United Republic of Tanzania

Ministry of Health, Community Development, Gender, Elderly and Children

Health Sector Public Expenditure Review, 2014/15

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List of Abbreviations

ADDOs	Accredited Drug Dispensing Outlets
CCHPs	Comprehensive Council Health Plans
CFS	Consolidated Fund Services
CHF	Community Health Fund
DHIS2	District Health Information 2
FY	Financial Year
GoT	Government of Tanzania
HBF	Health Basket Fund
HSF	Health Services Fund
HSSP III	Health Sector Strategic Plan III
LGAs	Local Government Authorities
MoFP	Ministry of Finance and Planning
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NBS	National Bureau of Statistics
NGOs	Non-Government Organizations
NHIF	National Health Insurance Fund
OC	Other Charges
PE	Personal Emoluments
PER	Public Expenditure Review
PO-RALG	President's Office - Regional Administration and Local Government
UHC	Universal Health Coverage
TZS	Tanzanian Shillings
WHO	World Health Organization

EXECUTIVE SUMMARY

The Health sector Public Expenditure Review (PER) for Financial Year 2014/15 (FY15) assesses the budgetary allocations and expenditures to inform stakeholders about progress made in key health financing milestones over the 2011/12–2015/16 period. Specifically, the PER FY14/15 provides:

- A review of PER FY13/14 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions.
- Analysis of the trends in the sources of funding for the health sector for the past five fiscal years.
- Analysis of the trend of recurrent and development budget and expenditures for the past five fiscal years.
- Analysis of budget and expenditure trends for the different sectoral and sub-sectoral levels including the central-local government split.
- Assessment of budget performance (allocation versus actual spending) by classification (development and recurrent), funding sources (government funding and foreign funding), and different levels (central and local).

KEY PER 2014/15 HIGHLIGHTS

Total public health spending has increased from TZS 1.051 trillion in FY 2011/12 to TZS 1.192 trillion in FY 20143/15 which is a 13% increase, while actual public health spending in real terms declined by 6% - a decrease from TZS 645 billion in 2011/12 to TZS 606 billion in 2014/15. The fund spent at central level has increased from 57% in 2010/11 to 59% in 2014/15 and the fund spent at regional level has fluctuated but remained below 10%. The fund spent at Local Government Authority (LGA) level has declined from 37% in 2011/12 to 35% in 2013/14.

The health sector is financed by both government and foreign fund. In percentage terms, government health spending for FY 2014/15 was 75%, which has increased by 13% from 62% in 2011/12. Out of all these sources the recurrent expenditure has increased from 64%% in FY 2011/12 to 79% in FY 2014/15 while the development expenditure has declined about threefold (34%) in the review period.

The performance of the recurrent and basket fund was consistently high – above 85% for each year in the review period. Execution of development budget is the lowest; it has performed below average (50%) in three years and it was as low as 20% in

2013/14. The performance of the non-basket fund budget is inconsistent with the highest performance in 2013/14 (83%) and lowest in 2014/15 (41%).

Membership of the National Health Insurance Fund (NHIF) grew by 6% for principal members down from 12% growth experienced from 2012/13 to 2013/14. A comparison of figures from 2012/13 and 2013/14 indicates an increase in the premium contribution to NHIF and income from other sources by 20% although there is a decline by 8% in 2014/15. Compared to 2012/13 figures, the NHIF unspent balance has declined slightly from 51% to 49% in 2013/14 but there is a significant decline to 44% in 2014/15. The share of NHIF going to public facilities has remained largely constant, at between 28% and 30% per year. There is a substantial improvement in estimated population covered by Community Health Fund (CHF) from 8.1% in 2010/11 to 14.4% in 2014/15.

1.0 INTRODUCTION

The role of health financing in improving health services has been emphasized in various Tanzania Government policies and strategies. The National Health Policy of 2003 focuses on improving the health and wellbeing of all Tanzanians with a focus on those most at risk so as to achieve Universal Health Coverage (UHC). The policy emphasizes on UHC principles, that is, ensuring that services are of good quality and sufficient, and accessible to all people when needed without fear of financial hardships.To achieve this policy goal of the role of improving health service access and delivery, the health sector has been financed by different sources including public from general taxes, external funding through the government system including the basket funding, external funding through direct project support e.g. through Non-Government Organizations (NGOs), and the complementary funding through user fees, prepayment programs and insurance schemes. The health budget has been allocated in line with the priorities outlined in the Health Sector Strategic Plan III (HSSPIII) and the Government's five year development plan.

The Public Expenditure Review (PER) aims at monitoring the trend of health spending that passes though the exchequer system and complementary funding, and provides policy recommendations in relation to the key findings. Financing sources which pass through exchequer system include public funds which are specified as block grant specifically allocated for Personal Emoluments (PE) and Other Charges (OC), and external/donor funding, distinguishing between the pooled Health Basket Fund (HBF) and other non-basket sources.

The Health Sector PER for 2014/15 Financial Year (FY) sets out to assess the budgetary allocations and expenditures to inform stakeholders about progress made in key health financing milestones over the 2011/12–2015/16 period. Specifically, the PER FY14/15 provides:

- A review of PER FY13/14 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions.
- Analysis of the trends in the sources of funding for the health sector for the past five fiscal years.
- Analysis of the trend of recurrent and development budget and expenditures for the past five fiscal years.
- Analysis of budget and expenditure trends for the different sectoral and sub-sectoral levels including the central-local government split.

- Assessment of budget performance (allocation versus actual spending) by classification (development and recurrent), funding sources (government funding and foreign funding), and different levels (central and local).

This PER is informed by data collected from both the central-level institutions and Local Government Authorities (LGAs). The central-level institutions include: the Ministry of Finance and Planning (MoFP); the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC); the President's Office, Regional Administration and Local Government (PO-RALG), and the National Health Insurance Fund (NHIF). Data from the LGAs were collected from, among other sources, the Comprehensive Council Health Plans (CCHPs) and Technical and Financial Implementation Reports (TFIRs).

The PER FY14/15 is organized in six chapters. After the introduction in Chapter 1, the second chapter presents a review of PER FY13/14 recommendations and follow-up actions. Chapter 3 summarizes trends in overall public health spending (trends in the total public health budget and expenditures) and various subsector trends, with some detailed analysis of particular recurrent expenditure items and the development budget. Share of expenditure at different levels and budget execution of various sources of funds and by MoHCDGEC departments has also been presented. Analysis of the contribution of complementary financing in health care financing is presented in Chapter 4. Chapter 5 gives an overview of budgets and expenditures in LGAs using information from Comprehensive Council Health Plan (CCHPs), TFR PlanRep and Epicor. Chapter 6 points out key messages from the analysis and provides recommendations for the way forward.

2.0 REVIEW OF PER FY2013/14 RECOMMENDATIONS AND ACTIONS TAKEN

The main recommendations of the PER FY2013/14, together with actions taken during FY 2014/15 or planned, are presented in Table 2.1 below.

Table 2.1: Summary of PER FY2013/14 Recommendations and Actions Taken

Sn.	PER FY 2013/14 Recommendations	Comments/Actions Taken
4.	Performance of the domestic development funding fall to 20% in FY2013/14 from 51% in FY2010/11. The foreign funds also continues fall. It is recommended that Government increase the sector budget for development in order to ensure sustainability.	The Government allocation funding for the year 2015/16 has continues to decline though the execution rate of government development budget has increased to 23%. The Ministry of has continued to argue with MOF on the more allocation for Health.
5.	Analysis of the NHIF utilization together with the total value of claims paid indicates that the mean cost per visit increased by 41% over the year, from TZS 65,805 to TZS 92,847. The PER recommends further analysis of the drivers of this increase.	The analysis will be undertaken in the PER 2016/17.
6.	It has been observed that Community Health Fund (CHF) data are inconsistent, with missing data in some districts and other districts are charging different premiums in different parts of the district. It is recommended to strengthen the mechanisms for the collection of CHF data and the follow-up on basis of different premiums in one district.	The Ministry of Health has put in initiative which aims at introducing the Modifies CHF to all district. The analysis has been conducted based on donor funded project. Whereby, the Ministry is now planning to rollout the new CHF to the all with the same premium contribution and benefit package.
9.	Some of the facilities still do not have bank account while some of the facilities. It was recommended that the PER should do analysis of the facilities with bank account.	PER 2014/15 undertook field visit to analyze the availability of facility bank account. The finding showed that about 90% of facilities had bank account among which 60% had Government bank account with the rest facilities having Commercial bank account.

3.0 HEALTH BUDGET AND EXPENDITURE ANALYSIS

3.1 INTRODUCTION

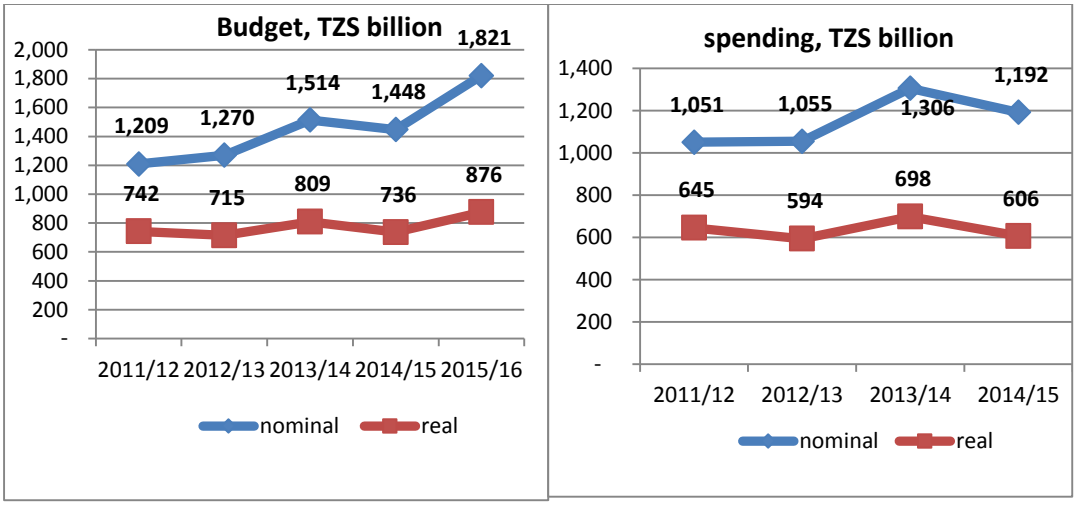
This chapter presents an assessment of public health budget and expenditure trends during the 2011/12 - 2015/16 financial years. The focus of this chapter is on public health sector expenditures that are financed by Government of Tanzania (GoT), including health insurance contributions on behalf of public servants, and by development partners through health basket and non-basket mechanisms, in as far as these are captured on-budget. The data used to carry out the analysis is appended at the end of this report (Annex A).

3.2 TOTAL PUBLIC HEALTH SPENDING

Figures 3.1a and 3.1b show the trends of public health budget and actual spending respectively in nominal and real terms between 2011/12 and 2015/16. The total public health budget in nominal terms increased significantly from Tanzanian Shillings (TZS) 1.209 trillion in 2011/12 to TZS 1.448 trillion in 2014/15, and was projected to increase further toTZS1.821trillion in 2015/16.That is, between 2011/12 and 2015/16 there has been a 50.6% increase in the public health budget in nominal terms, and a 18% increase in real terms.

In terms of actual health spending, it increased from TZS 1.051 trillion in 2011/12 to TZS1.192 trillion in 2014/15 which is a 13% increase, while actual public health spending in real terms declined by 6% - a decrease from TZS 645 billion in 2011/12 to TZS 606 billion in 2014/15 (Figure 3.1b).

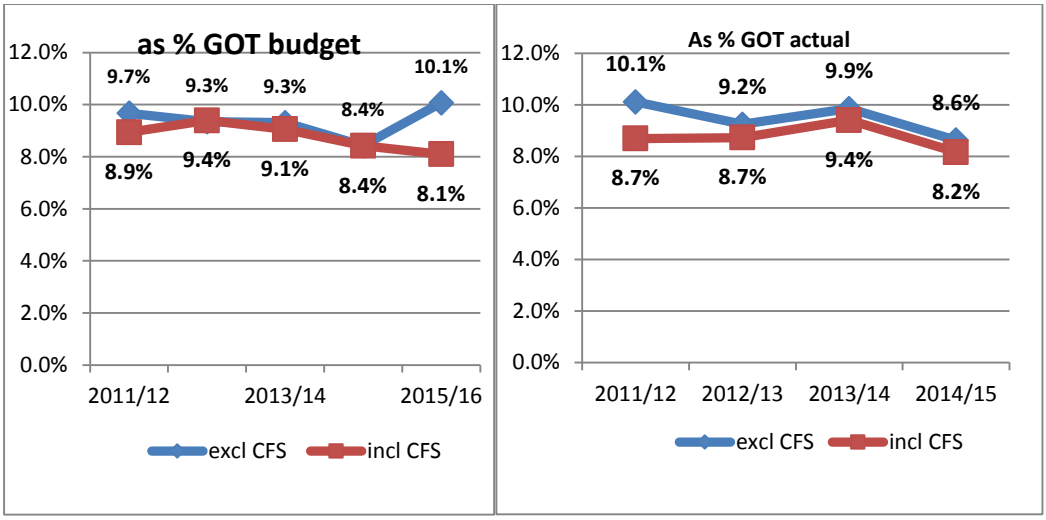
Figure 3.1a: Public Health Budget and Spending Trends (BN TZS)



Figures 3.2a and 3.2bshow the share of public health budget and expenditure in the total government budget, including and excluding Consolidated Fund Services (CFS). The share of public health budget in total government budget, excluding CFS, was 9.7% in 2011/12 but has increased to 10.1% in 2015/16.With the CFS included, the share of health budget actually fell from 8.9% in 2011/12 to a mere 8.1% in 2015/16.

Similarly, the share of actual health spending in total government spending (excluding CFS) declined from 10.1% in 2011/12 to 8.6% in 2014/15, while with CFS included the decline in the share of health spending was from 8.7% in 2011/12 to 8.2 in 2014/15. Based on the figures presented in Figure 3.2b, it is quite clear that the share of government actual spending to the health sector has not kept pace with general government spending between 2011/12 and 2014/15 – it has declined with and without CFS.

Figure 3.2a: Share of Health Budget and Spending as % of Government Budget



In nominal terms, public health budget allocations per capita increased from TZS 28,207 (USD 17.82) in 2011/12 to TZS 38,092 (USD 22.02) in 2015/16. Actual per capita health spending increased from TZS 24,521 (USD 15.50) in 2011/12 to TZS28,869 (USD18.25) in 2013/14 before declining to TZS 25,635 (USD 14.78) in 2014/15. In real terms, there is downward trend for both budget and actual expenditure (Figures 3.3a and 3.3b).Because of domestic inflation and depreciation of the shilling, the estimated per capita health budget and expenditures in real terms have consistently remained below USD11 throughout the review period which is shot of USD 54 recommended by the World Health Organization (WHO). Table 3.1 summarizes the indicators of aggregate health financing in Tanzania from 2011/12 to 2015/16.

Figure 3.3a: Trends of Per Capita Public Health Budget and Spending

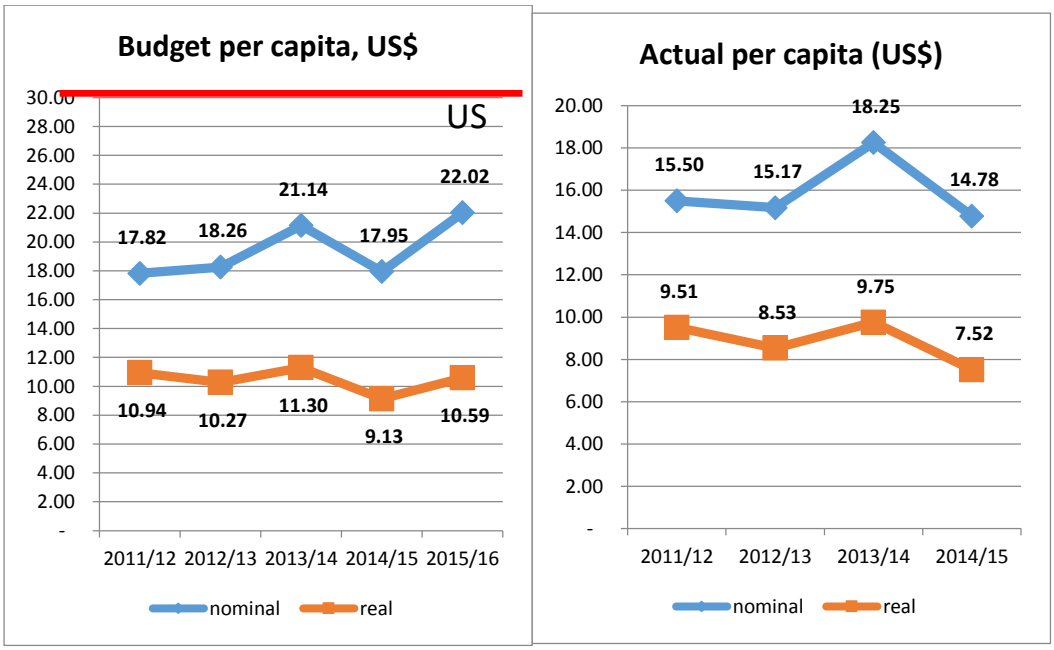


Table 3.1: Indicators of Public Health Financing

Description	2011/12		2012/13		2013/14		2014/15		2015/16
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Billion TZS									
Total Government Expenditure: Excl. CFS	11,616	9,559	12,447	10,262	14,930	12,001	15,499	12,170	16,099
Total Government Expenditure: Incl. CFS	13,526	12,094	13,526	12,094	16,711	13,958	17,194	14,604	22,495
Health Spending (Nominal)	1,209	1,051	1,270	1,055	1,514	1,306	1,448	1,192	1,821
Health Spending (Nominal less NHIF)	1,123	966	1,163	948	1,389	1,182	1,305	1,050	1,621
Health Spending (Real)	742	645	715	594	809	698	736	606	876
Sector Weights									
Share of Health Spending Excl. CFS	9.7%	10.1%	9.3%	9.2%	9.3%	9.9%	8.4%	8.6%	10.1%
Share of Health Spending Incl. CFS	8.9%	8.7%	9.4%	8.7%	9.1%	9.4%	8.4%	8.2%	8.1%
Health Spending as % of GDP	1.8%	1.6%	1.5%	1.3%	2.0%	1.8%	1.7%	1.4%	1.9%
Other Aggregate Indicators									
Per Capita Health Spending (TZS)	28,207	24,521	28,845	23,959	33,445	28,869	31,124	25,635	38,092
Per Capita Health Spending (USD)	17.82	15.50	18.26	15.17	21.14	18.25	17.95	14.78	22.02
Real Per Capita TZS	17,319	15,056	16,228	13,480	17,871	15,426	15,830	13,038	18,315
Real per capita USD	10.94	9.51	10.27	8.53	11.30	9.75	9.13	7.52	10.59
Memorandum Items									
Re-based GDP at current Prices - TZS Bn	57,098		66,194		74,651		83,850		94,867
Re-based GDP at constant 2007 prices - TZS Bn	35,058		37,242		39,889		42,647		45,613
Population (Million)	42.86		44.04		45.26		46.51		47.81
Exchange Rate	1,582		1,579		1,582		1,734		1,730
Deflator (2007 prices)	1.63		1.78		1.87		1.97		2.08

3.3 SOURCES OF FUNDS FOR THE PUBLIC HEALTH EXPENDITURE

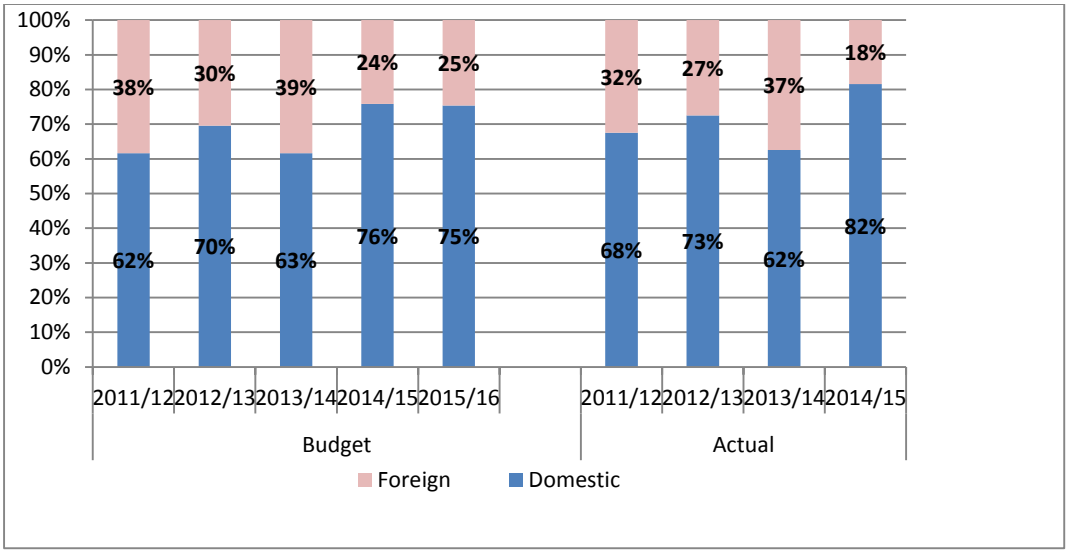
Table 3.2 presents a summary of government and foreign funding in health budget and expenditures from 2011/12 to 2015/16.Government funding remains the dominant source of public health financing. The actual government spending increased from TZS 710,096 billion in 2011/12 to TZS 972,342 billion in 2014/15 which

is a 37% increase. The actual expenditure for foreign funds declined from TZS 340,838 billion in 2011/12 to TZS 219,950 billion in 2014/15 which is a 35.5% decline. The expenditure from health basket in particular, declined by 24% from TZS 151,013 in 2011/12 to TZS 114,985 billion in 2014/15. Comparing the basket funds expenditure for 2014/15 with the approved budget for 2015/16 there is significant decline – TZS 114,985 billion to TZS 77,959 billion which is a 32% decrease. The overall decrease for the foreign funds is contributed by some donors dropping from the basket and decrease in the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Figure 3.4 portrays the shares of government funding and foreign resources in health financing.

Table 3.2: Sources of Health Financing (MN TZS)

Source	2011/12	2012/13	2013/14			2014/15			2015/16
	Actual Exp.	Actual Exp.	Approved Estimates	Revised Estimates	Actual Exp.	Approved Estimates	Revised Estimates	Actual Exp.	Approved Estimates
Govt. Funds	710,096	765,253	860,345	947,450	815,840	1,251,966	1,097,647	972,342	1,367,163
Foreign Funds	340,838	289,877	548,404	566,131	490,625	362,465	349,951	219,950	445,208
Basket	*151,013*	*142,766*	*123,391*	*135,470*	*135,231*	*108,600*	*118,515*	*114,985*	*77,959*
Non Basket	*189,825*	*147,111*	*425,012*	*430,661*	*355,394*	*253,865*	*231,436*	*104,965*	*367,249*
Total	**1,050,935**	**1,055,129**	**1,408,749**	**1,513,581**	**1,306,465**	**1,614,431**	**1,447,598**	**1,192,292**	**1,812,372**

Figure 3.4: Government and Foreign Contribution to Health Expenditures



3.4 TRENDS IN RECURRENT AND DEVELOPMENT EXPENDITURES

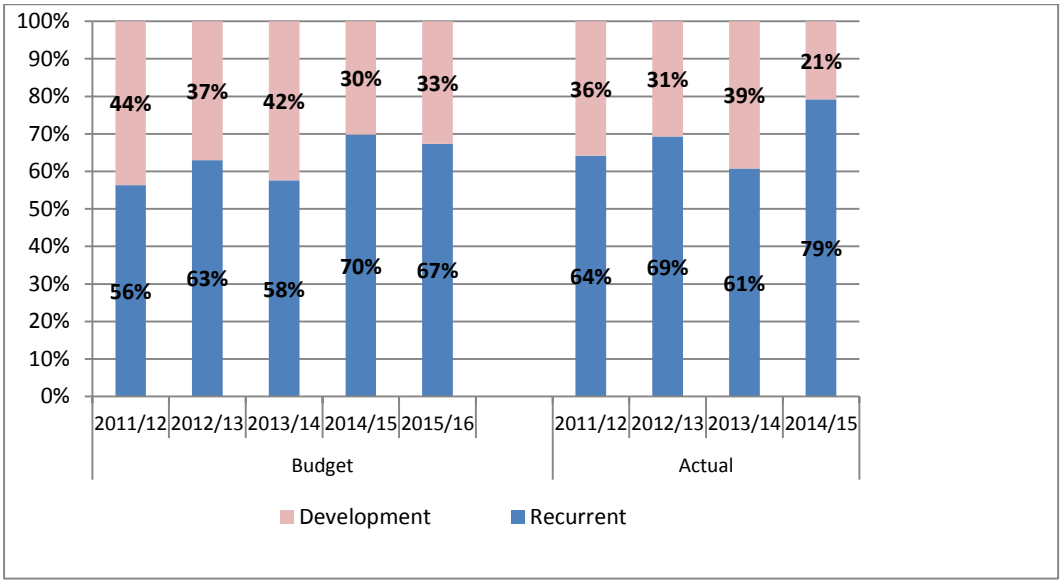
During the review period (2011/12–2015/16), the development budget decreased from TZS 611 billion in 2013/14 to TZS 591 billion in 2015/16 (a 3%decline). Actual development expenditure also decreased about threefold (34%) from TZS 376 billion in 2011/12 to TZS 248 in 2014/15. Throughout the review period, development budget has been consistently low than the recurrent budget. The recurrent budget has grown consistently throughout the review period, increasing by 126% from TZS 541 billion in 2011/12 to TZS 1,221 billion in 2015/16. Table 3.3 presents a summary of the development and recurrent budget and actual expenditures from 2011/12 to 2015/16.

Table 3.3: Summary of Recurrent and Development Budget and Expenditures (BN TZS)

	2011/12	2012/13	2013/14			2014/15			2015/16
	Actual Exp.	Actual Exp.	Approved Estimates	Revised Estimates	Actual Exp.	Approved Estimates	Revised Estimates	Actual Exp.	Approved Budget
Recurrent	675	731	797	872	794	1,131	1,011	944	1,221
Development	376	324	611	642	513	483	437	248	591
Total	**1,051**	**1,055**	**1,409**	**1,514**	**1,306**	**1,614**	**1,448**	**1,192**	**1,812**

Following faster growth in the recurrent budget and expenditures relative to development budget and expenditures, the share of the recurrent budget has increased significantly from 56% in 2011/12 to 67% in 2015/16. Also, the share of actual recurrent expenditure increased from 64% in 2011/12 to 79% in 2014/15. Figure 3.5 presents the trend of the relative shares of development and recurrent budget and expenditures during the period under review.

Figure 3.5: Trend of Shares of Recurrent and Development Budget and Expenditures



3.5 PERFORMANCE OF THE HEALTH SECTOR BUDGET

Figures3.6a, 3.6b and 3.6c present the budget performance indicators over the period 2011/12–2014/15, summarized according to budget classification (recurrent and development budget), and sources of funds (government and foreign funds). Overall, the execution of the total budget was consistently high (above 80%) from 2011/12 but it experienced a significant decline in 2014/15; decline to 75%. The performance of the recurrent and basket fundis consistently high – above 85% for each year in the review period. Execution of development budget is the lowest; it has performed below average (50%) in three years and it was as low as 20% in 2013/14. The performance of the non-basket fund budget is inconsistent with the highest performance in 2013/14 (83%) and lowest in 2014/15 (41%).

Examination of budget performance by the Departments in the Ministry of Health shows inconsistent pattern (Figure 3.6d). While Departments such as Finance and Accounts, Information, Education and Communication, Policy and Planning and Preventive Services have high performance (95% and above) the Social Welfare

Department has the lowest performance (62%). This is a concern given the magnitude of social welfare issues in the country.

Figure 3.6a: Overall Budget Execution

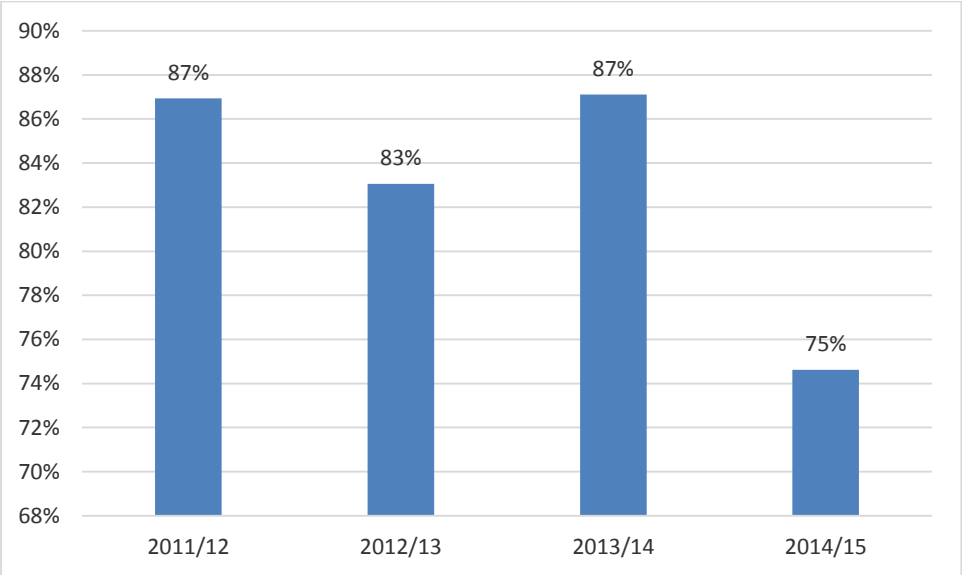


Figure 3.6b: Local Funding Budget Execution

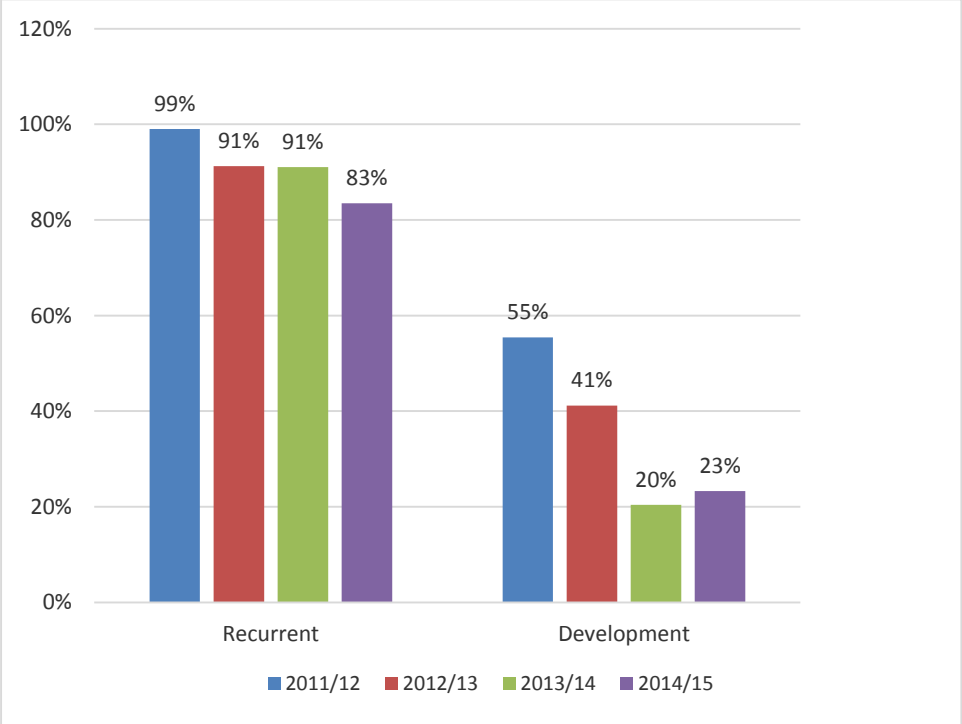


Figure 3.6c: Foreign Funding Budget Execution

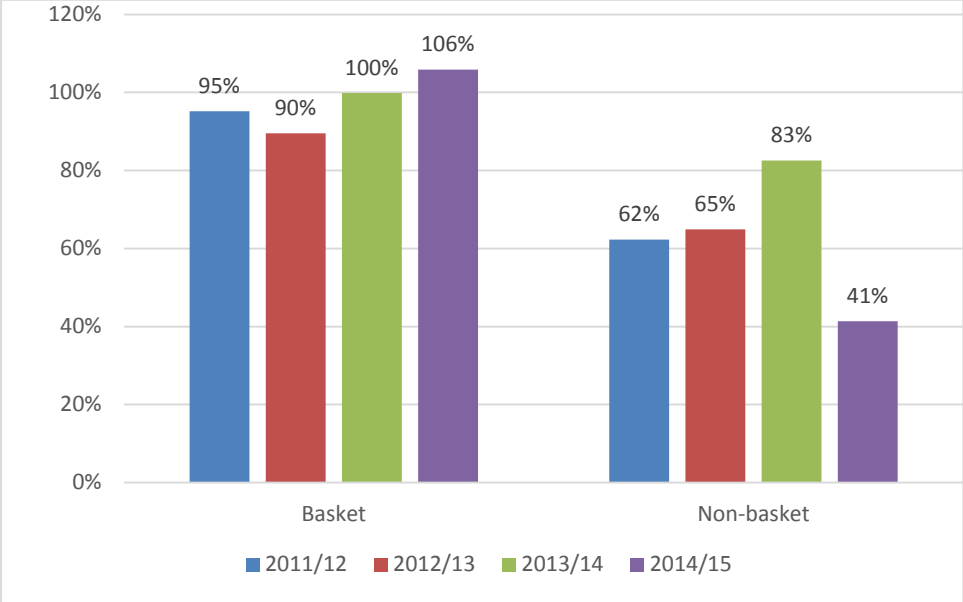
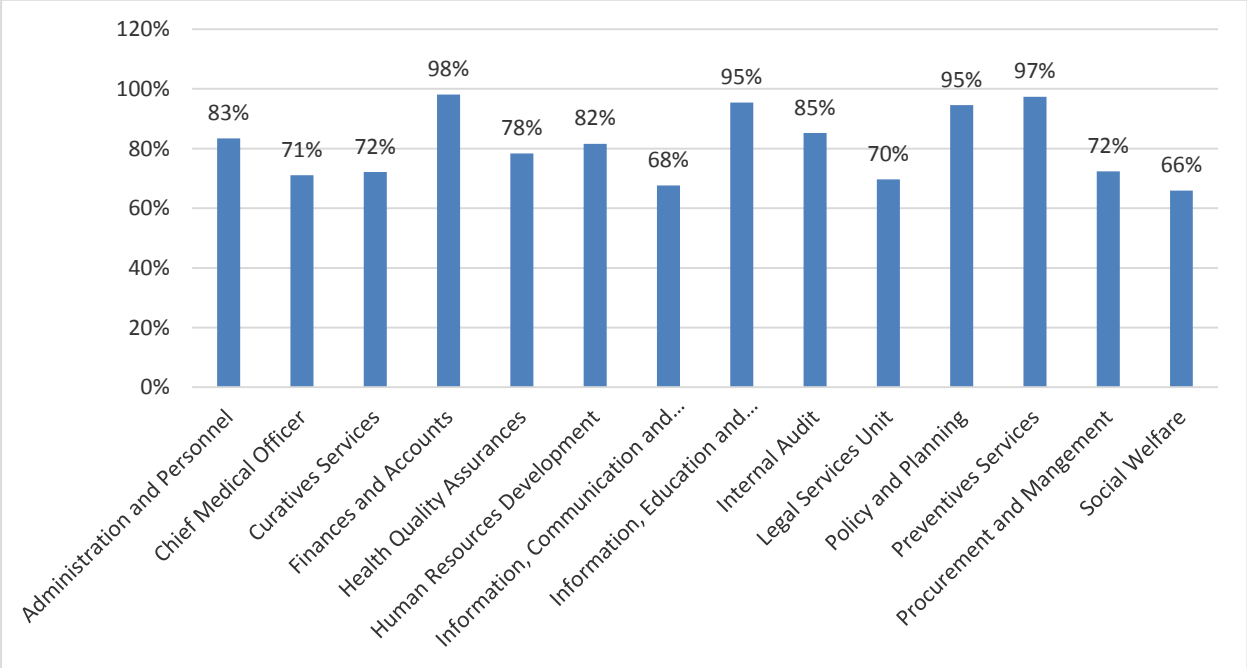


Figure 3.6d: Budget Execution by MoHCDGEC Department, 2014/15



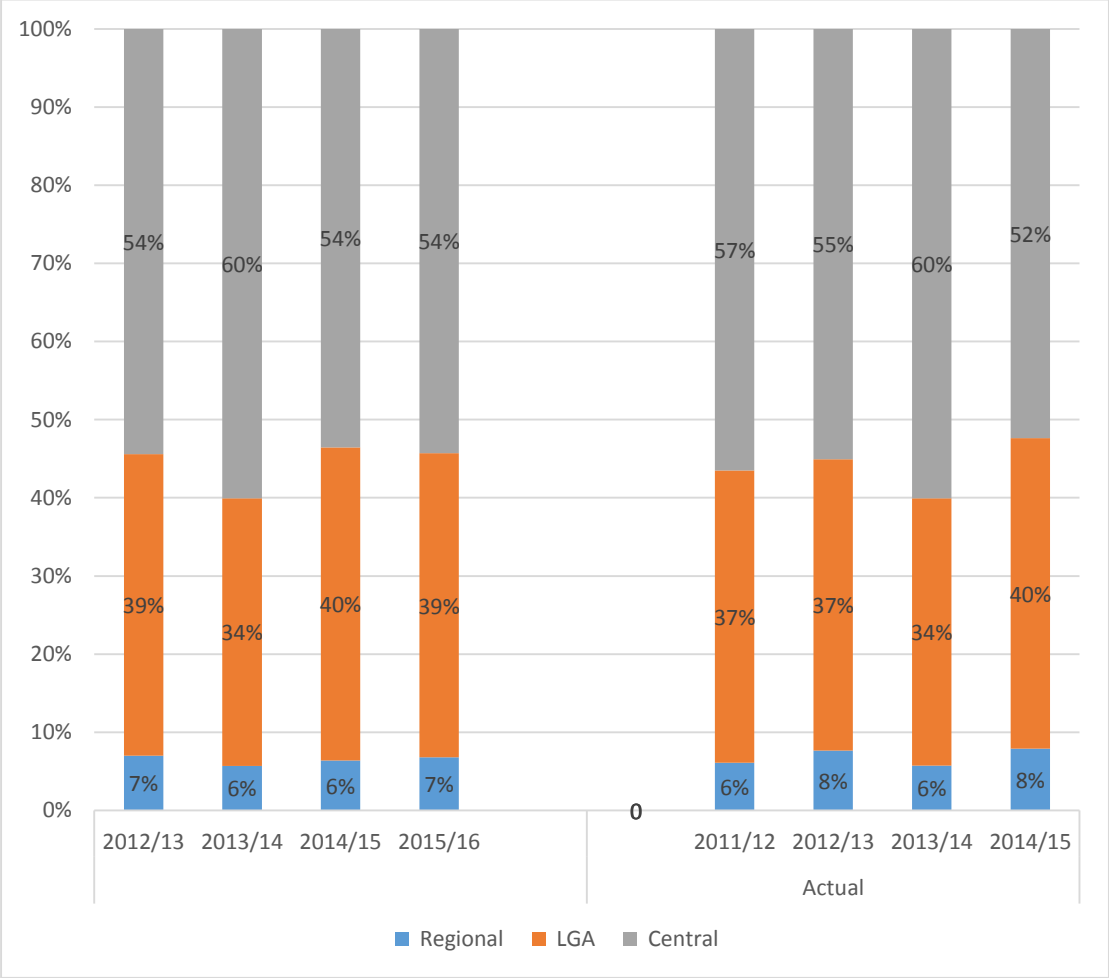
3.6 SECTOR BUDGET AND EXPENDITURE BY LEVELS OF GOVERNMENT

The relative shares of resources among levels of government have not changed much over the review period, with the share of resources controlled by the central ministries in particular Ministry of Health and PO-RALG remaining dominant throughout. The share of resources going to the Local Government Authorities (LGAs) has been fluctuates from 39% of the budget in 2012/13 to 34% in 2013/14 but it increased to 39% of the budget in 2014/15 while the actual spending decreased from 37% in 2011/12 to 40% in 2014/15. The funds spent at regional level has fluctuated but remained below 10%. Table3.4 and Figure 3.7 present a summary of total funding and shares of resources for the health sector at different levels of the government.

Table 3.4: Health Spending by Levels of Government (BN TZS)

	2011/12	2011/12	2012/13	2012/13	2013/14	2013/14	2013/14	2014/15	2014/15	2014/15	2015/16
	Budget	Actual	Budget	Actual	Budget	Revised	Actual	Budget	Revised	Actual	Budget
Central	719	594	691	581	845	899	785	865	812	624	984
Regional	71	64	89	81	80	87	75	103	106	94	123
LGA	419	393	490	393	482	527	447	647	530	474	706
Total	**1,209**	**1,051**	**1,270**	**1,055**	**1,409**	**1,514**	**1,306**	**1,614**	**1,448**	**1,192**	**1,812**

Figure 3.7: Shares of Health Resources to the Different Levels of Government



4.0 COMPLEMENTARY HEALTH FINANCING

4.1 INTRODUCTION

This section reviews three main sources of complementary funding: Health Services Fund (HSF), the National Health Insurance Fund (NHIF), and the Community Health Fund (CHF). HSF is basically the user fees paid by patients at the point of health service delivery. NHIF mobilizes funds from employees and employers to finance health care services for its members. The contribution rate is provided in the Act establishing the Fund as 6% of the employee's gross monthly salary (met equally by both employer and employee – 3% each). CHF is a rural health insurance mechanism whereby districts set their own payment premium and the number of beneficiaries per CHF card as directed by the CHF Act of 2001.

4.2 HEALTH SERVICES FUND

The HSF continues to be an important source of funding for health facilities especially for operations and maintenance. The HSF receipts has increased in 2014/15 has increased by above 100% form 2013/14 accounted for 3% of health expenditures by the LGAs in 2014/15. However still there is a challenge in capture this fund both at LGA level and on Epicor system (Table 4.1). Although , the user fee are increasing they are known to limit access to care especially for the poor and thus it is important to ensure that all funds collected are utilized to improve service delivery, and as a corollary, stimulate the demand for health services. It is also important to continue sensitizing communities on the advantages and importance of prepayment schemes, especially in rural areas where incomes are not predictable.

Table 4.1: HSF Revenues and Expenditures, FY2011/12 – FY2014/15

F/Y	**Balance BF (TZS BN)**	**Receipts (TZS BN)**	**Payments (TZS BN)**	**Closing Balance**
2012/13	405.00	10.49	14.08	(4.00)
2013/14	(8,003.16)	6,662.91	5,881.07	(8,296.90)
2014/15	(8,003.16)	25,271.29	17,268.13	(5,154.96)

4.3 THE NATIONAL HEALTH INSURANCE FUND

4.3.1 MEMBERSHIP AND UTILIZATION OF HEALTH SERVICES

Membership of the NHIF grew by 6% for principal members (from 602,955 in 2013/14 to 640,341 in 2014/15) down from 12% growth experienced from 2012/13 to 2013/14 (increase from 536,829 to 602,955). The number of total beneficiaries declined slightly by 3% from 3,328,312 in 2013/14 to 3,237,434 in 2014/15 resulting in a fall in the ratio of members to beneficiaries from 5.52 to 5.06 (Table 4.2). Visits by beneficiaries grew substantially (69%) from 3.3 million visits in 2013/14 to 5.6 million in 2014/15 resulting in an increase in the mean contacts per beneficiary from 1.00 to 1.74, reversing the previous year's decline.

Table 4.2: Basic Data on NHIF Membership and Utilization of Health Services, FY2011/12 – FY2013/14

	FY2012/13	FY2013/14	FY2014/15
Number of Members	536,829	602,955	640,341
Number of Beneficiaries	2,963,296	3,328,312	3,237,434
Ratio of Beneficiaries to Members	*5.52*	*5.52*	*5.06*
Visits by Members/Beneficiaries	3,904,863	3,334,137	5,636,373
Contacts per Capita	*1.32*	*1.00*	*1.74*

Sources: NHIF Annual Performance Report 2014/15; NHIF data submitted for PER FY2014/15.

4.3.2 INCOME AND EXPENDITURE

A comparison of figures from 2012/13 and 2013/14 indicates an increase in the premium contribution to NHIF and income from other sources such as investment from TZS 256,959 Million to TZS 309,563 million which is a 20% increase. This increase emphasizes the importance of NHIF in financing health services. However, there is a decline by 8% in 2014/15. Compared to 2012/13 figures, the NHIF unspent balance has declined slightly from 51% to 49% in 2013/14 but there is a significant decline to 44% in 2014/15 (Table 4.3). Despite the decline, the unspent balance is still huge which a concern considering the financing shortages facing the health sector.

Table 4.3: Basic Data on NHIF Income and Expenditure, FY2012/13 – 2014/15

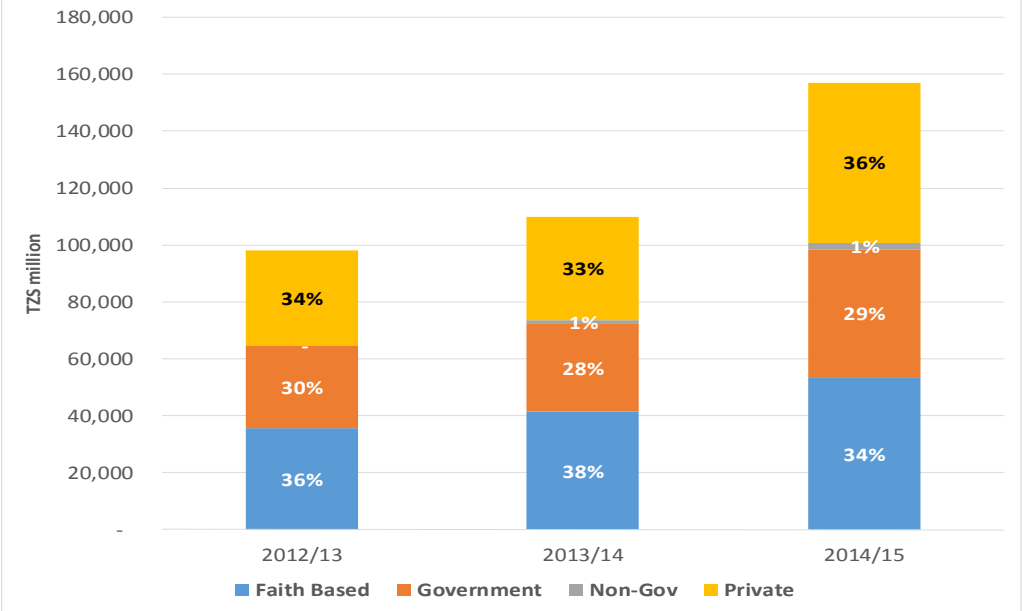
Description	FY 2012/13 ('000)	FY 2013/14 ('000)	FY 2014/15 ('000)
Income from contributions	207,502,104	245,176,068	286,702,261
Total Revenue	266,533,121	318,065,681	370,476,062
Value of claims paid	97,924,614	132,033,592	156,710,205
Total expenditures	132,651,720	182,185,013	224,914,659
Surplus (Revenues less expenditures) before tax	133,881,401	135,880,668	145,561,403
Surplus as % of total revenues	50%	43%	39%

Source: NHIF Audited report 2015

4.3.3 NHIF SPENDING BY OWNERSHIP OF FACILITIES

Faith-based organizations received 34% of the funds paid out as claims by NHIF in FY2014/15, which represents a fall when compared to 38% of the claims payments in FY2013/14. Faith-based health facilities are important actors in health service delivery, especially in marginalized areas. The largest share of NHIF claims was paid to private facilities, which received 36% in 2014/15 up from 33% in 2013/14. The share going to public facilities has remained largely constant, at between 28% and 30% per year. Figure 4.1 shows the relative shares of the three main ownership groups.

Figure 4.1: NHIF Payments by Facility Ownership Type, FY 2012/13 – 2014/15



Note: The Non-Government category is a new category. It was introduced in FY 2013/14 and it includes CCBRT, some parastatal facilities, and some other private facilities.

That the government facilities are receiving low and constant total reimbursement is cause for concern given the fact that they provide more services than faith-based facilities. The reimbursement is according to fees for service. It is understandable that the government facilities receive less given their lower charges, but this would effectively mean that the government is subsidizing the NHIF.

4.3.4 NHIF SPENDING BY LEVEL OF THE HEALTH SYSTEM

Figure 4.2 shows the distribution of FY 2014/15 claims payments by type of facility, or level of the health system, whereby referral hospitals received over half of NHIF payments, at 52%. The addition of regional hospitals results in 66% of claims payments going to higher level hospital facilities. Regional hospitals, district hospitals and pharmacies each received around 9-14% of the payments. The figure shows that only 22% of NHIF claims payments go to the primary lower level health facilities (district hospitals, health centers and dispensaries).Over half of the budget and spending is going to referral hospitals as shown in Figure 4.2. There are many factors involved in this, including the following:

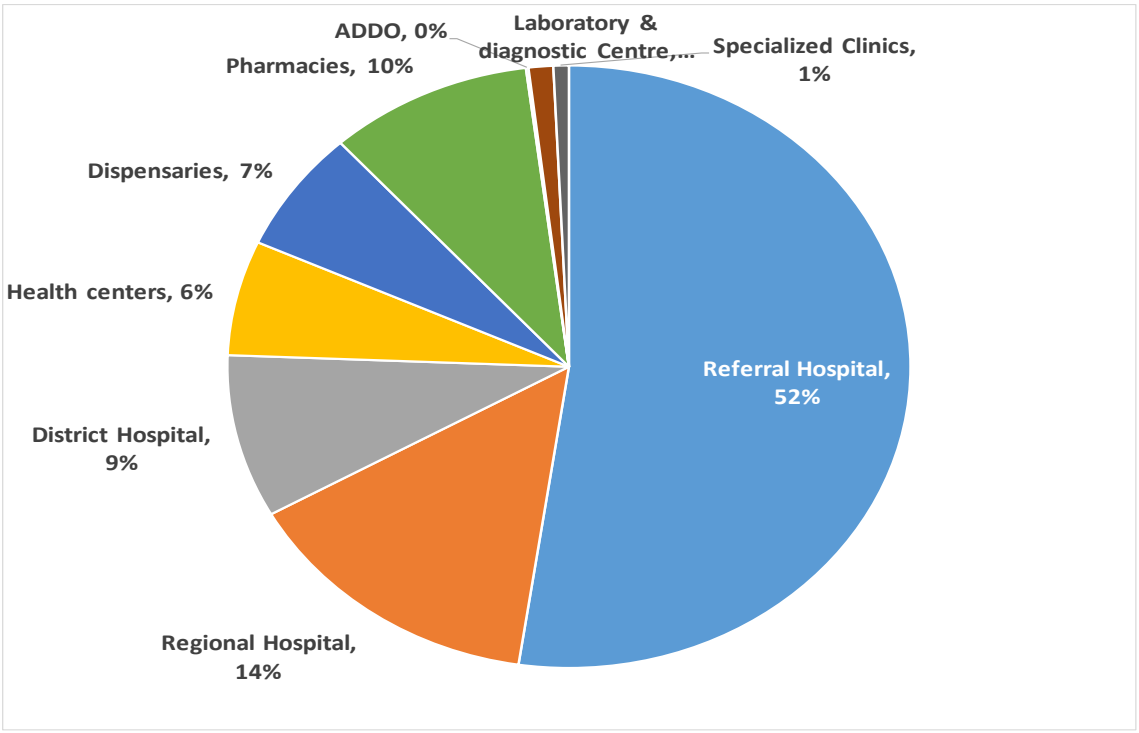
- Most of the services provided at the referral level are very expensive compared to lower levels.
- Prices per service are higher at the referral level and most referral hospitals have reviewed their fee schedules.

- Most of the NHIF "Green Card"[1] members are found at the urban centers compared to rural areas.

Payments to pharmacies alone accounted for 10% of the total disbursements. This is an important entity in addressing the problem of access to medicines. However, disbursement to Accredited Drug Dispensing Outlets (ADDOs) is negligible, which is partly a reflection of the size of these entities countrywide. However, the ADDOs are key conduits for making medicine accessible to rural marginalized areas and more efforts should be made to collaborate with these entities. This is also an area where the CHF funds could be used effectively.

[1] Majority of teachers and nurses reside in rural areas and they are all members of NHIF. However, these are the members with brown card not green card which allows access to limited number of services. Contrary, those in urban areas some have big salaries and thus qualify for green card. With green card, they consume more advanced services.

Figure 4.2: NHIF Spending by Type of Facility, FY 2014/15



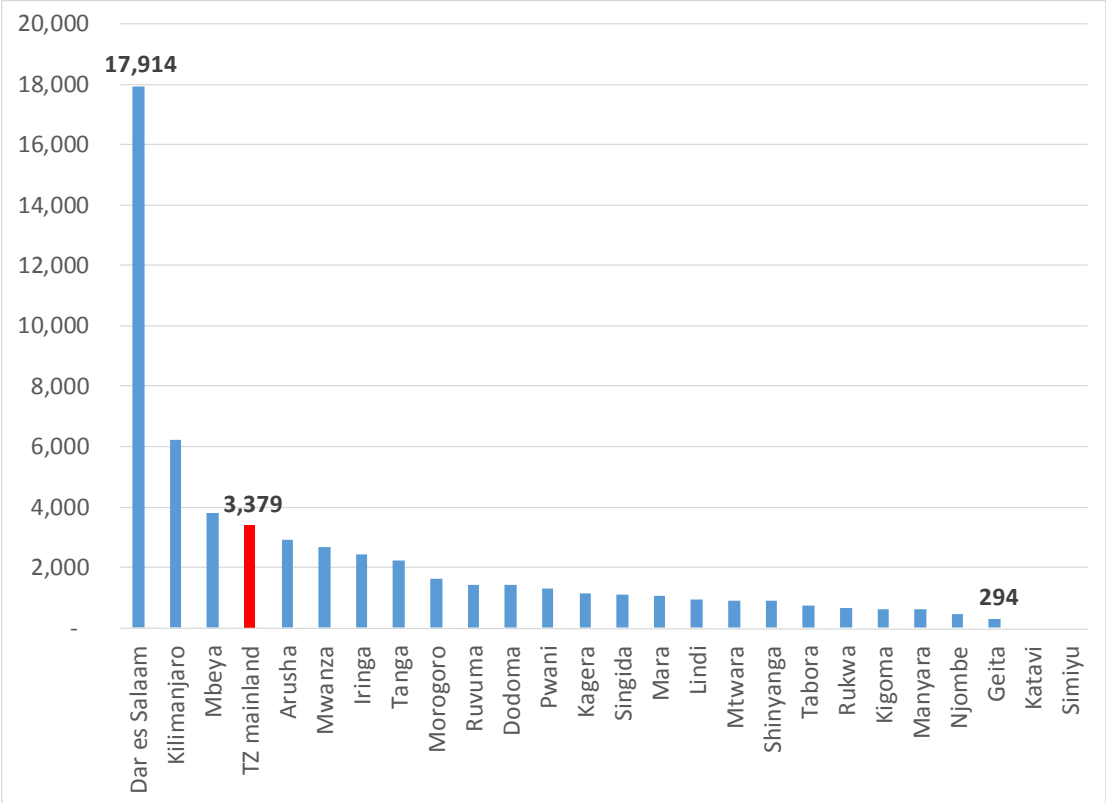
Source: NHIF Data submitted for PER.

4.3.5 NHIF SPENDING BY REGIONS

The geographical distribution of claims payments continues to be very skewed towards the more urban areas, in large part due to the concentration both of higher level government facilities and private facilities in those regions. Figure 4.3 shows that per capita claims in Dar es Salaam region were five times the national average, while in Katavi and Simiyu regions, no claims were recorded.[2]

[2]It is important to check on whether NHIF has included the new regions in the database.

Figure 4.3: Per capita NHIF Claims by Regions, FY 2014/15 (TZS)



4.4 COMMUNITY HEALTH FUND

Progress in expansion of the Community Health Fund (CHF) continued in 2014/15, showing a substantial improvement in estimated population coverage from 8.1% in 2010/11 to 14.4% in 2014/15 as shown in Figure 4.4. The number of member households almost doubled (98%) from 561,370 in 2010/11 to 1,112,874 in 2014/15.

Figure 4.4: CHF Coverage and Membership, FY 2010/11 – FY 2014/15

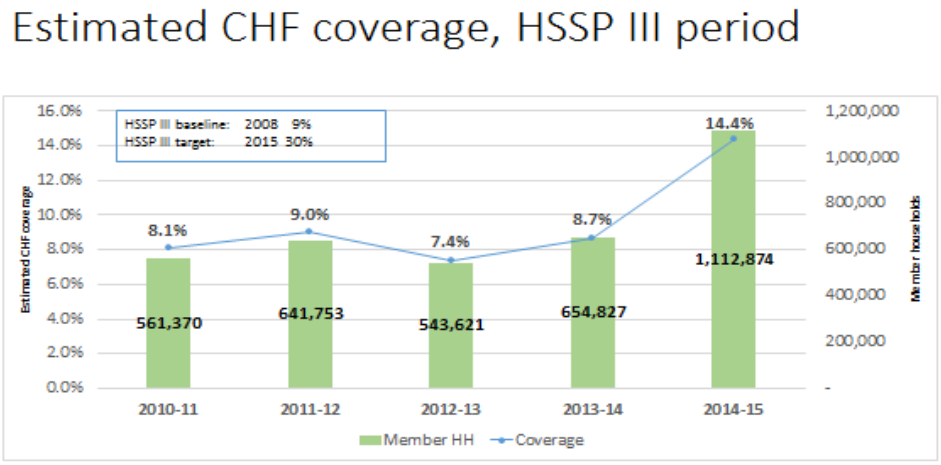
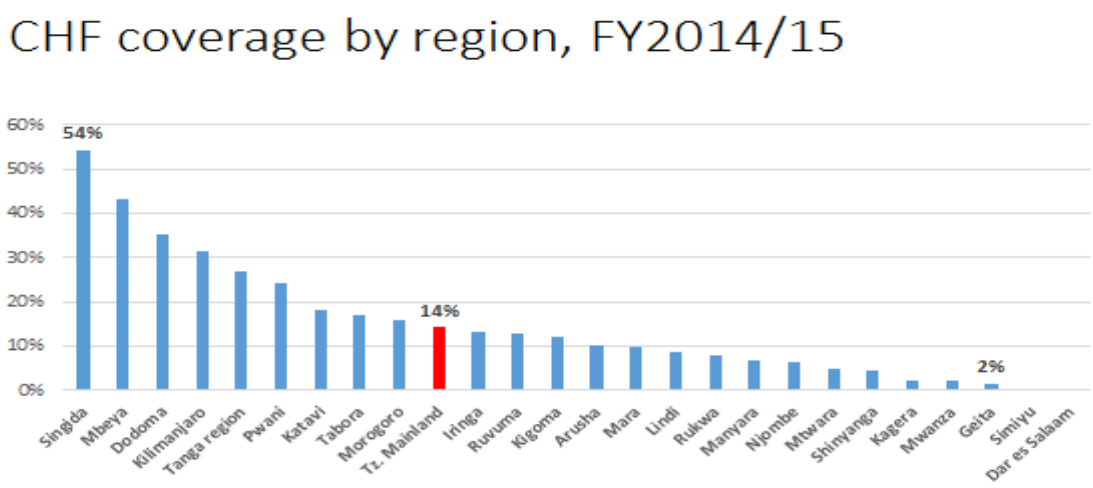


Figure 4.5 shows the variation in CHF coverage by regions in FY 2014/15. The numbers are based on an estimated six persons per household, although this is not always the case – there are variations per district. Accurate population coverage is not yet available, except in Dodoma region where a detailed membership database has been established under the Health Promotion and Systems Strengthening project. Details of the reported number of member households per region are provided in Annex B.[3]

[3] The annex table shows large variations in CHF performance across the country, with the 20% increase year on year in the national total member households masking growth of over 100% in 4 regions, and falls of more than 40% in another four regions. These extremes should be further investigated to determine reasons, both to share best practices and to stem the decline in those regions where membership is falling. Data quality should also be checked.

Figure 4.5: Estimated CHF Coverage by Regions, FY 2014/15



4.5 CHF REVENUES AND MATCHING FUNDS

NHIF data for 2013/14 indicate that the CHF premium were generally low. Of the 159 LGAs for which data were available, 89 (56%) were charging TZS 10,000 while 19% were charging only TZS 5,000 per household.

CHF membership revenues are intended to be matched by central Government in recognition of the fact that the CHF cannot be self-financing given the limited ability of the majority of the informal sector to pay full cost, and the government's role in financing essential services. The Memorandum of Understanding between MoH, the then PMO-RALG, and NHIF was renewed after its lapse in June 2009, and the responsibility for channeling matching funds lies with NHIF. Table 4.4 below presents NHIF-reported revenues and expenditure on matching grants between FY 2011/12 and FY 2013/15. It is important to note that due to delays in the processing of matching grants, payments made do not necessarily relate to the CHF revenues raised in a given financial year. Further work to assess and address such delays is warranted.

Table 4.4: NHIF Data on Matching Grant Funding Received and Paid Out, FY2010/11 – FY2013/15

Year	Brought Forward	Received from MoH	Paid to LGAs	Carried Forward
2011/12	2,582,022,830	1,000,000,000	1,160,367,150	2,421,655,680
2012/13	2,421,655,680	1,900,000,000	-	4,321,655,680
2013/14	4,321,655,680	1,900,000,000	752,352,500.00	5,469,303,180
2014/15	5,469,303,180	1,400,000,000	1,053,983,820.00	5,815,319,360

5.0 LOCAL GOVERNMENT HEALTH SECTOR SPENDING

5.1 INTRODUCTION

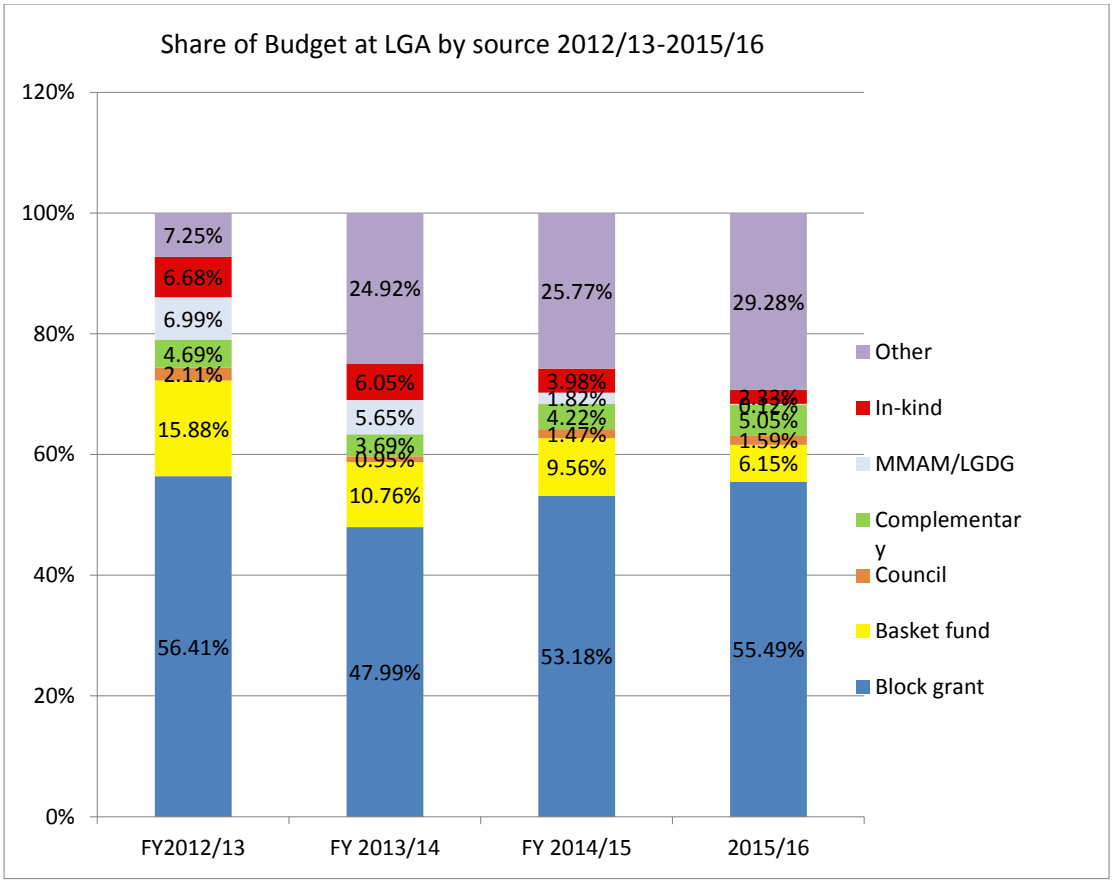
This chapter presents information on the financing of Local Government Authorities (LGAs), covering sources of funding, breakdown by cost centers, and budget performance. LGAs are responsible for the delivery of primary health care services which, as stated in MKUKUTA II, MMAM, and HSSP III, remains the priority for the Government as the most cost-effective and equitable level of the health system. It is therefore useful to examine both the level and composition of financing at this level. Data consistencies regarding LGA funding are substantial, with variation between MOFP data, PO-RALG data, and data from the LGA Epicor system and as reported in the CCHP implementation reports. CCHPs capture direct funding to LGAs which is not always reflected in central government data sources. The findings in this section are therefore not all consistent. However, the picture is slowly improving, in particular as efforts are made to better link Epicor outputs with the PlanRep system.

5.2 SOURCES OF FUNDS TO FINANCE HEALTH SERVICES IN LGAS

There are various sources of funds in health sector in LGAs, namely budgetary allocations from the government, external financing through either the health basket or non-basket mechanisms, funds from councils own sources, and complementary sources which include fees and subscriptions from various schemes. Each financing source has its modality for raising and managing its own collection for the aim of financing the health sector in Tanzania.

Figure 5.1below presents the budget funds for LGAs over the past four yearsas reported in successive CCHP implementation reports. The Figure shows that the Block Grant which covers both Personal Emoluments (PE) and Other Charges (OC) continues to be the major source of funds at council level. As a share of reported funds, it has been relatively stable at 48% -56% of the budget. The health basket funds budget has been fairly unstable; 6% -16% of the total council budgets. In 2015/16 only 6% of the councils' budget was expected from the basket funds. Complementary funds budgets are broadly similar across years, at 4% - 5% of the total budget.

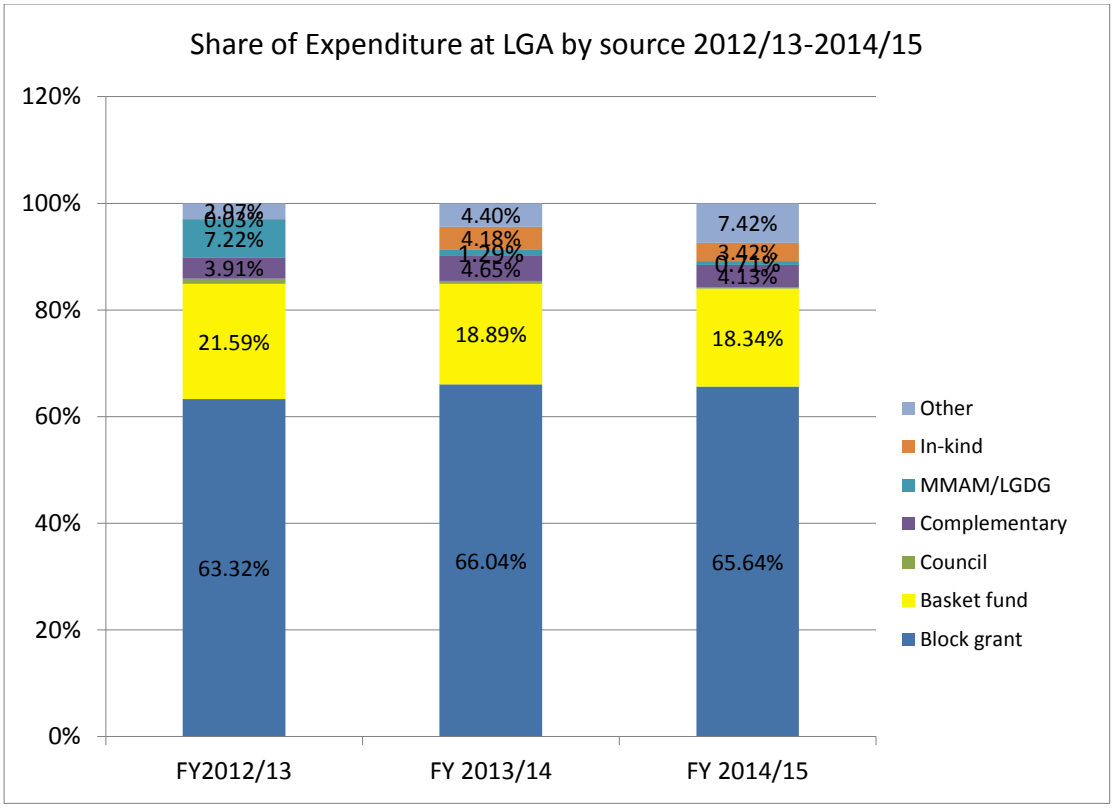
Figure 5.1: LGA Budget by Source



Source: PlanRep data from Comprehensive Council Health Plans (CCHP) Reports.

Figure5.2 shows the actual LGAs spending over the past three years. As a share of reported funds, Block Grant has been relatively stable at 63% - 66% of the expenditure, and in FY 2013/14it regained its slightly higher share of 66% of actual funding available from a low of 63% in the previous year. The health basket funds have also been fairly stable, between 18% - 21% of actual funds received. Complementary funds are also broadly similar across years, at 4% of the total actual spending.

Figure 5.2: LGA Expenditures by Source

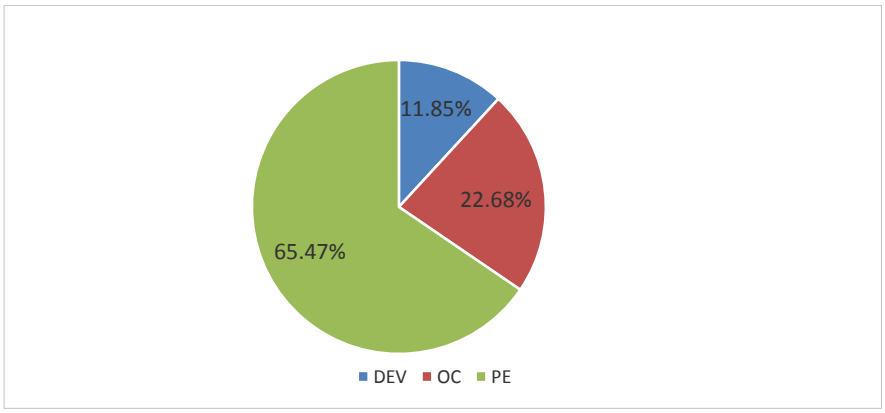


Source: PlanRep data from Comprehensive Council Health Plans (CCHP)Reports

5.3 RECURRENT AND DEVELOPMENT SPENDING AT LGA

Analysis of expenditure by recurrent (PE and OC) and development categories was done as shown in Figure 5.3. In 2014/15, development activities consumed 65% of LGAs expenditure followed by OC (23%) and PE (12%).

Table 5.3: Government Recurrent and Development Spending at LGA, FY 2014/15

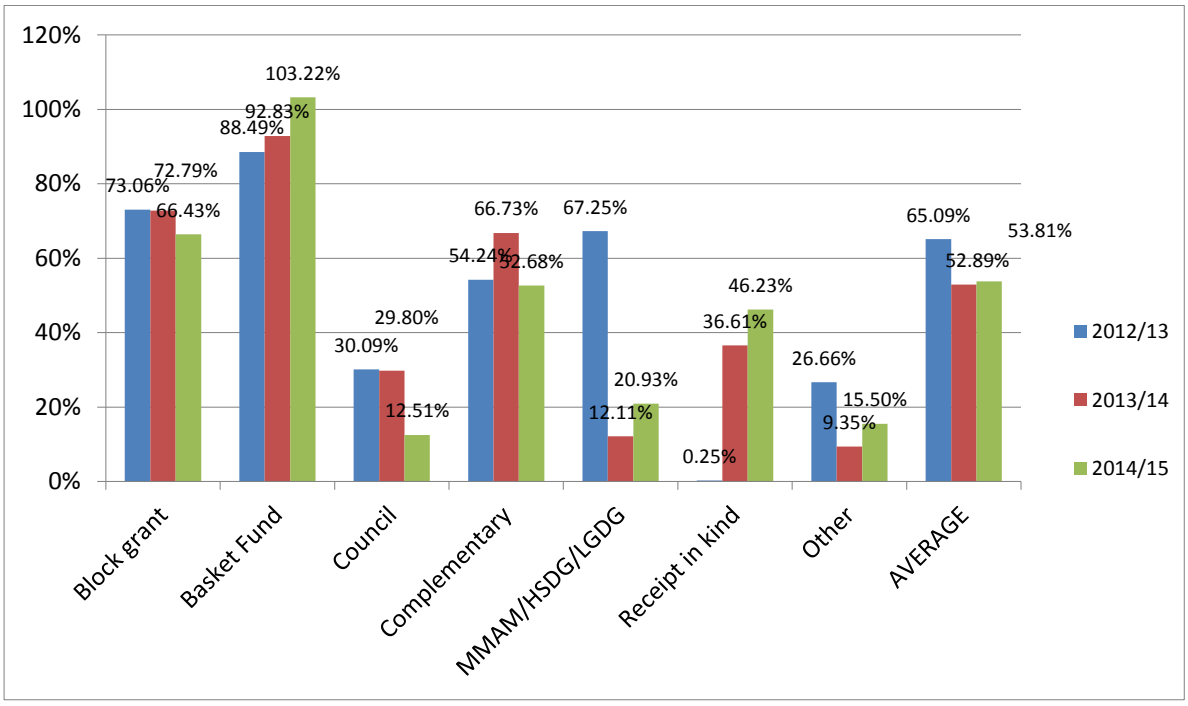


Source: LGA Epicor.

5.4 BUDGET PERFORMANCE AT LGA LEVEL

Figure 5.4 shows the budget performance for the past three years. The average performance ranged from 53% to 65%. The performance of the basket fund is fairly good and in 2014/15 the basket fund was fully released. The performance of the block grant was above 65% in the three years. Other sources of funding (except MMAM in 2012/13) have consistently performed poorly.

Table 5.4: Budget Performance at LGA, 2012/13-2014/15



Source: LGA Epicor.

6.0 LOCAL GOVERNMENT HEALTH SECTOR SPENDING

6.1 INTRODUCTION

Due to the need of strengthen the use of complementary in efficient way; in previous years the government provided a circular to all districts with direction of closing all subaccount and open one miscellaneous account which among other funds the health fund of cost sharing and CHF are deposited in this account. More over the government also gave the direction of close all facilities bank account which the main aim was to reduce the misuse of this funds and facilitated its management.

However, due to challenges which has been reported in various meeting on difficulties faced by DMO and health facilities in accessing the complementary fund the government gave another direction of re open the facilities bank account. However still there has been complains from the facilities that they still face challenges in accessing the fund. Even more some of the facilities they still do not the facilities bank accounts. Therefore among other things the PER 2014/15 analyzed the operation of District and facilities bank account; analyzed the challenges and came up with recommendation. The following districts were visited Moshi DC, Siha Dc, Arusha Dc, Mwanga Dc, Gairo Dc, under each district the data collector will visit two facilities one health center and one dispensary which was determined by the DMO. Whereby the Total number of 68 facilities were visited.

6.2 METHODOLOGY

Conduct data collection at the district and facility level which focused on the operation of facility bank accounts in term of strength, Challenges, and weakness. Total of 30 district were visited whereby, sample based on the best performing district in terms of collection of CHF and HSF and worst performing district in each zone were visited. In each district the team visited one health center and one dispensary which were sampled at the district. **(Annex C List of district visited).**

6.3 FINDINGS:

Facility Bank Account: the total number of facilities among districts visited was 722 whereby among which 90% of the facilities had bank account where 94% of the accounts are in operational. Moreover, among the facilities with bank 60% of Facilities has government bank account while 25% had commercial bank account. Most of the district in which had commercial bank account had no idea or knowledge on the process of open government bank account or were not able to differentiate between the Government bank account and the commercial bank account.

At the district level all monies are deposited into miscellaneous account at almost all districts with an exception of few district such as Gairo DC and Iramba DC. In these district the fund are deposited into Health Account and the facilities are submit their requirement which are purchased by the district. In almost all district there were no challenges in accessing fund from the miscellaneous account since the district produce weekly report on fund deposited into this account.

Collection of Complementary Fund: The modality of collecting the complementary funds differs by type of fund whereas the user fee are collected at point of services and the NHIF is collected inform of claims all over the districts. The CHF collection was different from various districts whereby some district are project funded programme such as in districts of Dodoma and Kilimanjaro regions. And some had self-Initiatives in collecting CHF premium. In most district such as Arusha DC, Mwanga and Iramba DC, Which they do not have donor support but they have put up self-initiatives where by the collection are done by CHMTs Members trough village meeting.

The field work also observe that in Some district such as Mwanga Dc they have corporation with the TASAF where as they conduct collection of CHF from poor household during the Cash transfer exercise while in some district such as Dodoma they have no corporation with TASAF at all.

Reimbursement Process: After the collection of complementary fund the process of reimbursement process differs from various district whereby mostly the user fee and CHF are deposited directly into the facility bank account while NHIF in all districts are reimbursed to the facilities through claims which are processed at the district level and the fund are deposited to the facility bank account after being deposited into district account mostly mislneous account. In regard to CHF it differs from one district to another where in most of donor funded project district the reimbursement is done in form of claims with an exceptional from Moshi DC where they use capitation as a form of payment to the facilities from the dispensary to the regional referral. In other district which are not donor funded they don't have any new form of payment where fund are deposited into facility bank account directly after the collection, with on exception of Iramba DC where the fund are deposited at district and the district reimburse the facilities after the request, also in Giairo the fund are reimbursed to the facilities rather the buy the requirement provided by the facilities.

Process for Facilities to access Fund: All complementary fund the facility committee body are responsible to approval all requested of fund which is submitted to the district together with the areas of spending, where the DMO endorse the expenditure after ensure that the specific facilities has the money in their account. The signatories are the per guideline which is Members form facility and FGC. However in some few case they did not follow the guideline where only facilities members were the signatories.

Period of accessing Fund: In average the period of accessing matching funding ranges from 3 month – 6 months this is after the using of new matching fund protocol. Whereby before the new matching funding protocol it took even about two years. On the side of NHIF claims it also ranges from 3-6 Month. The main challenges which has been identifies as the main reason for the delay of fund are such as;

- Incorrect filling of the claims forms
- Too many attachment in requesting matching fund
- Low enrollment
- Bureaucracy in applying the matching fund-to many attachment e.g list of CHF enrolled, members from HF Certified receipts of the true copy of the original which is expensive eg in Mwanga DC it cost 200,000 last time.

6.4 OBSERVATION

- CHF modified in Moshi is administered by NHIF with collaboration PHARMACESS, the DMO appreciates this operation as it has increased the number of CHF members and health revenues where by March 2016 the Targeted amount of 205,000,000 has been exceed to 280,000,000 (CHF, NHIF and User fee)
- In Arusha DC the user fee has increased from 2000 to 10,000 where by the CHF premium is also 10,000 this has led to decrease of user fee spending and increase CHF members. The service are available up to referral government district hospital.
- In Mwanga the CHF premium is 10,000 per HH, Where the service are available up to district hospital regardless of the point of contribution. User fee is 8,000 at HC, 10,000 at Hospital and 6,000 Dispensary. The District has made innovation of collect premium to the community during cash transfer of TASAF to poor HH. Where by TASAF has agreed to cooperate with the District by ensure that the HH are priorities expenditure by Health then education.
- In all district and facilities they don't receive the feedback from NHIF on rejected claims hence no room for improvement
- In almost all district facilities did not know the difference between Government and commercial account.
- Delays of facilities in access the fund was mentioned throughout the district
- Absence of clear records in the recording of user fee Lack of clear information of NHIF released at the LGA and facility level
- All facilities with bank account the monies are deposited into facility bank account
- In Dodoma MC claims are paid by district to all health facilities where services are available up to regional level.
- Out of stock in MSD, the process is always very long to buy somewhere else

- In some areas district hospital dose not register CHF but receive reimbursement for treating CHF members
- Members who live across the border can't access service at the facility nearby if is in other district

6.5 RECOMMENDATIONS

- The User fee should increase to motivate enrollment into CHF
- The CHF package is already offered up to the level of district hospital therefore new initiatives should increase the package up to regional referral hospital/zonal
- Before the operation of new CHF begun more there should be modification in The NHIF System of Claims and reimbursement to ensure that the facilities receive their claims every months as submitted. The Claims should be preprocessed at the district level.
- There should be a proper mechanism of providing feedback from NHIF to District to Facilities on the reasons of rejected claims to ensure that the same mistakes are not undertaken in the next claims
- PMORALG to provide circular/ letter to all District and inform the health facilities on the procedures for opening Government bank account.
- All complementary funding accounting should be the same to reduce the load at the lower level.
- All district thought CHF should be modifies, but the NHIF reimbursement system and feedback should be strengthened
- User fee- The facilities to direct deposit the monies into facility bank account instead of bring cash to DED Therefore the receipts will be issued upon submission of bank slip, NHIF/CHF- Direct deposit into facility bank account
- Since NHIF provided direction on request the funding every months they should modify the reimbursement process for every month. And the reimbursement should clearly indicate the amount claims and the reimbursed where the reimbursement should clearly indicates the reasons for not receiving all of the claims so as to ensure the era do not repetitive occur

7.0 CONCLUSIONS AND RECOMMENDATIONS

7.1 HEALTH FINANCING

General trend on health financing

The total public health budget in nominal terms increased significantly from TZS 1.209 trillion in 2011/12 to TZS 1.448 trillion in 2014/15, and was projected to increase further to TZS 1.821 trillion in 2015/16. That is, between 2011/12 and 2015/16 there has been a 50.6% increase in the public health budget in nominal terms, and a 18% increase in real terms. In terms of actual health spending, it increased from TZS 1.051 trillion in 2011/12 to TZS 1.192 trillion in 2014/15 which is a 13% increase, while actual public health spending in real terms decreased by 6% - a decrease from TZS 645 billion in 2011/12 to TZS 606 billion in 2014/15.

The share of public health budget in total government budget, excluding CFS, was 9.7% in 2011/12 but has increased to 10.1% in 2015/16. With the CFS included, the share of health budget actually fell from 8.9% in 2011/12 to a mere 8.1% in 2015/16. Similarly, the share of actual health spending in total government spending (excluding CFS) declined from 10.1% in 2011/12 to 8.6% in 2014/15, while with CFS included the decline in the share of health spending was from 8.7% in 2011/12 to 8.2 in 2014/15.

Per capita expenditures

In nominal terms, public health budget allocations per capita increased from TZS 28,207 (USD 17.82) in 2011/12 to TZS 38,092 (USD 22.02) in 2015/16. Actual per capita health spending increased from TZS 24,521 (USD 15.50) in 2011/12 to TZS 28,869 (USD 18.25) in 2013/14 before declining to TZS 25,635 (USD 14.78) in 2014/15. In real terms, there is downward trend for both budget and actual expenditure. Thus, the estimated per capita health budget and expenditures in real terms have consistently remained below USD11 throughout the review period which is shot of USD 54 recommended by WHO.

Sources of financing

Government funding remains the dominant source of public health financing. The actual government spending increased from TZS 710,096 billion in 2011/12 to TZS 972,342 billion in 2014/15 which is a 37% increase. The actual expenditure for foreign funds declined from TZS 340,838 billion in 2011/12 to TZS 219,950 billion in 2014/15 which is a 35.5% decline. The expenditure from health basket in particular, declined by 24% from TZS 151,013 in 2011/12 to TZS 114,985 billion in 2014/15. Comparing the

basket funds expenditure for 2014/15 with the approved budget for 2015/16 there is significant decline – TZS 114,985 billion to TZS 77,959 billion which is a 32% decrease.

Budget and expenditure by levels of Government

The relative shares of resources among levels of government have not changed much over the review period, with the share of resources controlled by the central ministries remaining dominant throughout. The share of centrally controlled budgeted resources, which includes MoH, PO-RALG, and the NHIF, declined from 60% in 2011/12 to 54% in 2012/13 but it went up again to 60% in 2014/15. The actual expenditure increased from 57% in 2011/12 to 59% in 2013/14. The share of resources going to the Local Government Authorities (LGAs) increased from 35% of the budget in 2011/12 to 39% in 2012/13 but it declined to 34% of the budget in 2014/15 while the actual spending decreased from 37% in 2011/12 to 35% in 2013/14. The funds spent at regional level has fluctuated but remained below 10%.

Recurrent and development expenditures

During the review period (2011/12–2015/16), the development budget decreased from TZS 611 billion in 2013/14 to TZS 591 billion in 2015/16 (a 3% decline). Actual development expenditure also decreased about threefold (34%) from TZS 376 billion in 2011/12 to TZS 248 in 2014/15. Throughout the review period, development budget has been consistently low than the recurrent budget. The share of the recurrent budget has increased significantly from 56% in 2011/12 to 67% in 2015/16. Also, the share of actual recurrent expenditure increased from 64% in 2011/12 to 79% in 2014/15.

Budget performance

Overall, the execution of the total budget was consistently high (above 80%) from 2011/12 but it experienced a significant decline in 2014/15; decline to 75%. The performance of the recurrent and basket fund is consistently high – above 85% for each year in the review period. Execution of development budget is the lowest; it has performed below average (50%) in three years and it was as low as 20% in 2013/14. The performance of the non-basket fund budget is inconsistent with the highest performance in 2013/14 (83%) and lowest in 2014/15 (41%).

Complementary financing

The Health Service Fund, which is essentially the out of pocket cost-sharing both at primary level health facilities and at hospital level, continues to contribute to the resource envelope at the LGA level.

Membership of the NHIF grew by 6% for principal members (from 602,955 in 2013/14 to 640,341 in 2014/15) down from 12% growth experienced from 2012/13 to 2013/14

(increase from 536,829 to 602,955). A comparison of figures from 2012/13 and 2013/14 indicates an increase in the premium contribution to NHIF and income from other sources by 20%. However, there is a decline by 8% in 2014/15. Compared to 2012/13 figures, the NHIF unspent balance has declined slightly from 51% to 49% in 2013/14 but there is a significant decline to 44% in 2014/15. Despite the decline, the unspent balance is still huge which a concern considering the financing shortages facing the health sector.

The share of NHIF going to public facilities has remained largely constant, at between 28% and 30% per year. The government facilities are receiving low and constant total reimbursement which is a cause for concern given the fact that they provide more services than faith-based facilities.

Progress in expansion of the CHF continued in 2014/15, showing a substantial improvement in estimated population coverage from 8.1% in 2010/11 to 14.4% in 2014/15. The number of member households almost doubled (98%) from 561,370 in 2010/11 to 1,112,874 in 2014/15.

Sources of financing at local government

Block grant continues to be the major source of funds at LGA level. Block Grant has been relatively stable at 63% - 66% of the expenditure. The health basket funds have also been fairly stable, between 18% - 21% of actual funds received. Complementary funds are broadly similar across years, at 4% of the total actual spending.

7.2 RECOMMENDATIONS

- All district thought CHF should be modifies, but the NHIF reimbursement system and feedback should be strengthened
- Pharmaceutical data should be included in the report
- Efforts should be undertakes to ensure that all complementary funding and own source are captured under the Epicor system
- Although the CHF matching fund application protocol has been reviewed, still it takes too long to access fund, there is a need to review again and see what the main course in delaying the funds.
- Some Information on CHF and NHF members should be integrated under HMIS system

- User fee- The facilities to direct deposit the monies into facility bank account instead of bring cash to DED Therefore the receipts will be issued upon submission of bank slip, NHIF/CHF- Direct deposit into facility bank account
- Since NHIF provided direction on request the funding every months they should modify the reimbursement process for every month. And the reimbursement should clearly indicate the amount claims and the reimbursed where the reimbursement should clearly indicates the reasons for not receiving all of the claims so as to ensure the erra do not repetitive occur

- Standardization of certain activities and funding sources should be strengthened within PlanRep and Epicor, ideally with pre-population of these labels to minimize spelling errors and inconsistencies. The possibility of introducing built-in mechanisms for flagging possible errors could also be explored, as for outliers and gaps in District Health Information 2 (DHIS2).

- The PER team in the Ministry of Health should immediately be trained and given access to real-time PlanRep data. This would enable desk analysis to take place ahead of PER fieldwork, which can then be tailored to explore identified gaps and discrepancies.

- When comparing cost per claims with the previous years there is an increase in cost per claims which suggests higher cost per visits. It is recommended to have more analysis on hospital capacity in terms of bed census to justify the claims.

- Due to concentration of NHIF Spending in Dar es salaam it is recommended that more analysis should be done on spending by specific facilities– e.g.Muhimbili National Hospital (MNH), ORCI, Dar-based private facilities etc. For equity, there might also be a bed census done here – how many patients actual originate from outside Dar es Salaam?

- Due to inconsistency of LGA data it is recommended on capacity building at health facility and LGA level, and also closer supervision and follow-up by council and regional management, in order to ensure that all data are filled per guidelines. Issue of the Epicor cost centers – needs urgent resolution as they combine true cost centers (i.e. levels within the council health system) with project or source of fund codes.

ANNEX A: AGGREGATE DATA USED FOR ANALYSIS (TZS MILLION)

Annex A Aggregate data used for analysis (TZS million)

	2011/12		2012/13		2013/14			2014/15			2015/16
	Approved Estimates	**Actual Expenditure**	**Approved Estimates**	**Actual Expenditure**	**Approved Estimates**	**Revised estimates**	**Actual expenditure**	**Approved estimates**	**Revised estimates**	**Actual expenditure**	**Approved budget**
Recurrent											
National Health Insurance Fund	85,538	84,798	106,937	106,937	90,033	124,204	124,204	202,913	142,112	142,112	199,813
Central government											
MOHSW	262,450	246,749	298,228	273,367	282,574	300,978	279,548	353,973	356,207	332,727	340,098
TACAIDS											
PMO-RALG Health Dept											133
Regional Administration (Regions)											
Government funds	55,894	53,458	59,929	62,003	61,896	68,273	65,249	81,099	86,123	78,937	102,545
Local Government Authorities											
Government funds	277,281	289,567	335,507	288,532	362,907	378,172	324,848	444,908	426,478	390,428	555,683
Salary adjustments								48,331			22,978
Total recurrent	***681,163***	***674,572***	***800,601***	***730,838***	***797,409***	***871,627***	***793,849***	***1,131,224***	***1,010,920***	***944,204***	***1,221,251***
Development											
Ministry of Health											

Government funds	14,830	14,830	19,143	11,004	36,100	36,100	6,002	54,000	54,410	12,913	66,024
Donor basket fund	72,736	70,019	65,786	62,658	43,218	43,218	43,502	23,800	28,616	28,604	12,567
Foreign (non-basket)	282,185	177,339	198,518	125,033	391,965	391,965	329,669	227,929	223,776	100,795	362,051
PMO-RALG											
Government funds	-	-	-	-	-	-	-	-	-	-	
Donor basket fund	687	174	687	681	618	618	525	600	5,771	5,733	818
Foreign (non-basket)	879	113	1,581	1,294	2,344	2,413	1,314	1,645	980	708	2,618
Regions											
Government funds	10,462	6,542	25,067	14,934	14,422	11,680	3,776	15,151	15,692	11,745	13,747
Donor basket fund	4,200	4,008	4,200	4,093	3,699	3,780	3,573	3,800	3,780	3,752	3,757
Foreign (non-basket)	198	-	150	417	422	3,605	2,406	2,759			2,580
Local Government Authorities											
Government funds	38,799	14,153	39,425	8,476	12,414	28,043	12,213	51,591	16,625	3,480	66,275
Donor Basket Fund	80,990	76,812	88,762	75,334	75,856	87,854	87,632	80,400	80,348	76,896	60,817
Foreign (non-basket)	**21,607**	12,374	26,388	20,367	30,282	32,678	22,004	21,532	6,680	3,461	
Total development	**527,573**	**376,364**	**469,707**	**324,291**	**611,339**	**641,954**	**512,616**	**483,207**	**436,678**	**248,087**	**591,254**

Total on budget	***1,208,736***	***1,050,936***	***1,270,308***	***1,055,129***	***1,408,749***	***1,513,581***	***1,306,465***	***1,614,431***	***1,447,598***	***1,192,292***	***1,812,505***
Govt	745,254	710,096	884,236	765,253	860,345	947,450	815,840	1,251,966	1,097,647	972,342	1,367,163
DBF	158,613	151,013	159,435	142,766	123,391	135,470	135,231	108,600	118,515	114,985	77,959
D-Non B	304,869	189,825	226,637	147,111	425,012	430,661	355,394	253,865	231,436	104,965	367,249
TOTAL	**1,208,736**	**1,050,935**	**1,270,308**	**1,055,129**	**1,408,749**	**1,513,581**	**1,306,465**	**1,614,431**	**1,447,598**	**1,192,292**	**1,812,372**

ANNEX B: CHF Enrollment per Region

Region	FY2011/12	FY2012/13	FY2013/14	*Growth year on year*
Arusha	1,692	5,765	15,429	*168%*
Dar es Salaam				
Dodoma	86,946	32,763	45,186	*38%*
Geita	9,480	1,625	4,672	*188%*
Iringa	9,679	12,244	14,759	*21%*
Kagera	34,466	23,338	5,794	*-75%*
Katavi	3,917	6,475	13,617	*110%*
Kigoma	28,723	39,055	29,683	*-24%*
Kilimanjaro	26,469	32,127	56,498	*76%*
Lindi	10,438	12,282	6,853	*-44%*
Manyara	4,450	11,133	8,293	*-26%*
Mara	1,525	4,814	8,249	*71%*
Mbeya	20,643	52,380	123,765	*136%*
Morogoro	27,410	20,337	37,227	*83%*
Mtwara	13,323	12,521	6,550	*-48%*
Mwanza	7,830	14,017	8,792	*-37%*
Njombe	4,239	11,893	11,482	*-3%*
Pwani	12,805	16,208	29,813	*84%*
Rukwa	1,846	15,847	21,339	*35%*
Ruvuma	2,423	17,278	23,501	*36%*
Shinyanga	44,787	5,085	6,323	*24%*
Simiyu	1,380	18,814	4,089	*-78%*
Singida	49,815	84,967	70,557	*-17%*
Tabora	9,841	23,517	52,555	*123%*
Tanga	227,626	69,136	49,801	*-28%*
Tanzania	**641,753**	**543,621**	**654,827**	***20%***

ANNEX C: List of Districts visited during the field visits

S/N	Districts	Number of facilities	Facility with Bank account	Commercial bank account	Government bank account	Accounts in Operational
1	Igunga	52	7	7	0	0
2	Nzega	43	42	42	0	42
3	Kasulu	37	37	0	37	37
4	Kigoma	34	34	0	34	34
5	Wangngombe	41	41	0	41	41
6	Makambako	4	4	0	4	4
7	Njombe DC	43	43	0	43	43
8	Mbeya MC	12	12	0	12	12
9	Mbozi MC	59	59	0	59	59
10	Moshi DC	47	39	39	0	39
11	Arusha DC	32	32	32	0	32
12	Siha DC	8	8	0	8	8
13	Mwanga DC	48	48	0	48	48
14	Ilemela	15	15	4	11	15
15	kishapu	46	46	4	42	46
16	mwanza	15	15	15	0	15
17	Shinyanga DC	38	38	0	38	38
18	Dodoma MC	35	35	35	0	35
19	Chamwino DC	63	63	0	63	63
20	Gairo DC	18	5	5	0	5
21	Iramba DC	32	32	0	32	32

26	Temeke	36	36	36	0	36
27	Ilala	27	27	27	0	27
28	kinondoni	46	44	44	0	44
31	Lindi MC	12	12	0	12	12
32	Nachingwea	44	44	0	44	44
33	Masasi TC	10	10	0	10	10
34	Masasi DC	33	33	0	33	33
Total		**930**	**861**	**290**	**571**	**854**