approved Estimates	Actual expenditure	Approved Estimates	Actual expenditure	Approved Estimates
Health Services	36,120	36,120	41,033	41,033	48,071
Preventive Services	18,133	18,133	16,710	16,710	17,293
Health Centers	26,749	26,749	35,128	35,128	35,598
Dispensaries	34,391	34,391	44,592	44,592	43,940
Total	**115,392**	**115,392**	**137,464**	**137,464**	**144,902**

Note: The actual and approved estimates to LGAs are the same here because it all the government funds to the LGAs for recurrent budget under these four sub-votes are spent.

The data presented in Table 10 shows a general increase in the amount of resources channeled to the LGAs from about TZS 115 billion in 2006/07 to TZS 145 billion in 2008/09 budget. However, the TZS 43.9 billion approved estimates for dispensaries in 2008/09 budget is lower than the amount that was approved in the previous financial year (TZS 44.6 billion in 2007/08). Concurrently, the resources approved for Health Services sub-vote increased from about TZS 41 billion in 2007/08 to TZS 48 billion in 2008/09. Local Government health spending is addressed in more detail as a sub-study in section 6 of this report.

3.4.3 Per capital Health Spending at Local Level

An attempt was made to compute generalized indicators of per capita health spending at the local level. The local level here is defined to include resources channelled through PMO-RALG, Regions and LGAs. Table 10 below presents the calculated figures for per capital local spending both in real and nominal terms and in local currency (TZS) and foreign currency (USD). The Table indicates that most of the previously computed per capital spending in health (overall), doesn't go down to the

[5] Note that, the totals in table do not add up to the total health sector budgets and expenditures because the figures reported here are for government funds going to the LGAs for recurrent budget, under four sub-votes: Health Services, Preventive Services, Health Centers, and Dispensaries.

local level. The real per capita health spending is less than 4 USD. However, these figures should be interpreted with caution because as mentioned earlier, significant portion of MoHSW expenditure also goes down to the local level through drugs and supplies to the health facilities.

Table 11: Per Capita Health Expenditure at Local Level[6]

	2004/05	2005/06	2006/07		2007/08		2008/09
	Actual expenditure	Actual Expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
Nominal in TZS	2,975	3,574	4,852	4,909	5,977	5,756	6,738
Real capita TZS	2,316	2,630	3,329	3,368	3,936	3,790	4,323
Nominal in USD	2.68	3.00	3.88	3.93	4.74	4.56	5.10
Real in USD	2.09	2.21	2.67	2.70	3.12	3.00	3.27

3.5 Health Spending by MKUKUTA Objectives

Using the information from the MoHSW (Vote 52) Annual Implementation Report for the FY 2007/08 we present the MoHSW budget and expenditure by Departments and by MKUKUTA objectives. Box 1 below provides MoHSW strategic objectives as presented in the annual report. It is worth noting that in this annual report budget and expenditures are tied to MoHSW objectives and the targets to be achieved.[7]

Box 1: Strategic objectives in the FY2007/08 MOHSW budget

52A	To improve services and reduce HIV and AIDS infection
52B	Equitable and gender sensitive health and social welfare services ensured
52C	Quality essential health and social welfare services provided
52D	Research, training and continuous professional development for improved performance, enhanced
52E	Burden of disease reduced
52F	Institutional, capacity and organization of the Ministry to implement its core functions enhanced.
52G	Policies, legislation, regulation for efficient and effective service delivery improved, and
52H	An efficient and effective governance system for the delivery of services in place.

Table 12 provides a summary of budget and expenditure by MoHSW departments and as percent of spending according to MKUKUTA objectives. It can be noted from the Table that, the overall performance of MoHSW budget by departments was just satisfactory. On average, only 77% and 52% of the estimates approved for recurrent and development expenditures respectively were actually utilized. Of particular concern at this juncture would be the low levels of development performance (52%), which could be partly explained by lapses in implementation of development projects

[6] Per capita health spending at the Local level is arrived at by dividing total health expenditure at the Local level by the total population. It gives a simple indicator of the extent to which health expenditure eventually gets down to the the beneficiaries.

[7] Presentation of expenditures per objective and as presented in all the MoHSW departments is not done due to tedious work of extracting the information from the source. However, as mentioned earlier, the report is explicit on which MoHSW objective the expenditures are addressing, the MKUKUTA, Performance Assessment Framework (PAF) and Ruling Part Manifesto objectives.

in the face of stringent procurement procedures. Also, the execution of the recurrent budget ranged from 41% (Administration and Personnel Dept) to 94% (Social Welfare department and Tanzania Food and Drugs Authority—TFDA).

Except for the Finance and Accounts Department under which there was no MKUKUTA related budget; overall, almost all the budget (99%) was mentioned to be aligned to MKUKUTA objectives. However, despite this high level of alignment with MKUKUTA, only about 86% of the actual expenditure was MKUKUTA related.

Table 12: MoHSW Budget Performance by Departments FY2007/08

MoHSW Department	Budget (Million TZS)	Cumulative Exp (Million TZS)	% Exp	MKUKUTA related budget (Million TZS)	MKUKUTA cumulative Exp (Million TZS)	% Exp
1001 Administration and Personnel	2,848	1,181	41%	2,294	955	42%
1002 Finance and Accounts	578	532	92%	0	0	0%
1003 Policy and Planning	1,404	813	58%	1,362	762	56%
2001 Curative Health Services	118,494	109,097	92%	118,494	109,097	92%
2003 Chief Medical Officer	3,761	2,492	66%	3,761	2,492	66%
3001 Preventive services	45,506	36,034	79%	45,158	35,722	79%
4001 Tanzania Food and Drug Authority	1,116	1,048	94%	1,116	1,048	94%
4002 Social Welfare	2,339	2,180	94%	2,339	2,180	93%
5001 Human Resource Development	7,660	5,262	81%	7,660	3,760	49%
Total Recurrent	**183,707**	**158,637**	**77%**	**182,185**	**156,016**	**86%**
Development	**181,936**	**95,286**	**52%**	**181,936**	**95,286**	**52%**

3.6 Health Sector Financing Indicators

As in previous years, the PER provides the opportunity to update selected performance indicators for the health sector as a whole. Table 13 provides an update on the first and second HSSP III indicators on health financing. The third indicator in the HSSP III is "the proportion of population enrolled in CHF/TIKA." This indicator has not been updated due to lack of current data. The figures are presented in Tanzanian shillings (current prices) while US dollar values for the health financing indicators are presented in Table 14 in order to facilitate comparison with other countries.

The first indicator on proportion of national budget on gives a rough measure to monitor the government's commitment to health sector spending. As explained earlier, the share of the health sector in total government budget and expenditures has remained well below the 15% target of Abuja Declaration. Actual health expenditure had increased from 10% of total government spending including CFS in 2004/05 to about 12% in 2005/06, and this has so far been the peak for the entire review period. However, this was followed by 11% decline in 2007/08 and a projected further decline to 10% in 2008/09.

Table 13 shows some improvement in nominal Tanzania Shilling per capita budget and spending, with general increase in GoT allocations to all levels. The increase is most noticeable at the central level, where the budgeted figure for 2008/09 has increased by 10% over 2007/08. At the regional level the increase is about 8% while at the District level, the increase is only about 1%. In terms of actual expenditure, the data in Table 13 indicates a 9% decline in Government Funds per capita spending at central level from the 2006/07 baseline to 2007/09. At regional level, government funds per capita spending increased by about 53%. This large increase is however a result of low baseline value (TZS 553), rather than significant improvements in the allocations and spending. At local government level, 2007/08 had a modest increase in actual government funds per capita expenditure of about 19% from the 2006/07 baseline. Table 14 shows that in US dollar terms, there has not been a significant increase from the 2006/07 baseline.

Table 13: Selected Health Sector Financing Indicators

	Indicator	**Level**	**Baseline (2006/07)**	**FY08**		**FYO9**
				Budget	Actual	Budget
1(a)	Proportion of national budget on health (including CFS)	National	11.8%	10.3%	11.0%	10.2%
1(b)	Proportion of national budget on health (excluding CFS)	National	13.3%	11.3%	12.2%	11.2%
2(a)	Total GOT public allocation to health per capita (Central, Regional and District) [TZS]	Central	4,603	4,815	4,204	5,313
		Regional	553	914	845	991
		District	3,024	3,750	3,598	3,775
2(b)	GOT and Donor allocation to health per capita (TZS)	National Average	13,214	15,368	14,253	17,768
2(c)	Per Capita GoT recurrent Expenditure at District level([TZS)	District	2,969	3,431	3,431	3,508
2(d)	Per Capita GoT recurrent expenditure on Primary Health Care (TZS)	District	1,573	1,990	1,990	1,926

Table 14: Selected Health Sector financing indicators in USD

	Indicator	**Level**	**Baseline (2006/07)**	**FY08**		**FYO9**
				Budget	Actual	Budget
2(a)	Total GOT public allocation to health per capita (Central, Regional and District)	Central	3.69	3.81	3.33	4.02
		Regional	0.44	0.72	0.67	0.75
		District	2.42	2.97	2.85	2.86
2(b)	GOT and Donor allocation to health per capita	National Average	10.58	12.18	11.29	13.46
2(c)	Per Capita GOT recurrent Expenditure at District level	District	2.38	2.72	2.72	2.66
2(d)	Per Capita GOT recurrent expenditure on Primary Health Care	District	1.26	1.58	1.58	1.46

4.0 COMPLEMENTARY HEALTH FINANCING

4.1 Health Services Fund

The appropriation accounts for FY 2006/07 and 2007/08 show detailed breakdown of the Health Services Fund (HSF) as collected from referral, regional and district hospitals in the whole country. Table 15 shows the balance brought forward (unspent cumulative funds from previous years' collections), total collection in the current year, total payment and the balance at the close of the financial year. Total receipts have increased by 92% from 2006/07 to 2007/08, and 95% and 89% of the funds in 2006/07 and 2007/08 respectively were used in service delivery. This finding is signifying the importance of cost sharing funds in the delivery of health service. However, there is still a huge cumulative sum of funds that remained unspent at the end of 2007/08 (TZS 3,615,303,786).

Table 15: Health Services Fund: Receipts and Payments (in Million TZS)

FY	Balance B/F (1)	Total receipts (2)	Total payment (3)	Closing balance (1+2-3)
2006/07	1,614	2,964	2,826	1,752
2007/08	3,016	5,696	5,089	3,615

Source: MoHSW appropriation accounts pages 55 (2007/08) and 34 (2006/07)

The Health Services Fund (HSF) collections were only about 1% of the OC allocations for 2006/07 total health sector budget, and 2% of the OC allocations for 2007/08 total health sector budget. But, since HSF is collected at the Local Government Level, it would be more informative to gauge HSF against OC at the local government level, rather than OC in the total health sector budget and expenditure. In this regard, an attempt was made to compute OC component of recurrent budget at local government level, using the figures from the budget books (Appendices to Volume II: Details on Urban and District Council Grants and Subventions) for the respective LGAs. The PE component is taken to be sum of the grants and subventions for Employment allowances (code 250300), and Basic Salaries for pensionable posts (code 250100) under votes 5010 (Health Services), 5011 (Preventive Services); 5012 (Health Centres) and 5013 (Dispensaries). The analysis indicates that HSF was approximately 2% of OC allocations to the LGAs in 2006/07, and increased to about 4% of the OC allocations to the LGAs in 2007/08.

4.2 The National Health Insurance Fund

Analysis of the income and reimbursement of the National Health Insurance Fund (NHIF) for the period 2004/05 up to 2007/08 indicates that the health facilities in general are currently utilizing only a relatively small percentage of the overall funds available from NHIF, i.e. about 15% of the overall annual income of NHIF as depicted in Table 16. This situation compelled the MoHSW to commission a study aimed at improving the fund flow from NHIF to Government facilities in 2006. The

recommendations from the study have been successfully implemented in Tanga, Mbeya, Mwanza, Kagera, Mara and Shinyanga regions where Government facilities were trained on NHIF claiming procedure including: NHIF benefit package, NHIF claiming forms, NHIF price schedule for investigations, medicines, surgery etc, concept of health insurance schemes as an alternative financing option, and basic tools for financial management for lower level health facilities.

Table 16: NHIF Income and Reimbursements 2004/5 to 2007/8

	2004/2005	2005/2006	2006/2007	2007/08
Contributions (Million TZS)	24,670	31,733	45,516	55,472
Total income (incl. Income from investments and others) (Million TZS)	28,610	39,142	56,884	72,168
Claims lodged (Million TZS)	4,900	5,400	9,600	10,800
Percentage of claims lodged against total income of NHIF	17.13%	13.80%	16.88%	14.97%
Reimbursements paid (Million TZS)	4,100	4,900	8,200	10,200
Reimbursement rate	83.67%	90.74%	85.42%	94.44%
Percentage of funds paid out to health services against total income of NHIF	14.33%	12.52%	14.42%	14.13%

Source: URT (2009)[8]

In order to improve NHIF claiming and reimbursement procedure, recommendations which were presented in the URT (2009) study should be implemented. The following recommendations should be implemented in the short run;

(i) All District Medical Officers and Regional Medical Officers should ensure that they prepare and implement a roll out plan of the training to lower lever facilities in order to improve claiming systems and financial management.

(ii) All health facility governing committees in all Government health facilities should be activated and empowered for the purpose of their effective participation in financial planning and supervision in their respective areas. This includes opening of individual bank accounts for each health facility and introduction of basic financial management tools.

(iii) Accountants at the District Council/DMO should prepare breakdowns of income and expenditure of all facilities and this report should be

[8] See URT (2009), Report on Training of Health Facilities in Lake Zone on Improvement of NHIF Claiming and Financing Management, Ministry of Health and Social Welfare, Health Sector Program Support.

availed to Council members as well as to regional authorities. The income from therein should be reflected in the Council's financial statements.

(iv) Breakdowns of income and expenditure of all health facilities should be regularly provided to each health facility by the DMO in order to enable them to make facility level plans and to utilise their funds. This is especially important for funds being kept at the district level on behalf of health facilities (NHIF reimbursements, CHF funds, user fees). Appropriate adaptations of procedures and accounting software should be worked out.

(v) Since the training program was implemented after preparation of budget for 2009/10, the MoHSW should consider providing additional support for those districts which did not make a provision in their budget. This support could either be through providing additional funds or through instructing them to prepare a supplementary budget for the same.

5.0 OVERVIEW OF BUDGET AND EXPENDITURE ON HUMAN RESOURCE DEVELOPMENT AND MATERNAL AND CHILD HEALTH

5.1 Human Resource Development

Human Resource Development (HRD) is one of priority areas in the Health Strategic Plan III. This is a result of the severe shortage of human resource for health in public facilities that was reported to be 65% on average in 2006.[9] The HSSP II 2003 – 2008 and the Human Resource for Health (HRH) strategy (2008 – 2013) identified four key areas of investment to address the problem of human resource for health shortage: right sizing and skills mix of health workforce; quality of training; balanced distribution of human resources; and incentives, motivation and remuneration package as needed investment to improve the delivery of health services and ensure quality of the services. Expanding facilities for pre and in-service training, personnel remuneration (wages and allowances, per diems and other entitlements e.g., bonuses, consultancies etc) form part of the investment and costing plan of the HRH strategy. According to the strategic plan, investments on HRH were expected to increase from TZS 82.79billion at the start of the plan (2008/09) and reach TZS 91.98billion in 2012/2013 with a cumulative total of TZS 458.48 billion by the end of the period.

In this section the review is done on the status of budget and expenditures on human resources, although this analysis is limited due to unavailability of disaggregated data.

5.1.1 Total Expenditure on Human Resource Development

Expenditures on human resource development amounted to TZS. 15.4 billion in 2006/07 and increased to TZS. 18.3 billion and TZS.26.0 billion in 2007/08 and 2008/09 respectively (Table 16). The total budget increased significantly (42%) between 2007/08 and 2008/09. The large increase in total spending on human resource development was accounted for by recurrent allocations, which increased by 56% compared with development (that increased slightly by about 17%) between the two time periods. Recurrent spending accounted for a larger share, about 70%, of the expenditures (actual and approved).

Comparison of the allocated funds with the required funds as estimated and indicated in the HR Strategic Plan (costed interventions) and HSSP III shows a huge resource gap in human resource for health component. If human resource needs as identified in the HR Strategic Plan are to be met, about 20% of the MoHSW budget should be allocated to this area. Nevertheless, only 6% of the MoHSW budget has been

[9] See United Republic of Tanzania (2008), Human Resource for Health Strategic Plan 2008-2013, Ministry of Health and Social Welfare, p 8.

allocated to human resource development in 2008/09, which accounted for 31% of total resource requirement for 2008/09.[10]

Table 17: Recurrent and Development Exp. on Human Resource Development

	Actual 2006/07	Approved 2007/08	Estimates 2008/09
Recurrent *	11,804,450,524	11,843,771,100	18,461,532,200
Development	3,601,190,300	6,498,931,400	7,605,665,000
Total	**15,405,640,824**	**18,342,702,500**	**26,067,197,200**

* Including training funds channelled through MoHSW departments (Table 18).

5.1.2 Expenditure on Training

Table 18 shows training expenditure per MoHSW departments. Although there was a huge decline in training expenditure by MoHSW departments in 2007/08, the 2008/09 estimates are more than double the approved estimates in 2007/08. This may be reflecting the fact that the Government is implementing the Primary Health Services Development Program (MMAM) and more resources are channelled to increase intakes for both pre-service and in-service training. Note that Program 50 (Health Training) is the one in charge of all training needs of the staff at the LGAs level. Thus, it receives a big chunk of the funds (94% of actual training expenditure in 2006/07 and 97% of estimates for 2007/08 and 2008/09). Some LGAs have some funding to support training of their staff though minimal; and it is hard to capture this from LGAs budget due to coding limitations.

Table 18: Training Expenditure, by MoSHW Departments (in Million TZS)

MoHSW Departments	Actual 2006/07	Approved 2007/08	Estimates 2008/09
Administration and General	94	17	114
Finance and Accounts	13	1	1
Policy and Planning	-	35	221
Curative Services	31	20	3
Chief Medical Officer	28	11	8
Preventive Services	247	28	78
TFDA	84	72	0
Social Welfare	103	58	63
Program 50 (Health Training)	11,205	11,602	17,974
Total	**11,804**	**11,844**	**18,462**

5.1.3 Development Expenditure for Human Resource Development

Further analysis of the development expenditure shows that building infrastructure takes the huge share followed by vehicles (
Table 19).[11] This can also be explained by the implementation of the MMAM. Doubling the number of students would need expansion of colleges and health

[10] HSSP III and HR Strategic Plan estimate the budget for HR development to be TZS 82,790,398,800 (USD 68,991,999 at exchange rate of TZS 1,200) for FY08/09/FY09/10.

institutions. Vehicles are also needed by the training institutions for administration but also students use during field training.

Table 19: Development Expenditure by Category

	2006/07	%	2007/08	%
Buildings	2,359,290,700	65%	5,607,261,831	89%
Vehicles	1,224,000,000	34%	650,000,000	10%
Other Procurement (Furniture)	17,900,000	1%	53,703,600	1%
Total	**3,601,190,700**	**100%**	**6,310,965,431**	**100%**

Breakdown of expenditure/budget by cadre was done for three major cadres; medical/clinical officers, nursing, and allied professions (Allied professions include professionals from Zonal Training Centres such as CEDHA). A big chunk of fund is directed to nursing cadre for both years although in 2008/09 more funds have been budgeted for allied processions (Table 20 and Table 21). Again, this kind of allocation may be reflecting the priorities in MMAM which indicates that in the first two years of its implementation (FY 2007/08 and FY 2008/09) a total of 652 Clinical Officers, 1304 nurses and 652 laboratory assistants have to be deployed to Tanzania Social Action Fund (TASAF) constructed dispensaries.

Table 20: Breakdown of Expenditure/Budget by Cadre (2007/08)

	Medical/Clinical	Nursing	Allied professions	General
Buildings	81,750,000	1,896,040,700	381,500,000	-
Vehicles	-	-	-	224,000,000
Other Procurement (Furniture)	17,900,000	-	-	-
Total	**99,650,000**	**1,896,040,700**	**381,500,000**	**224,000,000**

Table 21: Breakdown of Expenditure/Budget by Cadre (2007/08)

	Medical/Clinical	Nursing	Allied professions	General
Buildings	310,000,000	2,573,826,550	2,723,435,281	-
Vehicles	-	-	-	650,000,000
Other Procurement (Furniture)	10,000,000	43,703,600	-	-
Total	**320,000,000**	**2,617,530,150**	**2,723,435,281**	**650,000,000**

5.1.4 Specific Analysis of the Wage Bill

There have been attempts to analyse some specific components of health sector spending, and a particular study has attempted an analysis of the wage bill. The study noted that the current economic classification used by the government does not give an accurate picture of spending on the wage bill. This is on understanding that the composition of the wage bill includes more than just the personal emoluments portion (i.e. base salary and social security contributions) of the recurrent expenditure budget.

[11] The source of this information is the MoHSW MTEF and these figures are slightly different from the figures reported in the Budget Books.

It also includes the allowances, premia, honoraria and other direct benefits that are categorized under "hidden costs" and may be found in both the recurrent and development budgets. For the health sector, hidden costs are found in 2 main categories "other goods and services" and "transfers and subsidies." The authors reclassified the wage bill and got completely different picture than the current Recurrent/Development split and more specifically PE/OC/DE classification that is used.[12]

Table 4 is based on the conventional distinction, looking at the amounts allocated and spent for recurrent and development components as recorded in the official Government Estimates, for the purpose of comparison with previous years. As pointed out earlier, despite increase in allocation for personal emoluments by 30% and 16% in 2007/08 and 2008/09 respectively, the share of PE in the total health sector budget has increased slightly from around 6% in 2006/07, to about 10% in 2008/09.

5.1.5 Future Analysis on Human Resource Development

It is worth noting that doing a thorough analysis of allocations and expenditure for Human Resource Development may not be within the ambit of PER. This is due to the fact that such analysis would require the type of data and the level of disaggregation that may not be easy to collect and analyze with given time and resources for PER exercise. In some cases, some of the data may have to be collected from primary sources, which may necessitate consulting such sources like LGA level and private institutions. Thus, we propose commissioning of a separate study which will do a thorough analysis of expenditures based on the following classifications and whenever possible with urban/rural divide;

i) Training expenditures on pre-service training broken down by medical, nursing, allied professions.
ii) Training expenditures on in-service training broken down by medical, nursing, allied professions
iii) Training expenditures on continuing education
iv) Training expenditures broken down by the public and private institutions.
v) Expenditures on wages which includes salaries, allowances, entitlements, per diems, bonus, consultancies and by Central, Local Government, Regions, and Zonal Training Institutions.
vi) Travel expenditures (international and national)
vii) Fuel expenditures
viii) Expenditures on supervision

[12] See the Health Sector Analysis of the 2008/09-2010/11 Medium Term Sector Budget.

5.2 Reproductive and Child Health

Despite the gains made to improve some key health status indicators (increased immunization coverage and reduction in infant and under-five mortality rates), maternal health remains a challenge. Maternal deaths are estimated at 578 per 100,000 live births, with net negative effects on neonatal mortality and leading to the general worsening of infant mortality rates. Information in the HSSP III reveals the following trend in RCH indicators (Box 2).

Reproductive and Child Health Indicators

- Fertility rate - 5.7 births/woman
- Average age at first birth - 19.4 years
- At least one ANC visit – 62%
- Four or more ANC visits – 62%
- Births at health facilities – 47%
- Births assisted by skilled personnel – 46%
- Proportion of health centres with emergency obstetric equipment – 5.5%
- Post natal care attendance – 13%
- Knowledge of contraception – 90% (adult population)
- Married women using contraceptives – 20%
- Unmet need for family planning – 22%.

An analysis done as part of the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Health in Tanzania for the period 2008-2015 identified health systems and population-based problems as affecting maternal new born and child health situation in Tanzania. Poor health infrastructure, shortages of skilled personnel, poor referral network, lack of equipment and supplies, and poor coordination with the private sector were identified as some of the problems contributing to the low uptake of services, and the worsening of Maternal, Newborn and Child Health (MNCH) situation in the country.

The NSGPR/MUKUTA identified MNCH as a key priority and singled out as one of its goals improvement in the survival, health and well being of children and women as one of its strategies. In addition, the Health Sector Support Program III (2008 – 2012) and the Primary Health Services Development Program (PHSDP/MMAM 2007 – 2017) committed to address MNCH.

The measures proposed in the MNCH road map 2008 – 2015 were cast in the context of the overall improvement in the health system for better delivery of primary health care services. The budget and expenditure for maternal and child health services are therefore linked to interventions ranging from Focused Antenatal Care (FANC), care during childbirth—Emergency Obstetric Care (EMOC), postpartum care, Post Abortion Care (PAC), and family planning. Others include Integrated Management of

Childhood Illnesses (IMCI), Expanded Program on Immunization (EPI), Information, Education and Communication (IEC), Nutrition, and family planning, HIV and AIDS, Prevention of Mother to Child Transmission (PMTCT), and adolescent health services. This integration makes it difficult to isolate expenditures specifically linked to Reproductive and Child Health (RCH). In addition, some of the interventions are in the form of activities such as training of health workers to improve skills for service delivery, including RCH services.

Table 22: Summary of the MNCH Priorities

(Summary of some of the proposals to improve delivery and access to MNCH services from selected policy and strategy documents)		
Strategy Document	**Strategy/intervention**	**Budget (2009/10)**
HSSP III emphasis		
Access to MNCH Services	Increase number of health facilities offering quality MNCH services	
	Community participation in MNCH through IEC/Advocacy	
Health systems strengthening for MNCH and Nutrition	Ensure availability of essential equipment and supplies	
	Improved nutrition interventions	
Budget – MNCH (HSSP III) estimates		**USD. 194,083,333**
PHSDP/MMAM		
	Training of service providers on maternal, new born and child care	No budget
	Vaccines and essential paediatric care, equipment and supplies procured and supplied to all hospitals, health centres and dispensaries	No budget
	Improved access to skilled attendance at delivery – by issuing vouchers for facility based delivery	No budget
	Train medical assistants, anaesthetists, and nurses on theatre EmOC and general practices	No budget
MNCH Road Map		
Health Systems Strengthening and Capacity Development		
	i. Protocols for ANC, postnatal care, new born and child care, EmOC	USD. 647,000
	ii. Support for pre-service training institutions to offer competency based teaching on MNCH care	USD.980,000
	iii. Training CHMT/RHMTs	USD. 480,000
	iv. BEmOC and Comprehensive EmOC (dispensary/health centres)	USD.98,000,000
	v. Hospitals (BEmOC)	USD.68,000,000
	vi. Procurement and supply of essential commodities	USD.800,000,000
CCHPs	RH, Child Health Promotion listed as priority area of CCHPs	No budget

Table 22 shows a strong emphasis on health systems strengthening as a key strategic intervention to improve access and delivery of MNCH services. Analysis of progress made in addressing MNCH situation in Tanzania needs to take into account expenditure trends on personnel, infrastructure, etc. The results matrix to the MNCH road map identified performance targets for MNCH around:

- Government spending on health increases to 15%
- Budget for MNCH including Family Planning and nutrition increases by 50% by 2015
- Number of skilled workers increased to 100% by 2015

This PER cannot categorically determine expenditure performance for RCH services mainly due to the integration of RCH services within other preventive and primary health care services.

Limited figures obtained from the MoHSW Annual Performance Report for 2007/08 showed expenditures related to RCH were mainly on reducing maternal mortality and infant and child mortality, nutrition and prevention of stunting, wasting and underweight in children. The specific areas of spending included: training of trainers on life skills and adolescent friendly reproductive health; refresher training on IMCI; development of IMCI guidelines; supportive supervision for IMCI case management; and development of Kangaroo mother care training guidelines. Expenditures linked to RCH interventions as per the 2007/08 annual report were as follows:

Table 23: RCH Related Expenditures in 2007/08

Component	**TZS**
Medical Supplies including Contraceptives	36,062,107,379
Prevention of stunting	1,488,666,440
Nutrition	95,381,746
Refresher training	124,308,000.00
TOT on maternal health	2,300,000,000
Total	**40,070,463,565**

In relation to the overall on-budget health sector spending during 2007/08 of TZS 571 billion, the share of spending on RCH accounts for about 7% of spending. Presenting a single year figure does not provide a basis for judging the spending level, but could provide a basis for tracking expenditures related to RCH in the future.

6.0 LOCAL GOVERNMENT SPENDING SUB-STUDY

In order to supplement the central level data on budgets and releases to the local government level, a small local government spending study was proposed. The proposal was based on the importance of the Council level in terms of actual health service delivery, and the increased focus on "Decentralisation by Devolution." The study was to be undertaken in 2007/08 PER round but this was not done because of several delays in planning for this study. Thus, the study was conducted in the 2008/09 PER round but focusing on the twelve Councils that were sampled during 2007/08 review (see Annex D for Council selection criteria). The main objectives of the Local Government study were to;

1. Document budget, release and expenditure data from the selected local Councils for the FY 2007/08 from all available sources (GoT official estimates, Comprehensive Council Health Plans (CCHP), and Council Technical and Financial Implementation Report (TFIR)/Fourth quarter.
2. Document delays if any, in the process of receiving and using budgeted funds from these sources
3. Follow-up with Councils regarding any unreported sources of funding
4. Determine the share of reported Council income and expenditure from cost-sharing (Health Service Fund/User fees, Drug Revolving Fund (DRF), National Health Insurance Fund, and Community Health Fund).
5. Analyze the share of Council resources budgeted and actually spent by level of the Council health system.

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 CCHPs and also in their TFIRs. Thus, these two reports were expected to be major sources of data for the analysis presented in this section. However, CCHPs and TFIRs were accessed from six and two Councils respectively which made it impossible to conduct some of the proposed analyses including analysis of shares of Council budgeted resources and the funds that were actually spent by level of health care system. Other sources of data include regional budgets books for the FY2008/09, www.logintanzania.net[13] and qualitative data collected from the Councils using the data collection instrument presented in Annex E.

[13] www.logintanzania.net is a website prepared and maintained by the Local Government Finance Working Group, which is jointly led by PMO-RALG and the MoFEA. It provides an easily accessible database of budgeted and disbursed funds, together with actual expenditures, both in total, and disaggregated by sector and sources of funds.

6.1 The Level and Composition of Council Budgets

6.1.1 The 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 24 below.

Table 24: Council CCHP Budgets for FY2007/08 (TZS)

Council	CCHP Total	Population	Per capita
Biharamulo District Council (DC)	1,246,011,303	183,494	6,790
Mwanza City Council (CC)	3,402,903,863*	757,111	4,495
Tabora Municipal Council (MC)	1,386,102,504	216,250	6,410
Pangani DC	957,241,300	47,936	19,969
Same DC	2,931,913,123	229,373	12,782
Temeke MC	6,086,822,150	927,310	6,564
Total	**16,010,993,333**	**2,361,474**	**6,780**

*This figure was taken from the Annual Implementation Report.

The figures ranged from a low of TZS 4,495 in Mwanza CC to TZS 19,969 in Pangani DC, i.e. more than a four-fold difference. The mean for presented Councils is TZS 6,420. This average is very low compared to the national nominal per capita spending presented in Table 8. However, the budget as presented in the CCHPs does not capture funds like the ones channelled through the MSD for drugs procurement. The implication here is that, Councils have control over very little portion of resources going to the health sector (i.e OC, basket funds plus any cost-sharing revenues and other funds).

6.1.2 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 Table 25 and Figure 8 below. An interesting finding is the share of Other Sources of funds, which seems to be huge in particular for Biharamulo DC (40% of the total funds) although at a face value, block grant is the major source of fund for all the Councils (Figure 8). The finding from the Biharamulo data is reflecting the huge off-budget spending that is never captured when doing central level data analysis. Other funds in Biharamulo DC include funds from Columbia University, Acquire project, Concern, and GFR6.

Although the current move of encouraging other actors in the district to reflect their funds in the CCHPs will result into a more accurate picture of resources at that level over time, it is likely that the capture of Other Sources will vary considerably, and it would be useful to undertake a mapping at central level of where at least that

proportion of off-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.

It should be borne in mind that data presented in CCHPs provide only a crude picture as there are errors and inconsistencies within the CCHPs as a result of arithmetic errors, missing Council own funds (Biharamulo DC and Same DC), missing cost sharing fund (Tabora MC) and missing CHF/NHIF fund (Tabora MC and Mwanza CC). Except for block grant and basket fund, disbursement of different sources is expected to vary considerably. Thus, ideally the CCHP budget should be compared with disbursements or expenditures over some years to determine how realistic the resource envelope is.

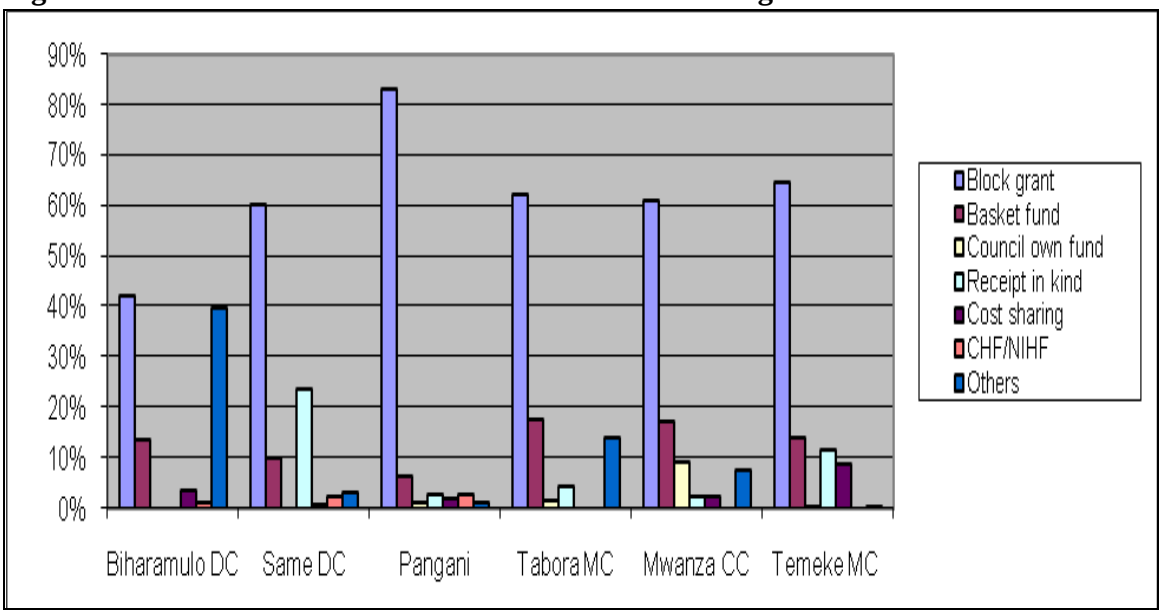
Except for Temeke MC, the CCHPs for the other five Councils didn't separate PE from OC. This makes it difficult to compare the share of OC from the government with the cost sharing funds from the health service clients which are also used as OC. There is evidence that in some Councils, the cost sharing fund is more than double the OC from the government.[14] Data from the Temeke CCHP show the cost sharing fund in 2007/08, to be bigger than the OC from the central government (148% of the OC). This evidence refutes the assumption by some stakeholders that "cost sharing fund is very little." It is important to note that the cost sharing funds are very crucial as they are used as OC which is important for service provision including child survival and maternal health in line with MDGs 4, 5 & 6. Further, these resources are used to finance the CCHPs as a whole, and not only for those who pay.

Table 25: Funding Sources for Sampled Councils: FY2007/08 ('000TZS)

Type of Fund/Council	Biharamulo DC	Same DC	Pangani DC	Tabora MC	Mwanza CC	Temeke MC
Block grant	659,363	1,771,321	796,915	862,492	2,080,958	3,937,191
Basket fund	211,307	289,543	62,844	245,328	592,436	866,389
Council own fund	0		12,000	22,240	316,963	23,625
Receipt in kind	0	689,596	26,000	63,240	75,889	714,907
Cost sharing	53,467	24,500	21,000	0	79,800	528,937
CHF/NIHF	15,696	65,000	27,000	-	-	-
Others	616,727	91,954	11,482	192,753	256,858	15,773
Total	**1,556,560**	**2,931,913**	**957,241**	**1,386,053**	**3,402,904**	**6,086,822**

[14] See Kessy, F (2009), "Council Comprehensive Health Plans Review for Kinondoni, Ilala, Temeke and Kibaha Councils for the year 2008/09," A consultancy report submitted to Youth Action Volunteers (YAV), Dar es Salaam, June 2009.

Figure 8: Relative Contributions of Different Funding Sources within CCHPs



6.2 Allocation of Council Resources

6.2.1 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 and includes any Council district hospital and District Designated Hospitals (DDHs), and allocations for Council Health Management Teams (CHMTs) and Council Health Services Boards (CHSB)]
- 5011 Preventive Services
- 5012 Health Centres
- 5013 Dispensaries.

Table 26 shows the allocation of recurrent block grant funding by sub-vote in the selected Councils.[15] There is no clear pattern on allocations to health services for the twelve Councils. Consistently, the spending for dispensaries (sub-vote 5013) is higher than spending for the health centres (sub-vote 5012) except for Songea MC. This is likely to reflect the higher number of dispensaries in the various Councils, although further exploration would be needed to confirm this. Except for Tabora MC, Songea MC, and Mwanza CC, spending for preventive services are the lowest ranging from 8%-12%. Although there are huge Council wise variations, the averages per sub-vote closely mirror the national averages.

[15] The data for this analysis were drawn from the regional budget books for FY2008/09

Table 26: Recurrent Block Grant Allocation per Sub-vote, FY2007/08

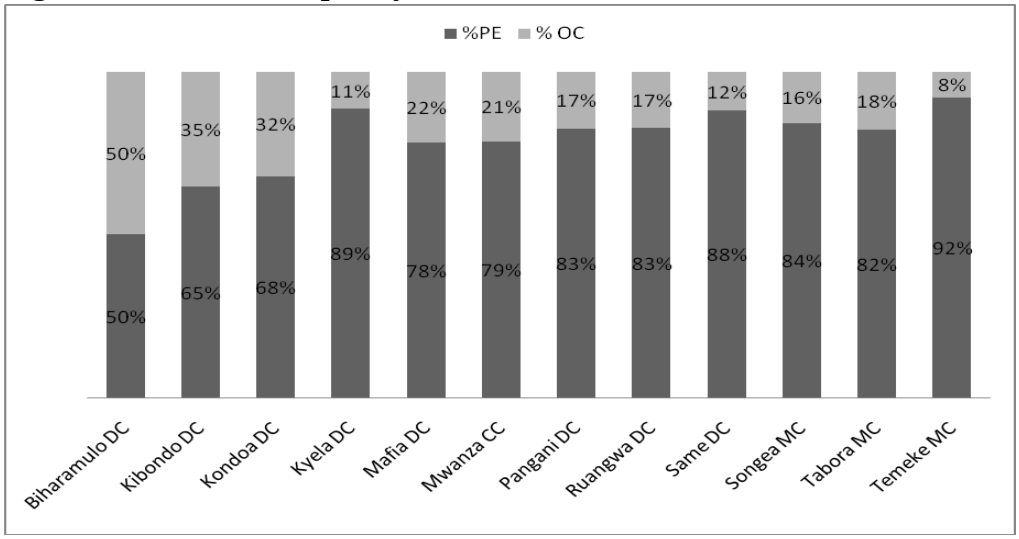
District/Sub-vote	5010	5011	5012	5013
Biharamulo DC	21%	10%	20%	49%
Kibondo DC	30%	10%	29%	31%
Kondoa DC	39%	10%	23%	28%
Kyela DC	43%	8%	17%	32%
Mafia DC	52%	8%	0%	40%
Mwanza CC	9%	19%	12%	60%
Pangani DC	39%	12%	21%	28%
Ruangwa DC	24%	8%	30%	39%
Same DC	41%	9%	23%	27%
Songea MC	5%	19%	45%	31%
Tabora MC	19%	32%	0%	49%
Temeke MC	51%	10%	18%	22%
Average	**31%**	**12%**	**20%**	**36%**

There was no spending under the health centre sub-vote in FY2007/08 for Mafia DC, while the majority of spending (52%) was allocated to Council hospital. Tabora TC has no allocation for sub-vote 5012 (health centres). In Mwanza CC, the health services sub-vote received the least, presumably due to the fact that hospital services are provided by the Regional hospital.

6.2.2 Allocations of Personal Emoluments and Other Charges

Data on Personal Emoluments (PE) and Other Charges (OC) split during the course of the financial year were obtained from www.logintanzania.net (Monitoring Report 9a). The split between PE and OC within the recurrent block grant is shown for the twelve selected Councils (Figure 9). Personal Emoluments range from 50% in Biharamulo DC to 92% in Temeke MC. It is worth noting that although the PE as % of total block grant is quite high for majority of the Councils, PE as % of the total Council health expenditure ranges from 22% in Biharamulo DC to 60% in Temeke MC (average of 51%).

Figure 9: PE:OC Split by Council



6.2.3 Budgeted vs. Received Funds

The details of what has been budgeted versus what has been received are normally presented in the Councils' annual Technical and Financial Implementation Reports (TFIRs). However, only TFIRs for two Councils were accessible to the team (Same DC and Mwanza CC), which makes it difficult to make a meaningful analysis of budgeted versus receipts. Looking at the TFIRs from these two Councils it is clear that 100% of the basket fund and receipt in kind funds were received by the two Councils. Conversely, Same DC received only 66% of the block grant while Mwanza CC received 100%. Cost sharing has the least performance (27% and 42% for Same DC and Mwanza CC respectively).

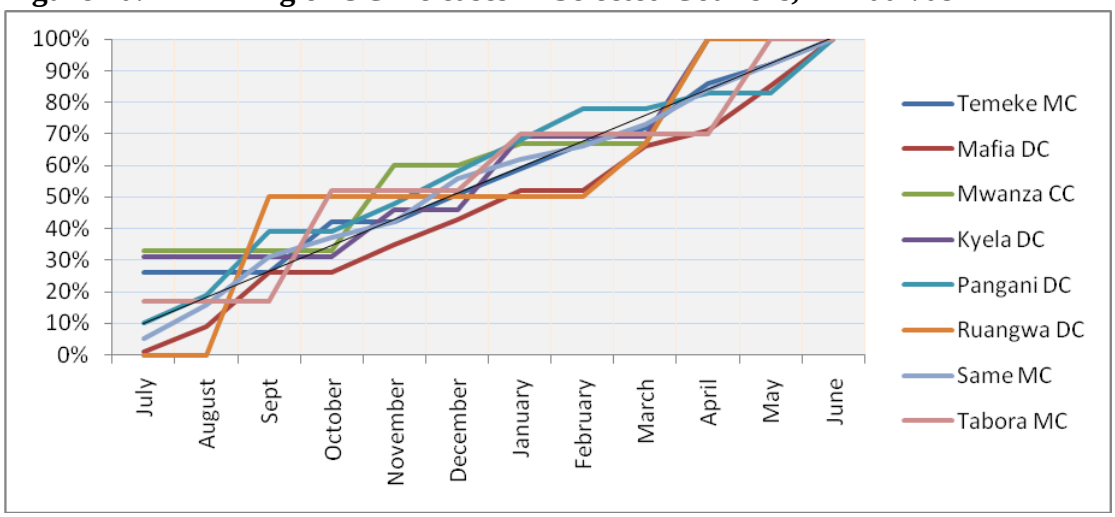
6.2.4 Timing of OC releases

Data on OC releases during the course of the financial year were obtained from the visited Councils. Data were available for only 8 Councils. Table 27 presents cumulative percentages of the releases which are then plotted in Figure 10 .The Figure shows a clear general pattern of the timing of releases of OC funds for the 8 Councils. Except for Mafia DC and Pangani DC, virtually 100% of OC funding has been released by May of the financial year in question. This is an improvement compared to last year's analysis which showed that on average 25% of the funds were released in the last quarter putting pressure to the Councils to absorb those funds. Comparison of budgeted OC versus released funds show that almost all the budgeted funds were released except for Pangani DC and Tabora MC. In fact some Councils (e.g. Mafia and Same) got more than what was budgeted (Table 27).

Table 27: Timing of OC Releases in Selected Councils, FY2007/08

	Temeke MC	Mafia DC	Mwanza CC	Kyela DC	Pangani DC	Ruangwa DC	Same MC	Tabora MC
July	26%	1%	33%	31%	10%	0%	5%	17%
August	26%	9%	33%	31%	19%	0%	16%	17%
Sept	26%	26%	33%	31%	39%	50%	31%	17%
October	42%	26%	33%	31%	39%	50%	37%	52%
November	42%	35%	60%	46%	48%	50%	42%	52%
December	51%	43%	60%	46%	58%	50%	56%	52%
January	59%	52%	67%	69%	68%	50%	62%	70%
February	67%	52%	67%	69%	78%	50%	66%	70%
March	72%	66%	67%	69%	78%	67%	73%	70%
April	86%	71%	100%	100%	83%	100%	84%	70%
May	92%	85%	100%	100%	83%	100%	92%	100%
June	100%	100%	100%	100%	100%	100%	100%	100%
% budgeted vs released	**100%**	**127%**	**102%**	**108%**	**86%**	**100%**	**154%**	**96%**

Figure 10: Timing of OC Releases in Selected Councils, FY2007/08



Figures 11-14 show typical releases to a sample of 4 Councils. The figures show different pattern of releases—one with more even releases (Temeke MC and Mafia DC) and the other one which shows the releases once per quarter (Mwanza CC and Ruangwa DC). The releases to Ruangwa DC were very erratic in the sense that the first tranche was released at the end of September and the second one in March. These kinds of trends remain to be explained.

Figure 11: OC Releases, Temeke MC

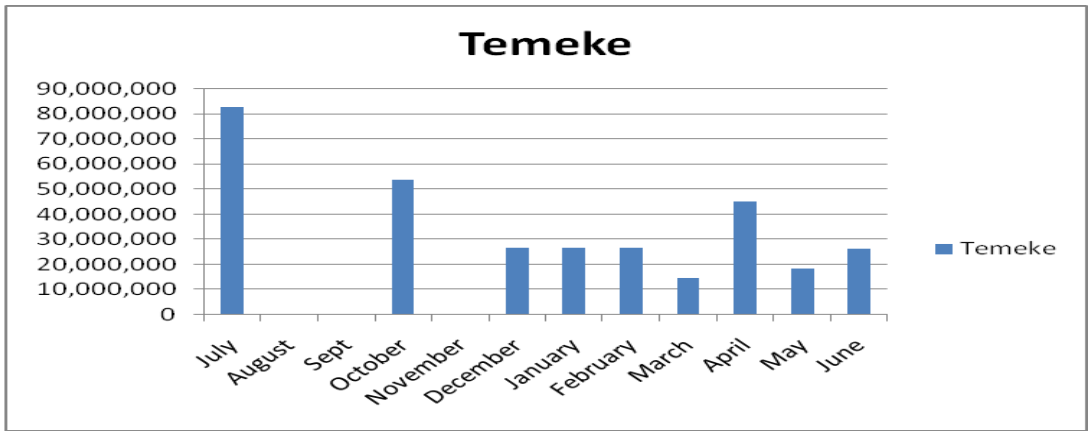


Figure 12: OC Releases, Mafia DC

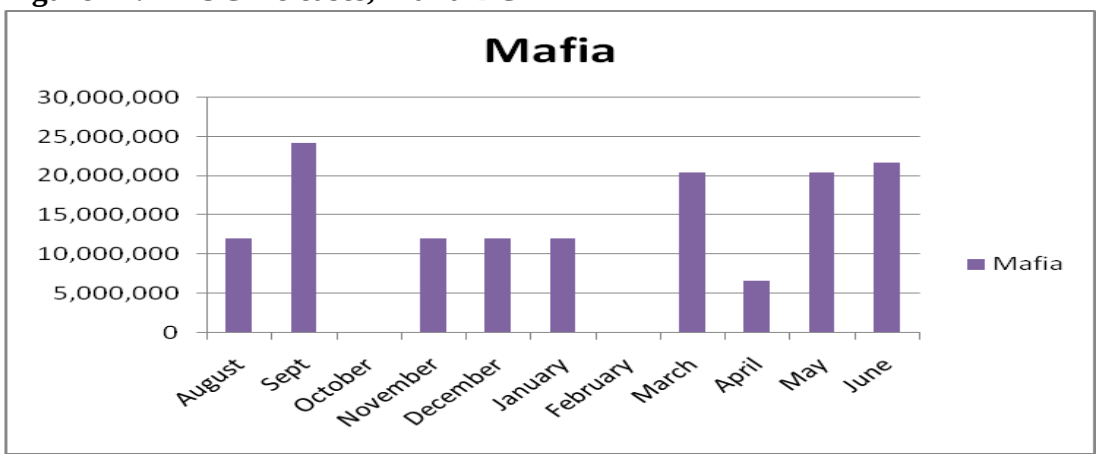


Figure 13: OC Releases, Mwanza CC

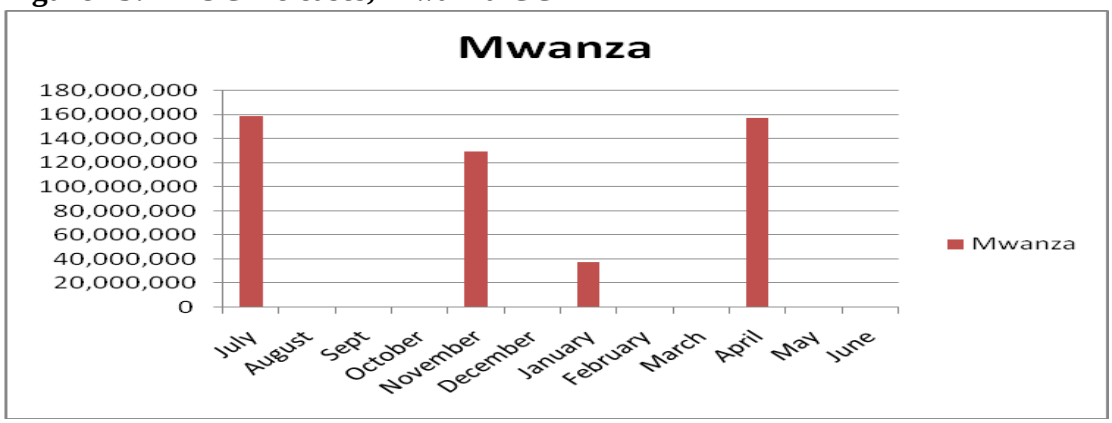
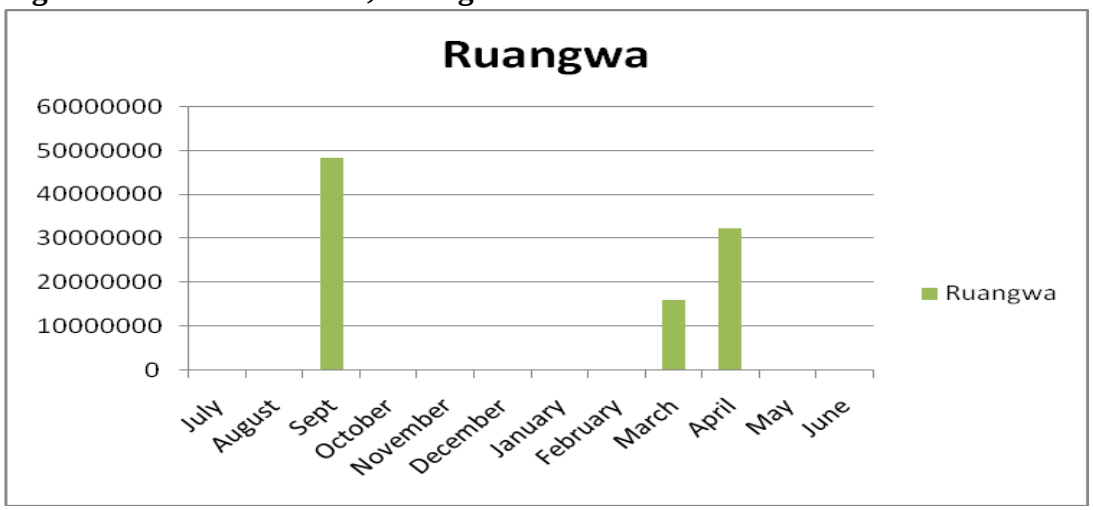


Figure 14: OC Releases, Ruangwa DC



It has not been possible to determine the share of reported Council income and expenditure from cost-sharing (Health Service Fund/user fees, Drug Revolving Fund, National Health Insurance Fund, and Community Health Fund) because of unreliability of the data collected at the Council level. In most cases CHF has been combined with NHIF and some Councils only provided balance in the bank at the end of the year in question and not actual collections.

6.3 Consistency of data

One major impediment in analysing LGAs spending, either budget or actual expenditure, lies in the inconsistency between various sources of data. Table 28 presents the different figures found during the desk review for recurrent block grant funding and as reported in the 2007 PER.[16] In addition to the data varying by source, it is perhaps striking that there is no consistency in this variation.

Table 28: Variation in Recurrent Block Grant Estimates by Source (Million TZS, FY2006/07)

Councils	MoFEA Database		Logintanzania.com		CCHPs		TFIR
	PE	OC	PE	OC	PE	OC	
Biharamulo DC	685	433	722	433	-	318	1,118
Kibondo DC	1,145	215	806	143	731	387	1,269
Kondoa DC	690	427	368	474	-	-	907
Kyela DC	837	139	776	164	755	146	940
Mafia DC	349	145	349	145	-	-	-
Mwanza CC	943	476	943	476	-	1,502	1,763
Pangani DC	705	132	705	132	-	670	-
Ruangwa DC	344	73	344	73	377	163	-
Same MC	1,275	162	969	162	-	1,132	1,230
Songea MC	353	133	353	133	387	134	521
Tabora MC	531	167	531	167	-	774	698
Temeke MC	2,024	322	2,822	303	2,822	322	3,144

There is no doubt that some variations are due to the fact that the documents are produced at different times of the budget cycle, resulting in figures which reflect the changing budget position during the financial year. The CCHP may be produced with an earlier budget ceiling than that available to MoFEA and www.logintanzania.net However, consistency in presentation and clarity regarding sources would be useful. Examples of changes which could be made include the following:

- All CCHPs should reflect both expected PE and OC allocations, as per the guidelines
- Reference to earlier figures should be given where appropriate, eg the 4th quarter TFIR could refer back to the CCHP and note any changes within year
- www.logintanzania.net has a potential to become a handy and very useful source of LGAs budgets and expenditures but it should indicate clearly the source of the presented data.

[16] This analysis was not done using the 2007/08 figures because as reported earlier only six CCHPs and two TFIRs were accessed.

7.0 DISCUSSION AND RECOMMENDATIONS

7.1 Highlights of PER 08 Findings

The review has shown that level of expenditures and allocation of available resources reflects the commitment by the government to increase health spending and to ensure the expenditures are allocated to support the primary health care approach to health sector development.

Level of Public Funding for Health

Public expenditures on health in Tanzania have increased over the years reflecting the commitment by the government to increase funding for health as part of the implementation of the country's poverty reduction and economic growth strategy (NSGRP). Between 2004/05 and 2008/09, government spending on health, excluding expenditures by other agencies of the government, increased from an actual expenditure of TZS 206,554 million in 2004/05 to TZS 378,113 million in 2007/08, representing about 55% increase over the period.

At the same time, the share of health financing from external sources (basket and non basket) has increased modestly over the review period. The share of eternal financing (basket and non-basket) in actual health expenditures increased from 30% in 2005/06 to 35% in 2007/08. The share of external resources in total health budget increased from 29% of the estimates for 2006/07 to 37% of the estimates for 2008/09. . The share of external resources which has remained stable at an average of about 30% over the period reflects: growth in health funding internationally as part of the global health partnerships; and the initiatives by the government to coordinate all resources either as basket funds or the overall SWAp framework that has matured in the health sector in Tanzania and which has facilitated better reporting and capture of information on external resource flows into the sector.

Except for user fees/HSF, comprehensive information on other domestic resources for health financing in particular CHF, Council own funds and other resources at the LGA level was not available for this review. In the case of user fees, for which information was available, the contribution from this source increased reaching well over US$5 million in 2007/08, which despite only being about 1% of the total spending in 2007/08, constitutes an important source of expenditures in the facilities where it is collected and spent. For instance, for the six local councils (Biharamulo, Same DC, Pangani DC, Tabora MC, Mwanza CC, and Temeke MC) for which information on spending on block grants, Basket Funds, receipts in kind, and other Council revenues was available for this review, the contribution of these local resources to health expenditures in the specific Councils varied. In Temeke MC, where user fee revenues were highest at about TZS 529 million (or US$0.41 million), this accounted for up to 8% of the total health expenditures for the Council. Given

that block grants, which are the largest source of expenditures at the Councils, are largely earmarked for PE and leaves very little for OC, it is clear that the contribution of user fees and other locally generated resources to the overall health expenditures including contribution to the availability and quality of health care services might be higher at the local units than when compared with the aggregate health expenditures. In Temeke, user fee revenues as a share of total spending excluding block grants amount to about 24%, which is substantial.

As a result of the increase in government, external and other domestic resources to finance health, the current level of public spending on health stand at about 11.5% as a share of total government expenditures, and per capita (nominal) expenditures of US$11.2, with real per capita (in US$) spending remaining stable over the four years at around US$7 due to stability in rates of inflation and exchange rate in TZS to US$.

Tanzania has achieved spending comparable to its neighbours Uganda (9.6% of total government) and Rwanda (10% of total government) based on 2007 spending periods. As is the case with the neighbouring countries Tanzania is yet to attain the level of spending required to provide an adequate package of basic services to combat malaria, HIV and AIDS, TB, as well as maternal and child health problems, estimated at US$34 per capita.

More importantly, the level of spending is still far short of HSSP III projection of achieving US$15.75 per capita spending by 2009/10 predicted on annual growth rates of 24% on on-budget allocations on account of parallel increases in recurrent and development budget allocations of 21% and 31% respectively.

These results show that on-budget allocations to health increased at an average annual rate of 18.5% over the period, with foreign funding (both basket and non-basket) increasing at average annual rate of 36%. With economic growth projected to be less robust – stabilising at around 7%, and revenues projected to reach 18% of GDP, it is unlikely that expenditures on health will increase dramatically.

Improving the utilization of available resources remains a strong option that can be pursued by the government to achieve spending flexibility and ensure achievement of higher results in terms of health outputs and outcomes from public spending. One area requiring improvement is the timing of the release of funds especially for OC at the district level. This PER has shown that although the release of block grants as well as other resources to the Councils had improved with 100% of budgets made available to Councils, in some of the Councils, the timing of the releases were erratic, with the bulk of the grants and other resources only getting released in the last quarter of the financial period – causing undue pressure – even possible under spending of the budgets by the close of the financial year (Figure 11– example of Temeke MC).

Pattern of Allocation of Expenditures

Through Primary Health Services Development Program (MMAM), the government intends to improve primary health care interventions, by increasing budget and expenditure allocations to local authorities and regions, while at the same time strengthening secondary and tertiary care services to provide referral care. The review shows that although a large share of the expenditures is retained centrally, it is released to the districts and regions in the form of block conditional grants for drugs and human resource spending. During the period under review, allocations to districts and regions accounted for an average of 38% of the expenditures at the local levels.

Spending at the LGAs revealed a focus on primary health care activities as shown by a larger share (70%) of the expenditures by LGAs concentrated on preventive services, health centers and dispensaries leaving only 30% for health Services [largely curative and includes any Council/district hospital and District Designated Hospitals (DDHs) (Table 10).

To improve the performance of the health sector, the government adopted a health systems approach emphasising the strengthening of human resources, infrastructure improvements, as well as improvement in the procurement and distribution of pharmaceuticals in order to increase the availability of quality services. Due to data limitations it was not possible to do a thorough analysis of expenditures on personnel, as well as on infrastructure improvements. Notwithstanding this, analyses of expenditures on human resource development and reproductive and child health services indicate that expenditure patterns reflect a focus on improving availability and quality of services. Expenditures on human resources development and management reveal an increasing pattern of expenditures for training from TZS. 15.4 billion in 2006/07 to TZS.26.0 billion in 2008/-09 (estimates). Expenditures on contraceptives although only available for one year, represented a sizeable share (6%) of the total expenditures in 2007/08 (as captured in the MoHSW annual report).

Budget Execution

Comprehensiveness of expenditures, assessed by the extent to which a sector's budget and expenditures reflect all/or most of the available resources is a common problem in most countries in Africa. However, this review has shown that Tanzania has managed to consolidate expenditures in health as reflected in the increase in the size of total health budget by 18% in 2007/08 and by 19% in 2008/09.

The significance of this greater expenditure consolidation cannot be over stated. First, it increases the predictability of the budget and provides an opportunity for accurate planning. Secondly, it appears to have contributed to the high budget outturn - of about 99% in 2006/07 – since planning and budgeting take place with better certainty of the resource envelope.

An area of weakness though remains in the accounting for CHF revenue which could not be captured as part of this PER but is presumably a significant source of revenue at the local levels and important source of discretionary spending especially for OC within the Council budgets. Mechanisms to ensure full reporting and accounting for locally generated resources are necessary. Comprehensive analysis of spending for off-budget resources (external finance database, HSF, CHF and other locally generated funds) may require separate in depth reviews as inputs to the PER.

Devolution of Expenditures to Local Governments

MoHSW is one of the pioneer ministries in the implementation of D by D policy whose thrust was to ensure devolution of expenditures to the LGAs over time. Despite having looked at expenditures of only 8 Councils, the impression is that the process of granting expenditure autonomy to the local levels is in progress in the health sector.

The analysis showed that block grants, which are the funds transferred by the central level to the local authorities constituted the largest share of the expenditures in all the 8 Councils for whom information was available. Similarly, block grants were allocated to PE and OC, which is consistent with the guidelines set out in the CCHP manual[17].

However, lack of information on expenditures for all the Councils limited a determination of a comprehensive picture of how much the transfers to the local authorities represent out of the total public spending on health, and therefore a better determination of the scope of transfers in total expenditures, which would have been a good measure of performance of D by D in health. At the same time, it was not possible to show a trend in the transfers to categorically conclude if there is consistency with the policy of fiscal devolution. In addition, it might be useful in future to combine quantitative review with in depth qualitative information to establish how the D by D process is perceived by district level managers, or if the restrictions imposed on how the transfers should be allocated are considered prohibitive, or if the districts have the capacity to plan and allocate the resources appropriately.

This review established that www.logintanzania.net is a useful and handy source of disaggregated data for LGAs. However, it is not clear what the source of this information is.

Limitations of the PER 2008

Due to data limitations, it was not possible to address all of the objectives spelt out in the Terms of Reference. For instance, the study team could not undertake an analysis of the Community Health Fund (CHF) due to unavailability of information, yet it is an

[17] . Comprehensive Council Health Planning Guideline. MOHSW and PMORALG, 2007. URT

important component of the overall health financing reforms in Tanzania. The problem of incomplete information also affected the quality of analysis on expenditures of LGAs, human resource development, and Reproductive and Child Health interventions.

In the case of human resources development, information available could not allow sufficient disaggregation to provide a clear picture of trends or offer a clear indication about the adequacy of the spending compared to resource requirements. As such the PER's findings with respect to spending on HR development cannot offer strong guidance on future budget formulation to address HR needs.

Expenditure tracking on RCH suffered from the challenge of isolating RCH specific spending in the context of integration of services and interventions as well as funding flows. Given the attention being paid on improving maternal and child health indicators, and the commitment by Government and partners to achieve better results with respect to maternal and child health situation, understanding the performance with regard to financing is critical especially if adequate information to measure results and outputs remains weak. Currently, RCH services and activities are integrated with malaria, HIV and AIDS, nutrition and other primary health care programs. For instance, an attempt to isolate and quantify the level of spending on RH commodities was not clear cut because expenditures on contraceptives were lumped up with malaria commodities.

In addition, apportioning expenditures on RH and family planning, and child health was made difficult due to lack of reliable cost and utilization data, which meant that even where spending on certain activities related to RH or child health was available judgement on the adequacy or not of the expenditures was not easy without comparing these with cost of requirements or with results and outputs from the interventions.

Another limitation encountered was due to the late start of the PER, which meant that while it is expected to feed into the budget preparation, the two coincided with each other. This limited the quality of interaction of the PER team and staff of MoHSW and MoFEA. Insights and qualitative information available with the relevant officers are lacking.

7.2 Recommendations

Drawing on the findings and limitations above, our recommendations are in two main areas: improving expenditure management and management of PER.

Expenditure Management

1. Capturing of off-funding spending has proved to be difficult. As such, only Health Services Fund (HSF) has been captured. In relation to this finding we recommend the following;

a. The MoHSW should be fully responsible in making sure that information on CHF collection and expenditures is made available for future PER analyses.
b. With collaboration with MoFEA, the ministry should devise a system of capturing off-budget funds from the external finance database.
c. At the LGA level, there is also a substantial off-budget in form of "Council Own Funds" and "Other Funds." These funds are captured in the Annual Technical and Financial Reports. It is imperative to do a trend analysis of these finances as a way of showing the true health financing picture at that level which is important in the determination of resource envelope for the sector.

2. In order to improve NHIF claiming and reimbursement procedure, the recommendations as presented in URT (2009) should be implemented. In particular, the following recommendations have to be implemented in the short run.
    a. All District Medical Officers and Regional Medical Officers should ensure that they prepare and implement a roll out plan of the training to lower lever facilities in order to improve claiming systems and financial management.
    b. All health Facility Governing Committees in all Government health facilities should be activated and empowered for the purpose of their effective participation in financial planning and supervision in their respective areas. This includes opening of individual bank accounts for each health facility and introduction of basic financial management tools.
    c. Accountants at the District Council/DMO should prepare breakdowns of income and expenditure of all facilities and this report should be availed to Council members as well as to regional authorities. The income from therein should be reflected in the Council's financial statements.
    d. Breakdowns of income and expenditure of all health facilities should be regularly provided to each health facility by the DMO in order to enable them to make facility level plans and to utilise their funds. This is especially important for funds being kept at the district level on behalf of health facilities (NHIF reimbursements, CHF funds, user fees). Appropriate adaptations of procedures and accounting software should be worked out.
    e. The MoHSW should consider providing additional support for the Councils which did not make a provision in their budget. This support could either be through providing additional funds or through instructing them to prepare a supplementary budget for the same.

3. Low performance of development budget has been blamed on the stringent government procurement system and this has been reported in several

MoHSW reports. Initiating a national discussion on public procurement system in order to tease out measures to simplify procurement procedure is imperative.

4. Spending on specific programs and interventions: While integration of services and interventions is desirable, it makes it difficult to track and measure level of commitment for key interventions. In addition, it creates opportunity for fungibility of resources, and over time it becomes difficult to tell if the trend in spending is commensurate with the requirements. Since integration is accepted as a policy direction for the sector, attempts are needed to isolate and report spending on selected programs of special interest e.g. RCH, and human resource development. This could be strengthened by undertaking rigorous monitoring and measurement of performance so that results and outputs of the interventions can be used to gauge the effectiveness of spending.

5. A thorough national study to examine expenditures on HRD by central, LGAs and private institutions ought to be commissioned. The current sub-study concentrated only at the national figures and as reported in Vote 52 (MoHSW). A thorough analysis of the HRD is instrumental in the review of the costing figures in the HRH Strategic Plan.

6. The local government financial tracking study suffered from the problem of having only one data point in time which makes it difficult to see any improvement or deterioration over time. In order to establish trends over time for the sources of funds and in particular other sources of funds (DRF, CHF, NHIF, and user fees etc), we propose a resource tracking study that will not only look at one year data but establish a trend over time. The study could be organised in two parts: a desk review of CCHPs, TFIRs, and www.logintanzania.net to obtain a picture of budgets and reported spending on the one hand, and field study to get more detail, and also to verify some of the reports.

7. The next public expenditure reviews should include a thorough analysis of the expenditures by MoHSW on drugs and other supplies going down to the local level (both at LGA and Regional level). This will give a much clearer picture of the resources that go to the local level.

8. Financing from other sources to the LGAs should be part and parcel of health sector public expenditure review. The LGA sub-study carried out in this review has found this category of financing to be quite significant in some LGAs, for instance, in Biharamulo District Council, it accounted for about 40% of financing.

9. In the face of low reimbursements by the National Health Insurance Fund (NHIF), measures should be taken to expedite 'training for claiming', which has already started. But also, there should be concerted efforts to minimize delays in re-imbursements.

10. Cumbersome procedures have been found to contribute significantly to the low rates of reimbursements at NHIF. Efforts should be made to make the procedures amicable in order to increase the rate of reimbursement.
11. Status of complementary financing should be known clearly in every facility. This should be part of integrated planning, which will clearly indicate resources from all sources. This has to appear in the Comprehensive Council Health Plan in all districts. This will be an essential component for the transparency of the budget.
12. Decentralization should be expedited to allow the LGAs use the resources effectively. With the current procedures, even if more resources were to be sent to the LGAs, there would still be 'left-overs' because procurement rules prohibit them from using the resources.

Management of PER

1. Timing of PER process needs to be fixed and observed to feed into, rather than conflict with budget preparation.
2. Where preparatory studies are necessary, they need to be identified and conducted early enough and their findings agreed upon by all stakeholders, including the MoFEA before adoption for PER purposes. Including several sub-studies under PER has proved to be challenging due to different data requirements.
3. Data gaps have persisted largely because of weaknesses in record keeping, particularly at the local levels. Therefore, measures should be taken to improve record keeping at all levels in order to better inform decision making

ANNEXES

Annex A: Terms of Reference for Health Sector PER update for 2008

Background for the Health PER update for 2008

The role of the PER in the health sector has always been of providing the Ministry of Finance and Economic Affairs, Ministry of Health and Social Welfare, Prime Minister's Office Regional Administration & Local Government and other key stakeholders (Development Partners, Non-State Actors) in the sector with a medium term overview of budgetary allocations and expenditures. In one hand it helps all stakeholders to have informed views on sectoral allocation as well as how allocations within the health sector matches with the national strategic objectives such as MKUKUTA, MDGs and Vision 2025. In the other end it helps track allocations against priorities and achievements in Health Sector Strategic Plan (HSSP).

Therefore, the purpose of the PER is to support efforts to ensure efficient and effective use of scarce resources by strengthening the planning, budgeting and allocation within and across the sector. In addition, the PER should also provide information on: the anticipated resource envelope for the medium term, the cost of fully-financing all priority items within the budget, and the scope for progressively shifting resources to priority items within the sector over the MTEF period.

Beginning the financial year 2005/06 resources allocation to sectors was in line with the three clusters outlined in the framework of the National Strategy for Growth and Poverty Reduction (MKUKUTA). These are growth and reduction of income poverty, Improvement of quality of life and social wellbeing, and Governance. Sectoral expenditure plans would therefore take cognizance of respective sector's contributions to cluster strategies and outcomes.

Purpose and Key Objectives

Since PER is now organized within the framework of MKUKUTA clusters, this PER will focus mainly on getting specific trends and allocation and expenditures in the health sector. Last PER (2007) was expected to undertake a more detailed analysis of Income and expenditure at district level, through a district tracking study in 10 districts[18]. Due to number of reasons this was not possible. Therefore, this PER will focus on the same main objectives. Therefore, Health PER FY08 main objectives are to:

1) Strengthen Ministry of Health and Social Welfare's position in tracking health allocation and expenditure trends with the view of improving equity and efficiency in resource allocation within the sector.
2) Provide a detailed analysis of program support and development partner funded projects in the Ministry of Health and Social Welfare budget with regard to pledge, disbursement and expenditures;
3) Review on the implementation and monitoring of the MKUKUTA, with particular attention to (a) ensuring that updating and coverage of costing sector interventions and activities is complete (b) aligning sector development

[18] This has not been undertaken by the Health PER since FY02

programs (SDPs) to the achievement of MKUKUTA targets and related Millennium Development Goals (MDGs),

4) Undertake a more detailed analysis of Income and expenditure at district level

Scope of Work

In order to meet the objectives outlined above the consultants will have to undertake the following tasks:

a) Review the PER Health FY07 report and highlight all gaps and ToRs which were not accomplished. From these identified gaps the consultants will need to work on them

b) Review Health PER 2007 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.

c) Analyze the recurrent and development budget performance for the past three-years (aggregate actual vs budget).

d) 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 Reproductive and Child Health and Human Resources. They should undertake a detailed analysis at all levels regarding to resources allocated for human resource development that is salaries, allowances, and entitlements etc. The analysis should be in levels, urban rural divide, if possible type of the human resource.

   i) Assess whether and how far these trends reflect policy objectives with practical suggestions for improvement;

   ii) Review deviations in overall budget performance (budgeted, release vs actual expenditure) indicating clear justifications for such deviations and factors constraining the allocations of resources

   iii) Examine allocation of health allocation and expenditures in reproductive and child health and human resources areas at central and local government level and provide an analysis on the pattern of expenditure and how it contributes to the Ministry's efforts to meet the MDG.

   iv) Analyze information on the contribution of user fees in government health facilities, Community Health Fund, National Social Security Fund and National Health Insurance Fund and assess its contribution towards financing of health services assessing its potentiality in enhancing equity and efficiency in health care financing.

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

f) 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: Details of Expenditures in Health Sector (in TZS Millions)

	2004/05	2005/06					
	Actual Expenditure	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Estimates
Recurrent							
National Health Insurance Fund	16,534	20,457	24,050	23,950	27,971	26,719	30,177
Ministry of Health							
Government funds	104,162	180,306	195,981	178,822	192,875	168,379	196,378
Donor basket fund	24,178		20,389	31,482			
Regional Administration							
Government funds	10,456	11,893	19,115	19,052	28,761	26,024	30,927
Local Government Authorities							
Government funds	68,800	75,314	114,779	115,392	145,286	139,168	144,902
Donor basket fund	18,697	20,075	23,331	23,094			
Total recurrent	242,829	308,045	397,644	391,792	394,894	360,290	402,384
Development							
Ministry of Health							
Government funds	3,090	5,000	7,123	7,010	5,481	4,940	13,029
Donor basket fund	44,441	28,486	34,766	25,534	36,595	36,595	49,302
Foreign (non-basket)		57,377	48,969	56,018	113,357	103,826	166,707
PMO-RALG							
Government funds	20	100	70	70	57	57	23,057
Donor basket fund	4,460	19,738	21,424		450	450	650
Foreign (non-basket)				2,435	2,435	2,435	1,320
Regions							
Government funds	1,134	1,169	3,852	2,435	7,848	7,848	10,012
Foreign (non-basket)	2,896	3,880		3,059	5,742	5,742	8,726
Local Government Authorities							
Government funds	2,357	2,579	6,021	2,159	4,979	4,979	11,013
Donor Basket Fund				23,094	43,912	43,912	47,678
Total development	**58,399**	**118,329**	**122,226**	**121,814**	**220,854**	**210,782**	**331,494**
Total on budget	**301,227**	**426,374**	**519,871**	**513,606**	**615,748**	**571,073**	**733,878**
Off budget expenditure							
Cost sharing							
HSF – Hospital	2,698	2,698		2,964		5,696	
CHF – PHC	687	666					
Total off budget	**3,384**	**3,363**		**2,964**		**5,696**	
Grand total	**304,612**	**429,738**	**519,871**	**516,570**	**615,748**	**576,769**	**733,878**

Annex C: Selection of Councils for Inclusion in LGA Study

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)[19]. 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 Council 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 thus 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 the Table below.

Selection of Councils for Tracking Study

Performance	Region	Council	Score	Urban/ Rural	Poverty Status
Well-performing	Dodoma	Kondoa DC	75.8	R	0.36
	Kilimanjaro	Same DC	74.3	R	0.32
	Cost	Mafia DC	74.3	R	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	R	0.23
	Lindi	Ruangwa DC	67.5	R	0.57
	Kigoma	Kibondo DC	67.5	R	0.39
Poorly-performing	Kagera	Biharamulo DC	57.0	R	0.29
	Tanga	Pangani DC	56.0	R	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.

[19] See MoHSW (2007). Detailed statistical analysis of evaluation reports—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 D: Data Collection Instrument for LGA Field Tracking Study

General Objective of the Sub-Study:

To 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.

Specific Objectives of District Tracking Study

- To document budget, release and expenditure data from a selection of local councils for the FY 2007/08 from all available sources (GOT official estimates, Comprehensive Council Health Plans (CCHP), Council Fourth quarter/annual reports)
- To identify and follow-up any discrepancies in data on key budgetary sources (eg block grant, basket funds
- To document the reported flow of funds for key sources over the course of the financial year (intergovernmental transfers – PE, OC, Development; basket funds), and to document delays in the process of receiving and using budgeted funds from these sources
- To follow-up with councils on the impact of identified shortfalls or delays
- To follow-up with councils regarding any unreported sources of funding
- To determine the share of reported council income and expenditure from cost-sharing (Health Service Fund (user fees), Drug Revolving Fund, National Health Insurance Fund, Community Health Fund.
- To analyze the share of council resources budgeted and actually spent by level of the council health system
- To analyze the share of council resources budgeted and spent by EHP priority areas
- To comment on and make recommendations regarding any aspect of council resources and spending as arising from the data

---

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

- Districts have been selected (See Annex 3).

Step 2: Conduct field interview using this tool as a guide

Step 3: Desk review of existing secondary data on these districts (CHP, 4th quarter technical and financial reports.

- Each team has to collect the CCHP and 4th quarter technical and financial report from each Council. We will need these to assess the flow of funds.
- Each team should also get the contact, preferably mobile phone number of the DMO and/or DT for further communication on the information provided should the need be.

Scope of review: 2007/08 only

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.

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?
<<Probe for the process>>

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 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). *<<Check on whether we 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 for implementation of CCHP should be detailed (ie dates and amounts, so that we can identify and quantify delays in the system). See the proposed data capturing tool at the end of this tool.

3. Did you experience any delays in the receipt of funds during FY2007/08? (Please indicate specific instances.)

4. What was the cause of these delays? *(do not prompt, but examples might include late release, failure to provide complete or timely accounts etc) – need justification for the response*

5. What was the impact of the delays?

6. What about the process for other key sources of funding to the Council, eg project support from development partners or NGOs, cost-sharing revenues?

7. Cost-sharing
<<We 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 Financial Report and try to get details of expenditure).

Get information on the following:

(a) CHF—*bank balance at the time of study, total CHF fund collected for the past three years, total matching funds applied for the past three years, major items of expenditure for CHF funds in the past three years.*

(b) NHIF—*bank balance at the time of study, total claims for the past three years, and major items of expenditure for CHF funds in the past three years.*

(c) NSSF (if any)—get any relevant information on NSSF contribution and the whole process of accessing NSSF fund by health facilities.

Please describe the whole process of accessing CHF and NHIF funds <<*probe for any impediment and any recommendation for solving the observed impediments*>>

8. Probe for any other information relevant for the PER process.

Proposed table for completion by DMO/CHMT/DT for FY2007/08

Source of funds	Specific timefra me	Budgeted amount	Date requested (if applicable)	Amount received	Date received	Where deposit ed	Date notificatio n received by DMO/ CHMT	Date first request made by DMO to DED	Amount requested	Date approval received	Date of first expenditure (cheque date)
a	b	c	d	e	F	g	h	i	j	k	l
Block Grant OC Q1											
Block Grant OC Q2											
Block Grant OC Q3											
Block Grant OC Q4											
Block Grant PE Q1											
Block Grant PE Q2											
Block Grant PE Q3											
Block Grant PE Q4											
Basket Fund Q1											
Basket Fund Q2											

Thank you!!