# **Health Sector (including HIV/AIDS): Rapid Budget Analysis (RBA) for Annual Review FY 2013/14**

### Working Draft – November 4, 2013Prepared by DPG-Health and MOHSW RBA and PER Working Group[[1]](#footnote-1)

#### Table 1: Summary Statistics for the Health Sector

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| --- | --- | --- | --- | --- |
| Selected Statistics | 2012/13 Budget | 2012/13 Actual (expenditure) | 2013/14 Budget | Real Growth Rate |
| Total GOT Health Sector in TZS\* | 1,257,943,685,225 | 1,124,928,872,372 | 1,453,687,043,338 | 9.0% |
| Per Capita GOT Health in TZS\* | 28,835 | 25,7586 | 32,446 | 6.2% |
| GOT Health as a % of total GOT (excl. portion of CFS) | 9.6% | 9.7% | 8.7% | NA |
| GOT health expenditure as a share of GDP | 2.6% | 2.3% | 2.6% | NA |
| Share of Decentralized GOT Health Budget | 46% | 44% | 38% | NA |

\*TZS expressed in nominal currency; \*\*MOF/World Bank Estimates; \*\*\*Population based on Census 2012 estimates assuming 2.7% growth rate for 2013/14

#### Strengths:

* The health sector budget has increased in nominal, real, and per capita terms between FY 12/13 and FY 13/14.
* Non-basket foreign funding to the sector has increased, reversing the decline evidenced in the previous year’s RBA. The increase in non-basket foreign funding is particularly prominent in the area of medicines.
* Unlike FY 11/12, execution of the FY 12/13 budget was consistently strong across both *foreign and local-heath spending.*

***Weaknesses:***

* Increase in non-basket foreign funding to the health sector masks absolute and real term declines in health basket funds and GoT Local (domestic and GBS) resources to the heath sector.
	+ A declining share of GoTs own discretionary resources to the health sector further suggests declining relative priority of the sector (potentially linked to Big Results Now).
* Decrease in Health Basket foreign and GOT local (domestic and GBS) resources - fewer overall systems resources supporting increasing foreign disease specific resources – could potentially have negative impact on foreign on-budget execution in FY 13/14.
* Geographic inequality in Health Block Grant (OC and PE) distribution amongst LGAs remains substantial. Integrity of LGA budget data could be improved.

#### Overall Development

*Overall GOT health budget trends*

The RBA provides an overview of health spending through the GOT (including all funds going to the public sector through the exchequer).[[2]](#footnote-2) In this respect, the GOT budget for health (including HIV/AIDS) increased in nominal terms from 1.26 Trillion TZS to 1.45 Trillion. As opposed to previous years, the growth in the overall health budget was able to resist pressure from inflation and population growth. The budget increased by 9.0% in real terms and by 6.2% on a real per capita basis. However, the health sector’s share of the total GoT budget resources has reduced, from 9.6% in FY 12/13 to 8.7% in FY 13/14. The health sector share remains significantly below the Abuja target recommendation of 15%.

*Breakdown of financiers for GOT health budget*

In stark contrast to the FY 12/13 budget, where an increase in GoT discretionary funds (local and GBS) protected the sector from a substantial decrease in GoT on-budget foreign funds, the current year’s budget evidences quite the opposite as shown in Table 2. The overall GOT increase in amount for the health sector, as identified earlier, seems to be driven by a 45% increase in foreign investments. The significant increase in on-budget foreign funding masks a decline in local investments (domestic and GBS) to the health sector in both nominal (drop by 10 billion Tshs) and in real terms (reduction of 7%) between FY 12/13 and FY 13/14.

#### Table 2: Breakdown of GOT Budgets by Local and Foreign Contributions (FY12, FY13, FY14)

|  |  |  |  |
| --- | --- | --- | --- |
| **Foreign vs. Local (including GBS)** | **2011-12 Budget** | **2012-13 Budget** | **2013-14 Budget** |
| Local (including GBS) Contribution Health TZS |  691,628,000,000  |  876,336,770,053  |  866,316,764,203  |
| Foreign Contribution Health TZS |  471,946,000,000  |  381,606,915,171  |  587,370,279,135  |
| Local Health as a % of Local GOT | 9% | 8% | 6% |
| Foreign Health as a % of Foreign GOT | 15% | 17% | 22% |
| Foreign Share Health | 41% | 30% | 40% |
| Local Share Health | 59% | 70% | 60% |
| Foreign Share GOT overall | 28% | 18% | 16% |
| Local Share GOT overall | 72% | 82% | 84% |
|  |  |  |  |

#### Figure 1: Share of GOT health and overall budget by foreign and local sources (FY12, FY13, FY14)

**The significant increase in foreign investments can be attributed to an increased contribution towards medical supplies which accounts for 78% of the total increase in on-budget foreign funding. In terms of areas of foreign funding, the biggest increases were seen as related to the disease-specific areas of HIV/AIDS, Control of Communicable Diseases, Support to TB/Leprosy Programs, as well as to the Global Fund Management Project – suggesting significantly increased spending by the Global Fund for Aids, Tuberculosis, and Malaria. Foreign funds pooled through the Health Basket Fund declined in both absolute and real terms over the period. This is notable given the recent Mid Term Review (MTR) findings of the Health Sector Strategic Plan III (HSSP III) showing that disease-based programs are performing relatively well while the opposite is true for general and Reproductive health care—which are largely dependent on overall systems investments.

Moreover, prioritization of the health sector from GoT’s local (domestic and GBS) funds seems to be declining. In FY 12/13 the health sector received 8% of GoT’s local (domestic and GBS) resources; this has declined to 6% in FY 13/14. Exclusion of health from the first phase of Big Results Now could potentially be a factor. While increase in foreign non-basket funds did support declines in GoT local resources to the health sector, it is important to recognize that these resources, unlike that of the health basket, are in large part not fungible with GoT local resources.

This year’s RBA corroborates the recent HSSP III MTR findings that dependency on donors to finance health care is substantial – and that non-basket funding is the major source of external support. Furthermore, the MTR highlights concern about sustainability and notes that while many countries show a positive trend of increasing relative government contribution to the health sector, Tanzania is experiencing the opposite trend.

***Budget Execution***

In terms of health sector budget execution for FY 12/13, 89.4% of the budgeted amount was spent. Strong budget execution was consistent across both GoT local (89.9%) and foreign sources (88.3%). This is a welcome improvement from the FY 11/12, as reported in last year’s RBA, where more than 90% of GoT discretionary was executed while foreign budgets were spent to less than 40% (with low foreign budget execution linked to low execution of GFATM resources). Amongst other factors, the substantial increase in FY 12/13 of GoT discretionary (domestic and GBS) resources, alongside a reduction in foreign non-basket funding, might have contributed to improved execution of foreign funds. Given the significant shift in balance between the two (GoT discretionary and foreign non-basket resources), as identified earlier, it will be important to keep close track of foreign funding execution in FY 13/14.

***Relation to Priorities***

This year’s HSSP III MTR noted that the availability and accessibility of commodities remains a critical issue. In this regard, the overall budget for medical supplies has increased by 74% in real terms between FY 12/13 and FY 13/14. This is due to the increased funding for specialized medical supplies to support the HIV/AIDS Control Programme, Control of Communicable Diseases, and the TB/Leprosy Programmes. In terms of financing sources for commodities in the public sector, 90% of the medicines budget is foreign. Between 2012/13 and 13/14, foreign investment has increased by 89% (for reasons referenced above) and local investment increased by 1% in real terms. As a share of the total GOT health budget, the medical supplies budget has increased from 15% in 2012-13 to 24% in 2013-14. However, at the same time, the facility budget allocated to MSD has decreased by 28%.

At the 2012 London Summit for Family Planning, the GOT pledged to substantially increase investment in family planning over time. In reviewing the approved Medium Term Expenditure Framework (MTEF), the funds for family planning have not changed considerably. Rather, as in 2012/13, 1 billion TZS of local funds has been pledged for each year up to 2014/15. This is complemented by increasing investment by foreign financiers of 3 billion TZS in FY 2013/14, 3.75 billion TZS in FY 2014/15, and S4.6875 billion TZS in FY 2015/16.

***Geographic Equity***

Equity between LGAs has been traditionally assessed by plotting the ratio of per capita funding an LGA receives over the average across all LGAs. In the following chart (Figure 2), LGAs plotted on the left receive the highest allocations, while those on the right receive the lowest.

*This chart should be read with the following caveat in mind. The integrity of LGA data, challenge of applying 2012 Census population data, as well as comparability with previous LGAs data remains a concern. More specifically, in the LGA budget FY 13/14 there are 23 districts without any PE, of which 3 have OC.; 23 without OC, of which 3 receive PE;. 20 districts receive no funding in the budget, or the data is corrupted. Also 4 districts exist in the budgets but not in the census. This all means that of the 163 districts, the analysis below compares 135 districts.*

On a positive note, the LGA data for FY 13/14 (unlike for LGA data FY 12/13) matches the transfers in the approved budget. LGA budget FY 13/14 does not capture foreign development spending.

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| --- |
| ***Figure 2: LGA level per capita Health Block Grant Spending FY 13/14, as a multiplier of average per capita spending. Sorted in descending order.*** |
|  |
| Source: MoF, NBS |

The above graph (outliers excluded) speaks strongly to the persistence of highly unequal health block grant (OC and PE) distribution amongst LGAs. The top five districts - Njombe, Pangani, Kisarawe, Kibaha, and Mafia - average about 28,000 Tshs per Capita (270% of the national average); while the bottom five – Ukurewe, Tunduma Town, Rufiji, Uyuyi, and Masasi – average about 2,200 Tshs per capita (27% of the national average). On a population basis, those in the privileged top 10% of the population on average get 65% more than the national average; while the least privileged 10% get 63% less than the national average.

While comparison with previous year’s RBA is analysis is far from perfect given the incorporation of new districts and new population figures, increasing standard deviation in per capita health block grant spending at the LGA level (from 0.43 to in FY 2012/2013 to 0.51 in FY 13/14) suggests that inequality in resource distribution might be widening amongst LGAs. For FY 13/14, the variation is slightly lower in the OC than the PE (standard deviation of 0.48 and 0.53 respectively).

The relative level of long-standing inequalities in health resourcing are also reflected in HRH densities for skilled health staff (HRHIS). Inclusion of a Performance Assessment Framework indicator specifically aimed at improving availability of nursing staff in the most under-resourced districts has been jointly proposed by GOT and DPs for 2014.

***Conclusion***

In summary, the GOT health sector budget has increased and budget execution has improved. That said, financial sustainability of the health sector remains a considerable concern, particularly because donor funding (which is not necessarily predictable) appears to be replacing GOT local investment in health. This in turn has an impact on the accessibility of quality health care for Tanzanians. Therefore, the GOT and other national stakeholders should prioritize the development and implementation of strategies for strengthening domestic investment and fostering sustainability in the health sector.

#### Annex 1: What is Health?

To harmonize understanding of the health sector within the GOT budget, the working group used the following boundaries to frame its health sector analysis. It should be noted that unlike previous years, HIV/AIDS investment is included as part of the health sector definition. For purposes of this exercise, health does include NHIF contributions. It should be noted that the total GOT expenditure used in the denominator to calculate share of GOT spending on health excludes a portion but not all of Consolidated Fund Support – specifically it excludes all repayment of principal but not interest payments and other items in State House and Public Debt/General Services.  Another caveat to the health sector scope for the purposes of this RBA is that any salary readjustments that may have taken place in the health sector have not been addressed as this information was not readily available.

|  |  |
| --- | --- |
| To Include | To Exclude |
| Number | **Description** | **Number** | **Description** |
| 6 GFS code number: |  |   |   |
| 210319 | Medical and Dental Refunds  | 231101 | Other routine maintenance exp (medical and lab equip) EXCLUDE Ministry of Finance |
| 231101 | Other routine maintenance exp (medical and lab equip) INCLUDE Ministry of MOHSW and Ministry of Agricultrue | 220905 | Health Insurance Training foreign |
| 220526 | Medical Practitioners | 229930 | Contingency  |
| 260603 | KCMC | 230501 | X-rays (seems to only in M of Defense) |
| 260604 | XX hospital | 230503 | Ultrasound Equip (seems to be only in M of Defense) |
| 260605 | XX hospital | 280402 | Relief |
| 260606 | XX hospital |   |   |
| 260607 | Self-help (ONLY MOHSW portion) |   |   |
| 270209 | WHO Contribution |   |   |
| 270305 | Muhimbili  |   |   |
| 270344 | MOI (Also incl. in PER) |   |   |
| 270359 | NMRI |   |   |
| 270366 | Ocean Road Cancer Institute |   |   |
| 270601 | Nutrition food center |   |   |
| 270612 | Gov. Chemist agency |   |   |
| 270820 | Muhimbili hospital |   |   |
| 270821 | XXX hospital |   |   |
| 270822 | XX hospital |   |   |
| 270823 | XXX hospital |   |   |
| 271101 | District (general transfers) only health component. Note we don't need to use these GFS codes but can extract health portion from project numbers.  |   |   |
| 271102 | Urban (general transfers) only health component. Note we don't need to use these GFS codes but can extract health portion from project numbers.  |   |   |
| 271105 | health transfers (district and Urban) |   |   |
| 280201 | Medical treatment abroad |   |   |
| 280403 | Emerg. Med |   |   |
| 280404 | Settlement of med treat |   |   |
| 280505 | health costs |   |   |
| 280592 | Dar reg. hosp |   |   |
| 410406 | Medical Equip |   |   |
| 410908 | Medical and scientif instruments (ONLY MOHSW portion) |   |   |
| 411006 | Hospitals |   |   |
| 210605 | NHIF Employer contribution |   |   |
| 2204 cluster | vaccines |   |   |
|   | drugs and medcines |   |   |
|   | Hospitals supplies |   |   |
|   | Post mortem expenditures (with one exception- crimelab) | 2204XX | Post mortem (for crime lab) |
|   | lab supplies |   |   |
|   | special foods (only for health facilities, police med hospitals, military hospitals) | 2204XX | Special foods (for police dog and horses) |
|   |   |   | Medical gases and supplies (for Water lab) |
| VOTES: |   |   |   |
| 21 | Treasury -- GFATM and Drugs portion |   |   |
| 22 | ONLY NHIF portion (Gov contribution) |   |   |
| 52 | MOHSW (minus SW section) |   | Exclude SW |
| 56 | PMORALG Projects (BHSP, Basket) |   | Exclude central level salaries at PMO-RALG for health staff (not sig. amount) |
| 92 | TACAIDS INCLUDE ALL but highlight this amount separately in the analysis  |   |   |
| 70-89, 95, 36,47,54,63 | REGIONS: Look at 3001/2 (hospitals, preventive health), 2004 (health transfer), 2003 (infrastruct project) |   |   |
| PROJECT NUMBER:  |   |   |   |
| Vote 21: Proj # 5491 | GF PMU |   |   |
| Vote 56: Proj # 5420 | BHSP |   |   |
| Vote 56: Proj # 5421 | Basket |   |   |
| Vote 56: Proj # 5493 | HIV/AIDS prev |   |   |
| Vote 56: Proj #5495 | Prev of HIV transm |   |   |
| Vote 91: Proj#5497 | HIV against IDU |   |   |
| Proj # 5280  | MWSSP-Health Component |   |   |
| Proj# 5402-6 | Construction hospital  |   |   |
| Proj# 5411 | Referral hospital |   |   |
| Proj 5414 | Child Survival (74% health and 25% nutrition) |   |   |
| Proj 6517 | Child Survival (75% health and 25% nutrition) |   |   |
| Regional Projects: 5421, 5486. 5492. 5493. 5494. 5495. 5499 |   |   |   |

1. Comprised of representatives from the MOHSW, USAID, DANIDA, and the World Bank [↑](#footnote-ref-1)
2. Note, the scope of this RBA represents only a fraction of overall health care spending in the country (that going through the public sector exchequer). The latest analysis for the overall health care system is found in the 2009/10 National Health Accounts (NHA) report (that includes private sector and off budget support as well). Findings from the 2009/10 NHA show that as a funding source, the GOT contributes only 26% of all health expenditures in the country, with households providing for 34% (largely out-of-pocket) and donors financing the largest share at 40% (inclusive of on-budget and off-budget support). [↑](#footnote-ref-2)