

United Republic of Tanzania  
Ministry of Health

**Health sector PER update FY 2004**

Final Version

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Ministry of Health  
Tanzania

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### **Acronyms**

AGO	Accountant General's Office
AIDS	acquired immuno-deficiency syndrome
DANIDA	Danish International Development Agency
DFID	Department for International Development (UK)
DDH	Designated District Hospital
DPS	Department of Preventive Services (MOH)
FY	financial year (1 July to 30 June)
FY03	1 July 2002 to 30 June 2003
GBS	general budget support
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GFS	Government Financial System
GOT	Government of Tanzania
HIV	human immunodeficiency virus
HSD	Hospital Services Department
IFMIS	Integrated Financial Management Information System
IMR	infant mortality rate
JD	joint disbursement (donor basket funds)
LG	local government
LGA	Local Government Authorities
LGRP	Local Government Reform Programme
MDA	ministries, departments, agencies (government)
MNH	Muhimbili National Hospital
MOH	Ministry of Health
MOF	Ministry of Finance
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
OC	other charges
PE	personnel emoluments
PER	Public Expenditure Review
PORALG	President's Office, Regional and Local Government
PRBS	Poverty Reduction Budget Support
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit (World Bank)
PRSP	Poverty Reduction Strategy Paper
SDC	Swiss Agency for Development and Cooperation
TFNC	Tanzania food and Nutrition Centre
TSh	Tanzanian shilling
TORs	terms of reference
U5MR	under-five mortality rate
VA	voluntary agency
WHO	World Health Organisation

### **Acknowledgements**

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Finally, thanks are due to Ms Jacqueline Mahon, Health and Poverty Advisor for the Swiss Agency for Cooperation and Development (SDC) for her support and direction throughout.

## **Executive Summary**

### **Outputs and limitations**

The Public Expenditure Review (PER) was undertaken by a Task Team from the Ministry of Health (MOH), with support from other colleagues in the Ministry, officials from President's Office – Regional and Local Government (PORALG), and the Ministry of Finance (MOF), and an external consultant. The terms of reference (TOR), included in Annex A, were adapted from the generic TORs provided by the PER Working Group. Not all of the TORs were achieved, for reasons outlined below.

The key outputs of the PER update for FY04 were a summary of:

- Key trends in health sector income and expenditure, with breakdowns by source of funds and expenditure category;
- Financial performance at the Central level;
- Income and expenditure at the Local Government Authority (LGA) level;
- Sectoral expenditure in relation to stated PRS objectives;
- Information on future costs and revenues, in order to inform development of the budget and MTEF for FY04 onwards.
- Key recommendations and next steps for strengthening the current budgetary/review process.

It was not possible to meet all of the objectives outlined in the TORs. For instance, a full costing of priority interventions is beyond the scope of the annual PER; and detailed analysis of LGA financial trends is not possible given existing data. The early departure of the initial consultant disrupted the timetable resulting in non-availability of key Task Team members during the main period of work. This, together with delays in the receipt of essential information, led to substantial delays in the process which contributed to the failure to complete the TORs. In addition, substantial data queries were raised, including inconsistency between MOH and MOF documentation and errors in the MOH Integrated Financial Management Information System, and have been flagged in the recommendations.

The following sections provide a brief overview of the key findings and recommendations of the PER update for FY04.

### **Sectoral budget and expenditure trends**

The health sector is defined as follows: On-budget includes recurrent and development spending at MOH headquarters, and allocations by PORALG to Regional Curative and Preventive sub-votes, and to Local Government sub-votes for Curative, Preventive, Health Centres and Dispensaries. In addition, it includes the contribution from the Accountant-General's Office to the National Health Insurance Fund on behalf of public servants. Off-budget includes also the use of cost-sharing revenues at public sector hospitals, and through the Community Health Fund, and external funding of projects captured within the MOF External Finance database. Comments relate to on-budget funding unless otherwise specified.

The sector remains severely under-funded, both in relation to requirements to meet stated goals, and to the Abuja Declaration of 2001 in which African heads of state pledged that the health sector would receive 15% of government revenue. Despite previous annual increases in the share of the Government of Tanzania (GOT) budget, in FY04 the allocation has fallen

to 9.2%, from 10.4% recorded the previous year<sup>1</sup>. Even if the September reallocation of funds is included, this still takes the share to only 9.7%. In absolute terms the allocation to the health sector has increased by 75% in real terms over the past three years. However, this is from a very low base. On-budget, projected per capita expenditure was just \$5.27 in FY04.

Health relies heavily on external donors. In terms of budget, the share of foreign funding was fairly constant at around 30% of the total between FY00 and FY03, although the switch by the UK DFID to general budget support (considered as domestic funding) has resulted in a fall in the share of foreign spending to 22% of the FY04 budget. The foreign contribution to on-budget expenditure has increased from 15% in FY00 to approximately 34% in FY03, reflecting improved performance of foreign funds as the Sector-Wide Approach has progressed.

Off-budget finance remains important, accounting for a quarter of the total Sector budget in FY04, down from 35% in FY99. *In total, the sector per capita expenditure was just \$7.26 in FY04.* This remains below the very basic target of \$9 per capita<sup>2</sup>. At the same time, the cost of essential interventions is increasing significantly. The large off-budget foreign contribution remains problematic in terms of monitoring the total sectoral resource envelope, and the allocation of funding in line with stated priorities.

Taken together, the various cost-sharing initiatives provide a significant amount of the resources to the Sector. The GOT contribution to the National Health Insurance Fund (NHIF) amounts to 4.5% of the recurrent budget and 8% of the Other Charges budget. Moreover, available data suggests that user fees at public hospitals, ie the Health Service Fund, potentially contribute significantly to the recurrent expenditures of individual facilities. Unfortunately, information obtained for the PER update on the Community Health Fund (CHF) was very partial and its significance cannot be estimated at present. On the other hand, cost-sharing represents significant difficulties for Sector planning and access. The majority of the monies of the NHIF are currently not being used to deliver services. There are concerns over the design and sustainability of the CHF. Moreover, user fees and poor implementation of exemptions have been shown in a recent review to have a serious negative impact on equity, through the exclusion of those most vulnerable from basic public health care provision<sup>3</sup>.

In terms of aggregate expenditure, there was an approximate 80-20% split between recurrent and development activities, remaining relatively stable in the past four years. Foreign funds are playing an increasingly important role in financing recurrent activities, both through the basket which is treated as recurrent funding at both MOH and council level, and through selected development projects which provide drugs and supplies among other recurrent inputs.

Although problems remain with the classification of some spending items, the allocation of sectoral funds by level of the health system appears to continue moving in the desired direction, with the local government share increasing from 30 to 34% of the budget between FY03 and FY04. The share of LGA expenditure increased slightly from 33.8% in FY02 to

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<sup>1</sup> This includes spending by the health sector on HIV/AIDS in both years. This has since been removed from the definition of Health as a priority sector, to be combined instead with other HIV/AIDS spending in other government Ministries, Departments and Agencies (MDAs). The GOT budget excludes the Consolidated Service Fund (CSF), ie public debt.

<sup>2</sup> \$9 per capita was the estimated requirement for basic health services in 1998. This is undoubtedly on the low side, with more recent estimates for low income countries with Tanzanian epidemiological profile in the region of US\$ 34 per capita (WHO Commission on Macroeconomics and Health).

<sup>3</sup> Mamdani M and Bangser M (2004). *Poor people's experiences of health services in Tanzania: A literature review*. Women's Dignity Project. Dar es Salaam: 2004

34.1% in FY03. With the focus of the new Health Sector Strategic Plan on strengthening district health services, we would expect to see a continued move towards increased LGA spending in coming years. In addition, further work to disaggregate centrally procured items by level would improve the usefulness of this analysis.

The split between administration, hospital care and preventive/primary health care is subject to both definitional and measurement problems, which should be addressed in the next PER update. Notwithstanding, comparison of recurrent government spending by activity type in FY03 and FY04 shows that there was a move away from Preventive/Primary spending in favour of Administration, with the share of the former falling by 2.6%. Although potentially worrying, conclusions cannot be drawn due to the partial nature of analysis which excludes basket and development funding.

### **Budget performance**

Sectoral budget performance, defined as overall expenditure as a proportion of budget<sup>4</sup>, declined slightly in FY03 from almost 94% to 90%. Recurrent budget performance was stronger, as in past years, at almost 92%, while Development performance was 83%. The latter represents a substantial increase from FY02 where Development spending was only two-thirds of budget.

At MOH headquarters, under-budgeting of basket funds resulted in budget performance (release as proportion of budget) of 100%. Absorption (expenditure as a proportion of release), fell slightly from 100% in FY02 to 95% in FY03. Budget performance of Government funds fell in FY03, with 86% of budgeted funds released compared with almost 99% in FY02. This shortfall was entirely due to lower releases to the sub-votes for the Department of Hospital Services and the Chief Medical Officer.

### **Decentralised spending**

In FY04 there has been an annual increase of 20% in subventions to Local Government Authorities (LGA). This overall trend is in line with the policy of decentralisation. However, the increase slightly favours urban over rural councils and, as such, is not congruent with PRS aims. This urban/rural trend has occurred for the second consecutive year.

A new resource allocation formula has been applied to basket funding for 2004, and will be extended to the block grant from July 2004. This weights per capita allocations according to population, takes regional or council indicators of poverty and under-five mortality, reflecting health service need, and includes the mileage travelled by sectoral vehicles within a council as a proxy for health service costs. Application of the formula is expected to result in a more equitable distribution of funding, which should be monitored in future PER updates.

The share of the overall LGA budget (excluding basket funds) allocated to the health sector has fallen for the second consecutive year, from a baseline of 18% in 2001 to 16.6% in FY04. This merits further exploration to determine whether the basket funds are effectively replacing domestic funds at the council level.

Although the OC component of the LGA block grant was released in full in FY03, the flow of funds between quarters was uneven. Less than 22% of funds were released on average during the first quarter, and over 30% in the last quarter. No explanation was given for this variation, which could adversely affect plan implementation at the council level.

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<sup>4</sup> Local government expenditure is proxied by releases in the absence of actual expenditure data.

No data are available on foreign support to the local government development budget. Domestic development spending at the council level has risen in nominal terms by 61% between FY02 and FY04, with the share of spending on hospital development increasing over the same period from 5% to 14% of the total. All spending at this level is considered priority.

Arguably, the major problem at the LGA level remains the lack of actual expenditure data. The LGA level accounts for around a third of sectoral spending, yet for the block grants release of funds is still treated as synonymous with expenditure. The extension of the IFMIS to the council level is expected to improve the situation with time, but past tracking studies have shown that the assumption that OC funds are allocated as intended at the council level is false.

### **Spending on sectoral priorities**

The share of Health as a priority sector, as indicated above, has fallen from 10.4% of GOT expenditure in FY03 to 9.2% of the FY04 budget (excluding CFS). Within the sectoral budget, the allocation to priority items – recurrent spending on preventive services and the local government level - has increased slightly from 45% of the total in FY03 to 47% in FY04. In real terms, these priority items have seen an encouraging absolute increase of 22%.

Analysis of the MOH development budget shows that 70% of spending is in line with PRS priorities. Foreign (non-basket) funding is most clearly aligned with the PRS, with 94% of spending on priorities. Domestic funding, although relatively insignificant at only 13% of the total development budget, tends to favour infrastructure projects which do not directly contribute to the PRS priority area of primary care. Only 7% of the local development budget for FY04 was allocated to designated PRS projects.

Annual, on-budget, expenditure on drugs by MOH headquarters, on behalf of councils and hospitals, rose by 21 % in FY03 and is budgeted to increase by another 20 % in FY04, accounting for a relatively constant one-third of MOH recurrent spending. The per capita US\$ allocation to drugs and medical supplies has increased from \$0.64 in FY02 to \$0.77 in FY04. This figure under-estimates the true value of drug spending in the sector as it excludes major sources such as off-budget spending and expenditure through the Development budget. With the introduction of a crude population-based formula for hospital drug spending, geographical variation in regional per capita allocations reduced somewhat between FY02 and FY03. Significant questions remain on the volume, allocation and flow of resources for drugs and medical supplies and further study of this issue is strongly recommended.

### **Future costs and revenues**

It is recognised that costing is an essential element for the efficient allocation of resources, and the PER TORs have included such an exercise for the past three years. However, a proper costing is beyond the scope of the PER update, and the objectives for such a costing need first to be clarified. Cost information in the PER update was therefore drawn from a limited number of key programme documents, as per the original submission by the MOH as input to the Budget Guidelines for FY05. This indicates a relatively small increase required for drugs and medical supplies (from TSh33bn to TSh 36bn), a 52 % increase in allocations to the faith-based institutions, and a 120 % increase in the Human Resources Development budget. The FY05 costs of priority programmes within the Department of Preventive Services are projected at 115 % higher than the FY04 budget, at TSh120.1bn.

The future revenues section is based upon figures given in the Budget Guidelines, together with pledges by Basket partners for FY05. The resource envelope for the sector is projected to grow by 30% in real terms between FY04 and FY05, followed by a slight fall in FY06 and FY07. The increase in FY05 is largely due to 84 % growth in basket funding which in turn contributes to a 143 % increase in overall foreign development funding, from TSh45bn in FY04 to TSh109bn in FY05. Although not indicated in the Budget Guidelines, this is assumed to include expected future inflows through global health initiatives such as the Global Fund for AIDS, Tuberculosis and Malaria, and the Clinton Foundation-supported Care and Treatment Plan for HIV/AIDS. This has a substantial impact on the share of foreign funding in the overall budget, which is projected to increase from 21 % in FY04 to almost 40 % in the coming years. Leaving aside the question of sustainability, this demonstrates the volatility of external funding flows, and the extent to which such foreign funds result in offsetting domestic resources will need to be monitored.

### **Recommendations**

Several key recommendations are made in the report. Amongst the most important are the following:

- (Re-)activation of the Joint Health Finance Committee: despite the formation of a specific high level committee to address financing issues in the health sector following the 2003 Joint Health Sector Review, the JHFC has never actually met, with the result that opportunities for lobbying for a greater share of the GOT budget may have been lost. It is imperative that this committee actively address the issue of inadequate allocations raised in the PER and other fora during the coming year;
- Tracking studies: More in-depth study is required both for drug expenditures (from the central to beneficiary levels), and of council allocations and expenditures as existing routine information does not give the required level of detail to be able to determine the extent to which these two priority areas are actually benefiting from increased absolute allocations to the sector as a whole;
- Cost-sharing: the completeness and quality of information on existing formal cost-sharing mechanisms such as the Community Health Fund and the Health Service Fund is poor, resulting in a partial analysis of its contribution to the resource envelope. While accountability is most important at the level of the charging institution, the national level should be collating, analysing and presenting information on an annual basis;
- IFMIS at MOH: Given the large expected increase in the basket funds for FY05, and the importance of the IFMIS in providing data for regular performance assessment, the problems of mixed coding and inaccurate reports encountered during the FY04 PER update must be rectified, in order to ensure confidence in the systems;
- The PER process: MOH should raise the issue of capacity to undertake the PER on an annual basis with the PER Working Group, in order to clarify roles of the Task Team and the external consultant. If the PER is to be institutionalised as part of the budget process, higher priority should be given to this activity within the MOH, with appropriate incentives, in order to ensure the higher level of commitment needed from Task Team members. In addition, the process of data collection and collation must be streamlined and initiated much earlier, in order to permit fuller discussion of the issues arising.

## **1 Introduction**

### **1.1 Background and context**

The Public Expenditure Review (PER) in Tanzania has become an established component of the government planning and budgeting process, with one of its key objectives being to ensure that the expenditure patterns of the government match the policy priorities as stipulated in the Poverty Reduction Strategy Paper (PRSP). It incorporates a retrospective analysis of spending in priority sectors, generally undertaken in the second quarter of the financial year as an input to the budget process, and subsequent presentation and discussion of the same at a consultative meeting in the fourth quarter. To the extent possible, all funds, contributed by various sources including external development partners and utilized by the government in order to achieve PRSP targets are indicated under this review. It also gives a detailed picture of how the funds have been utilized in recent past by levels, functions and institutions and determine how the spending relate to stated strategic objectives.

The Health Sector PER update for the financial year 2003/04 (FY04<sup>5</sup>) is the fourth consecutive PER undertaken as part of a broader exercise through the Government of Tanzania that focuses particularly on the priority sectors as identified in the Poverty Reduction Strategy (PRS). The 2004 update started in October 2003 and builds on the data collected in earlier sectoral PERs.

A Task Team and Consultant carried out the study prior to the preparation of the Medium Term Expenditure Framework (MTEF) for 2004/05 to 2006/07 for the Ministry of Health (MOH). Members of the Task Team were:

- Mr Richard Mkumbo, Economist, Directorate of Policy and Planning (DPP), MOH (Coordinator)
- Mrs Regina Kikuli, Economist and Head, Planning and Budget Section, MOH
- Ms Mariam Ally, Economist, DPP, MOH
- Ms Nainkwa Mnzava, Economist, DPP, MOH
- Mr Kenny Lawson, Economist, DPP, MOH
- Ms Sally Lake, Consultant

Two main definitions of the sector are used throughout this document. Firstly, the on-budget sector includes recorded allocations (recurrent and development, domestic and foreign) to the MOH, Regions, Local Government subventions through the President's Office – Regional and Local Government (PORALG), and the government contribution to the National Health Insurance Fund (NHIF) through the Accountant General's Office (AGO), as captured in the official books of Estimates at the start of each financial year. The second definition is the off-budget sector which, in addition to the on-budget sector, includes revenues from cost-sharing within public (health) institutions, ie hospitals and councils, and additional foreign revenues not captured within the official development budget, but recorded in a database maintained by the External Finance department at the Ministry of Finance (MOF).

### **1.2 Terms of Reference**

The Terms of Reference (TORs) for the health sector PER were developed by members of the MOH Sub-committee on Health Planning, Budgets, Review, Monitoring and Evaluation on the basis of the generic TORs issued through the overall PER Working Group. These were broadly similar to previous years, and the final version is attached at Annex A.

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<sup>5</sup> Throughout this document, the notation FYXX is used to refer to the financial year ending on 30 June 19XX or 20XX, eg FY02 refers to the period 1 July 2001 to 30 June 2002.

The core expected outputs of the health sector PER update for FY04 included the following:

- A review of PER FY03 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions for FY04;
- Analysis of recurrent and development budget performance for the past three years;
- Analysis of expenditure trends at sectoral and sub-sectoral level including the central-local government split, including an analysis of priority areas/items of expenditure highlighted in the Poverty Reduction Strategy;
- A review of existing plans and strategies for the sector, with a view to harmonising the PRS, sector policies/objective and the MTEF;
- A costing of priority interventions over the medium term, and comparison of the financial requirements for meeting PRS targets with the projected resource availability.

Due to changes in the timing of the consultancy commissioned to assist the MOH undertake the PER, TORs relating to outputs required to feed into the preparation of the MOH Budget Guidelines became irrelevant as the guidelines had already been submitted to the Ministry of Finance. In addition, due to constraints in terms of both time and MOH staff availability, several of the TORs could not be met. There is perhaps need to review the TORs, particularly in relation to expected inputs from MOH staff, and this is taken up further in Section 6 below.

### **1.3 Process**

As was the case the previous year, the process of updating the Health sector PER for FY04 was undertaken entirely in Dar es Salaam, through desk review, and data collection from relevant ministry departments and other agencies. Initially, an attempt was made to incorporate information from the local government level through desk analysis of the quarterly technical and financial implementation reports submitted to headquarters, but a combination of non-availability of complete sets of reports, incomplete data within them, and lack of time meant that this was abandoned as an effort to obtain more detailed information for all LGAs. A subsequent attempt to undertake such analysis for a small, non-random subset of reports in the hope of presenting an example of what is possible was also abandoned due to non-availability of Task Team members and incomplete sets of documents. This is commented upon further in Sections 4.1 and 6.1.

Prior to the arrival of the consultant, some initial work to gather some of the required data had taken place by MOH members of the Task Team, although much was still outstanding, and data entry had been limited. As for the FY03 PER update, the process of obtaining much of the data was long and drawn out, with substantial gaps still remaining at the end of December 2003. This was the case both in relation to information from within the MOH itself (notably relating to drugs and supplies, but also due to lack of staff time to clarify questions regarding other MOH data), and also to data from outside the MOH, eg on actual disbursements to local government authorities. In other cases, data was not available at all, eg regarding HIV/AIDS spending at the Regional level.

Progress against the original Terms of Reference is summarised in Annex B. Recommendations to strengthen the process for the FY05 update have been included in Section 6.

## **1.4 Structure and contents of the report**

### **1.4.1 Changes from PER update for FY03**

As with the previous PER update for FY03, the aim of the report, as per the TORs, is to concentrate on the key findings of the assessment, and the implications of these findings for the coming budget preparation cycle.

It should be noted that last year's PER update did not include the government contribution to NHIF, including instead estimates of actual expenditure on health services by the Fund in the analysis of off-budget spending. This has resulted in a break in series between the analysis in the FY03 and FY04 updates, with implications for various sections of the report. These are flagged when they arise.

In addition, an annex was included in the FY03 PER update documenting health spending in other government Ministries, Departments and Agencies (MDAs). This has been excluded this year as it was not possible in many cases to determine whether the spending was on HIV/AIDS-related expenditure (captured in the cross-sectoral HIV/AIDS PER update) or on other Medical Supplies and Services. As this accounted for an additional 1% of on-budget estimates in FY02 and FY03, its exclusion is not expected to alter the main findings or conclusions of this report. It is anticipated that spending in such MDAs will be captured through the National Health Accounts exercise planned for this financial year, but data permitting it could (and arguably should) be included in future PER updates.

The sub-section on indebtedness of the sector has been dropped due to time constraints. However, this was recently indicated as a problem within the sector, and analysis of this issue during the course of the financial year might therefore be indicated.

### **1.4.2 Report structure**

Section 2 summarises recent trends in on-budget 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 then reviewed, with a more detailed analysis of particular recurrent expenditure items and of the development budget in the final sub-section.

Section 3 goes into more detail on the subventions to Local Government Authorities (LGA), a priority level within the Tanzanian Poverty Reduction Strategy (PRS). The first sub-section looks at the level and composition of local government subventions for health in FY02 and FY03, while the second outlines the current context in relation to fiscal decentralisation and proposals for future allocations between geographical areas.

Section 4 reviews sectoral performance in relation to the PRS, analysing the extent to which budgets and expenditures have supported the priority items within the health sector. It also includes an initial assessment of the MOH development budget in terms of PRS priorities. The performance of the sector in relation to its own defined financial performance indicators is also updated.

Section 5 attempts to assess potential future costs and revenues within the health sector, looking at the projected revenues from both domestic and foreign sources, and planned expenditures particularly by priority areas.

Section 6 summarises and discusses the main findings of this year's PER update, and presents some conclusions and recommendations for action, including further analysis. Immediate steps forward in relation to the PER process are also proposed.

Sources, notes and assumptions for each of the graphs and tables within this document are available at Annex B.

PLEASE NOTE: Discrepancies remain between the figures published by Ministry of Finance in their Central Government Expenditure table (as of November 2003) and those collated by the PER Task Team. These are flagged wherever possible, and Table 27 in Annex D shows the current extent of the discrepancy over recent years. This may be due to early re-allocations having been taken into account in the MOF figures. The PER reports on original estimates only for FY04 rather than including re-allocations which will be covered in the FY05 update. However, this does mean that the analysis in various sub-sections will show inconsistencies with MOF data as produced during the current financial year as we have used our data as we are able to attribute sources to each of the figures. We are happy to be corrected by MOF where necessary/possible, but it should be noted that the continued lack of clarity in terms of definitions and sources of data between documents complicates the PER process, although it is acknowledged that this situation is gradually improving.

## 2 Recent trends in health sector expenditure

### 2.1 Review of previous PER studies

In order for the PER to serve its intended purpose, its conclusions and recommendations need to be agreed and acted upon in order to strengthen the future level and allocation of sectoral resources. This is the fourth consecutive PER exercise, and it is useful therefore to begin by highlighting key findings of the most recent PER update in order to set the context for the analysis presented below. Main findings and recommendations of the FY03 health sector update, together with actions taken by the sector to address them where necessary, are summarised in Table 1 below.

**Table 1 Key findings and actions from last year health sector PER update**

<b>Finding/recommendation</b>	<b>Action taken</b>
Slow increase in on-budget allocation to the health sector in recent years	<ul style="list-style-type: none"> <li>Participants at the 2003 Joint Health Sector Review undertook to establish a Joint Health Finance Committee (JHFC), comprised of MOH, PORALG, MOF and Partner representatives, in order to further analyse in detail the level and type of resources coming into the sector as well as to set future targets, and to lobby the Ministry of Finance<sup>6</sup>. Members have been identified, but the Committee has not yet met<sup>7</sup>.</li> </ul>
Downward trend in share of domestic funding within on-budget expenditure	<ul style="list-style-type: none"> <li>As above, the JHFC was tasked to take up this issue but has not yet met.</li> </ul>
Worrying reversal in trend of subventions to local government level as a share of the sectoral total and in health share of overall LGA grants	<ul style="list-style-type: none"> <li>As above, the JHFC was also tasked with examining further the downward trend of health subventions to Local Government. As noted this Committee has not yet met</li> <li>Finalisation of resource allocation formula as a means of strengthening the equity in the distribution of devolved funds, both from the basket and the block grants for Other Charges</li> </ul>
Encouraging shift in spending towards Preventive Services	<ul style="list-style-type: none"> <li>This emphasis towards Preventive Services has been further reinforced by the development of the medium term Health Sector Strategic Plan (2003-2008) with one critical objective to increasingly allocate funds towards priority areas and programmes of the Sector (e.g., strengthening immunisation services, improvement in the availability of drugs and medical supplies, provision of quality health services through the delivery of the essential health package).</li> </ul>
Improved capture of external resources through MOF database	<ul style="list-style-type: none"> <li>Development Partners have been encouraged to provide regular quarterly financial updates to the Treasury for Projects/Programmes that do not use the Exchequer System. However, despite this, there still remain significant gaps in the data that is currently available on this Database making it difficult to obtain a clearer picture of off-budget expenditure. Thus, the Health Sector, in preparation for the development of the MTEF FY2005, has circulated the latest figures from the database to each development partner for further checking and updating.</li> </ul>
Improvement in central level absorption capacity	<ul style="list-style-type: none"> <li>Although budget performance continues to improve at the Central Level in FY03 particularly in terms of the development budget, there is still room for further improvement.</li> </ul>
Significant increase in spending on drugs and supplies from central level	<ul style="list-style-type: none"> <li>This has been maintained in FY03, particularly through Basket funding. Problems remain in determining their allocation however.</li> </ul>

<sup>6</sup> Para 14 of Side agreement, Annex x to 2003 JRM Report

<sup>7</sup> Progress against agreed milestones, as of 18<sup>th</sup> February 2004

<b>Finding/recommendation</b>	<b>Action taken</b>
Weak capture of spending at Local Government level	<ul style="list-style-type: none"> <li>• There have been continued efforts in the past financial year to strengthen capacity at the local level, through training of the CHMTs in recording income and expenditure, and wider circulation of the financial and implementation report.</li> <li>• In addition, there has been general government strengthening of the budgeting and financial management system through extension of the GFS coding system to councils, enabling clearer identification and comparison of key sub-items.</li> </ul>
Inadequate MOH staff time dedicated to PER process with resulting over-reliance on consultant inputs	<ul style="list-style-type: none"> <li>• Discussion is required between MOH and MOF regarding realistic assignment of roles between MOH officials and external consultant support.</li> </ul>

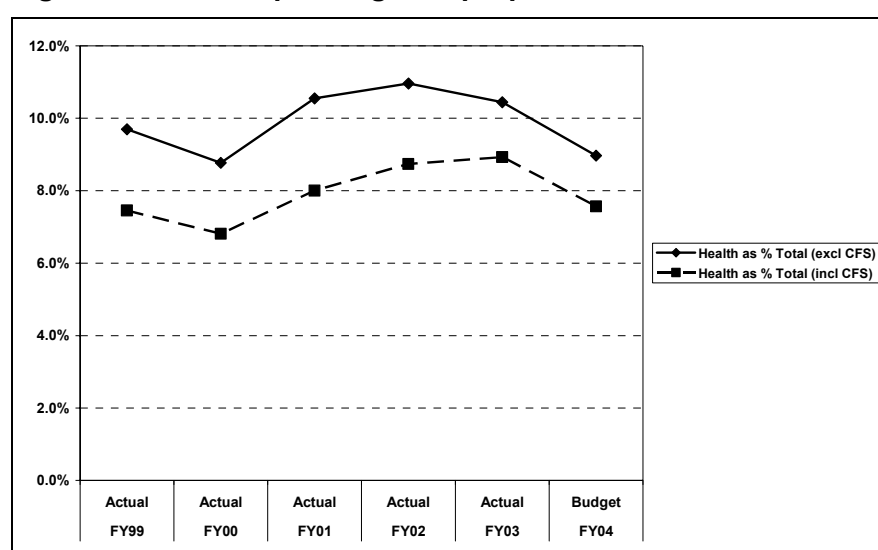
## 2.2 Total public health budget and expenditure

### 2.2.1 Health in relation to the total GOT budget

Health has been identified as a priority sector within the Poverty Reduction Strategy, and as such is expected to benefit from increases in both the absolute level of government funding, and in its share of the budget. Figure 1 below plots total on-budget spending on health as a percentage of total government spending over the past five years, together with the budgeted amount for the current financial year (FY).

It should be noted that the definition of Health as a priority sector has been clarified by the Ministry of Finance for the purposes of budget and expenditure analysis in FY04 and beyond, as shown in Table 28 in Annex D. The major change is the inclusion of the contribution to the National Health Insurance Fund (NHIF) made under the Accountant General's Office (AGO), on behalf of civil servants (both employee and employer contributions). The budget for this item is TSh 6.6bn in FY04, which represents a sizeable contribution towards the sector (8% of the Other Charges budget, 4.5% of the total recurrent budget, and 3.4% of the total budget for the sector in FY04). The MOF figures on which Figure 1 is based also include this budget item for FY02 and FY03, ie since the NHIF was established<sup>8</sup>.

**Figure 1 Sectoral spending as a proportion of the total GOT budget, FY99 – FY04**



Source: MOF (2003)

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

<sup>8</sup> Personal communication from K Manek, Ministry of Finance.

Figure 1 shows that although the health sector benefited from an initial increase in its share of government spending following publication of the PRSP in 2000, the share is projected to fall with the current year's budget, and indeed did so already in FY03 with respect to its share of total government expenditure (ie including Consolidated Fund Services which largely comprises the budget line for public debt)<sup>9</sup>. This is a worrying picture, particularly given the acknowledged under-funding of the sector which persists in relation both to international commitments such as that made in Abuja, reproduced for information in Box 1 below, and also to the ability of the sector to achieve its sectoral, PRSP and Millennium Development Goal objectives.

**Box 1 Abuja commitment on budgetary allocations**

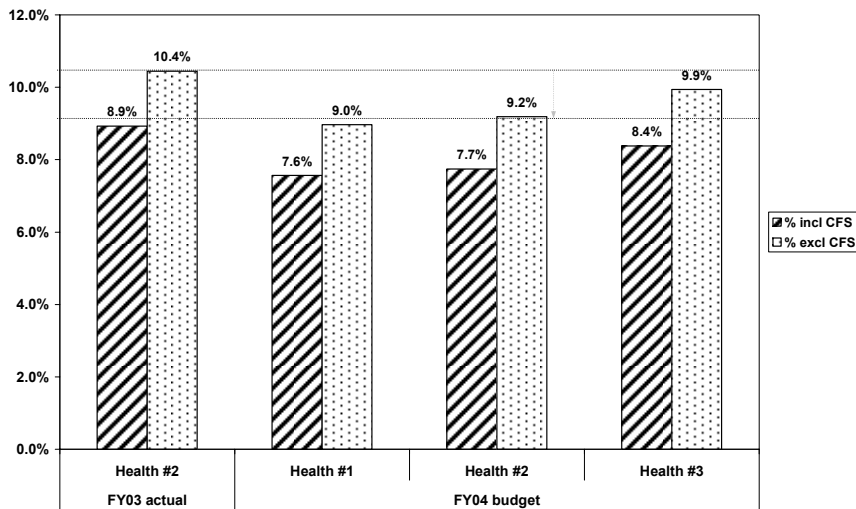
Para 26. *"WE COMMIT OURSELVES to take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilized. In addition, WE PLEDGE to set a target of allocating at least 15% of our annual budget to the improvement of the health sector. WE ALSO PLEDGE to make available the necessary resources for the improvement of the comprehensive multi-sectoral response, and that an appropriate and adequate portion of this amount is put at the disposal of the National Commissions/Councils for the fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases."*

Source: OAU 2001

Notes: Emphasis from original.

The Abuja Declaration does not indicate whether it is referring to total budget or the 'discretionary' budget after debt repayments and other such commitments, ie excluding CFS. However, Figure 2 shows a move away from either in Tanzania, from a peak which was still almost 4% short.

**Figure 2 Fall in Health sector budget as share of total for FY04, various definitions**



Source: MOF data (CGE and additional tables)

Notes: Health #1 – Health sector as defined by MOF

Health #2 – Health sector PLUS budgeted MOH HIV/AIDS spending<sup>10</sup>

Health #3 = Health sector PLUS Total budgeted HIV/AIDS spending

<sup>9</sup> MOF data show that there was a fall in the share of total priority sector expenditure within the overall budget (excluding CFS), from 54.5% in FY03 (actual) to 51.3% in FY04 (budget). However, planned reallocations, including TSh17bn to the Health sector development budget, were expected to reduce if not reverse this drop. Even with the reallocation, the fall in % share of the health sector exceeds that in other sectors (14.1% without the reallocation, 6.7% with the reallocation of Education, 6.4% fall in share; Water, 0.8% increase in share; Agriculture, 23% increase in share. See Table 29 in Annex D for details.

<sup>10</sup> Presumably the most relevant in terms of the Abuja Declaration.

This is the case even after HIV/AIDS spending is added, as some of the decline is due to the removal of spending on HIV/AIDS at MOH, regional and local government level from the definition of health sector spending. However, this alone does not account for the drop, as even if all budgeted HIV/AIDS expenditure is included with Health, the graph still shows a drop in the share of expenditure between FY03 and FY04, as shown in Figure 2 above.

It was hoped that we would be able to present an update of analysis undertaken in the FY03 update, comparing the sectoral share of budget with the share of actual spending in consecutive financial years. However, it proved surprisingly difficult to obtain series data of final budget figures, ie the net approved estimates which take account of reallocations during the financial year<sup>11</sup>. Figure 3 uses original figures taken from successive years' budget speeches, together with initial on-budget estimates of health spending from consecutive PER updates for the period FY01–FY04, to show the trend in terms of sectoral share of original budget estimates<sup>12</sup>. The pattern differs from that in the PER update for FY03 as the NHIF budget figures have been added.

**Figure 3 Health budget as share of original GOT budget estimates, FY01 – FY04**

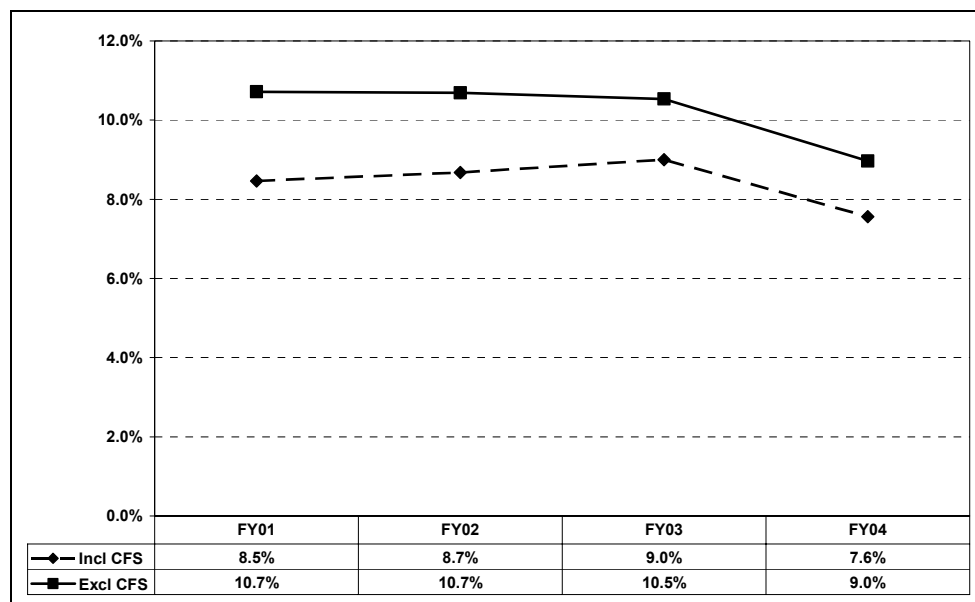


Figure 3 shows a worrying fall in the share of the original GOT budget between FY03 and FY04, following stagnation and a slight drop of 0.1% in previous years. Although in the absence of data on the net approved estimates this does not give a true picture of final budget figures, it is interesting in the context of a stated commitment to increase the share of the sector, as we would expect to see evidence of such an increase in each successive budget.

## 2.2.2 Total on-budget health spending

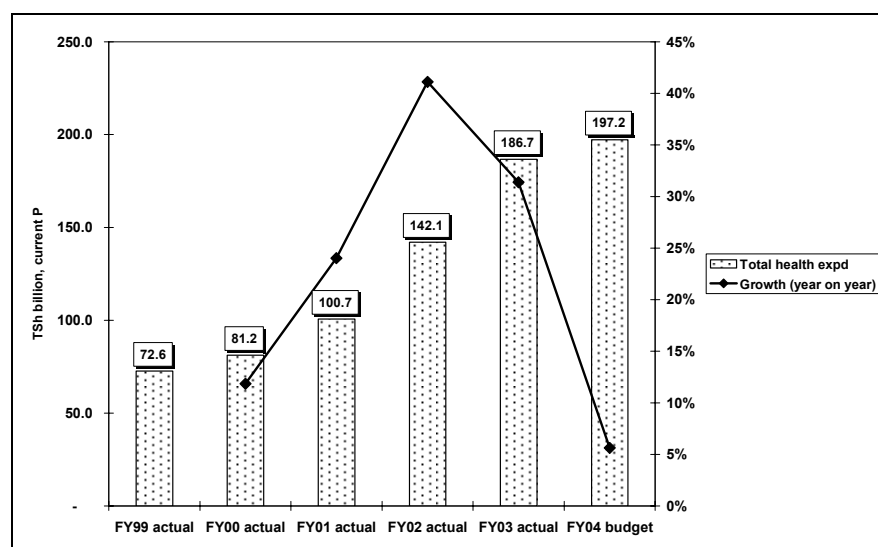
### In nominal terms

As noted in Section 2.2.1 above, following the publication of the PRS the allocations to the sector increased in terms of share of total government spending. This is mirrored in the pattern of absolute spending in nominal terms, which continues to rise, but at a decreasing rate, as shown in Figure 4 below.

<sup>11</sup> When requested, MOF referred the team to the IMF website for such information. However, no consistency could be found between data from this website and that included for Actual expenditure in the MOF table on Central Government Expenditure.

<sup>12</sup> Data are given in Table 30 in Annex D.

**Figure 4 Nominal on-budget health spending and rate of growth, FY99 – FY04**



Source: MOF data (CGE)

Figure 4 shows that the value of total nominal spending on the health sector in Tanzania has risen from an actual level of TSh 72.6bn in FY99 to a budgeted TSh 197.2bn in FY04, representing an increase of over 170% in five years. This most likely reflects both the release of HIPC funding into the general budget, and the rapid growth in health sector basket funding. For FY01 and FY02, the rate of growth in the nominal allocations to the sector grew by 25% and 40% respectively, but has since slowed with the FY04 budget being an estimated 5.6% higher than in FY03 (according to MOF figures)<sup>13</sup>.

### **Other measures of health spending**

Table 2 below presents a number of other useful measures of health expenditure and budget using the MOF data. Firstly, by deflating by Consumer Price Index (CPI) in recent years, we can obtain a measure of real spending in the health sector, ie taking account of general inflation in the country. The allocation has therefore been revalued in FY01 prices<sup>14</sup>. Secondly, the equivalent figures in US dollar terms are given, in order to enable some comparison with other countries. Finally, the per capita figures are presented, in both Tanzanian shilling and US dollar terms.

**Table 2 Additional measures of spending, MOF on-budget data FY01 – FY04**

	FY01	FY02	FY03	FY04
Nominal health spend	100.7	142.1	186.7	197.2
In real terms (FY01 prices)	100.7	135.6	170.6	176.1
In US \$ (million)	120.9	152.1	185.4	187.1
Per capita TSh	3,109	4,256	5,424	5,558
Per capita US\$	3.73	4.56	5.39	5.27
CPI deflator	100	104.8	109.4	112.0
US\$ exchange rate	833	934	1,007	1,054
Population	32,391,792	33,390,850	34,420,722	35,482,358

Although less dramatic than the nominal figures, Table 2 shows that real health sector expenditure and budget has risen substantially since FY01, from TSh101bn to TSh176bn, or by 75% over the three year period compared with a 96% increase in the nominal value over the same period. However, the recent slowdown is very clear, with comparison of the FY03

<sup>13</sup> This figure is for the original budget, which predates the TSh17bn re-allocation in favour of the health sector development budget (foreign spending), made in September 2003.

<sup>14</sup> An arbitrary base year determined by availability of CPI data on the web.

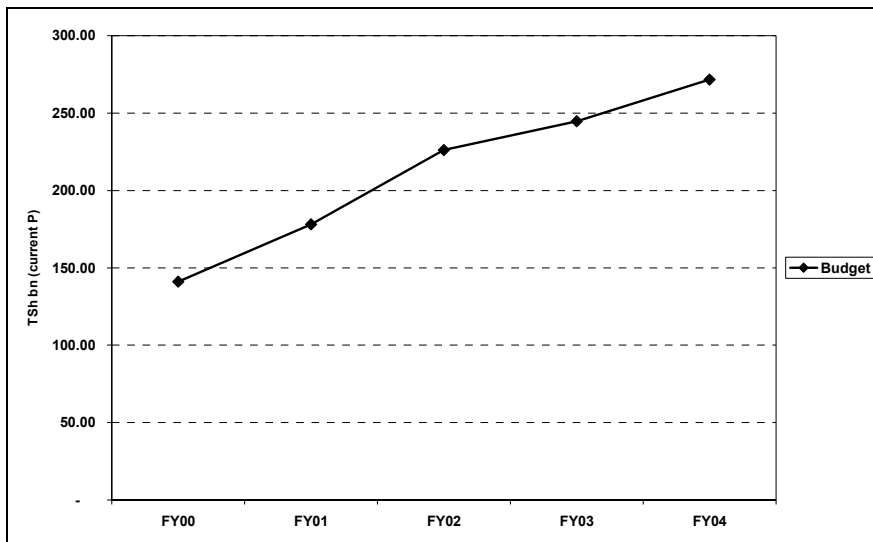
actual expenditure with the original FY04 budget showing a rise of only 3.2%. In Tanzanian shillings, this translates to a per capita growth rate of 2.5% on the previous year, although over the three year again there has been substantial growth of 79%.

In US dollar terms, the figures show a similar picture, with a period growth rate in the total value of 55%, from US\$121m to US\$187m, and in per capita terms of 41%, or US\$ 1.54. Year on year, however, the increase for FY04 is less than 1%, and in per capita terms there is an actual fall of 2.1%<sup>15</sup>. As the original target for the health sector was set at US\$9 per capita, as per the costing undertaken in 1998, this presents a worrying picture.

### 2.2.3 Trends in overall public health expenditure

In nominal terms, the trend in public expenditure in the Tanzanian health sector in recent years has been steadily upwards, as shown in Figure 5 and Table 3 below. Unlike the earlier graphs in this report, both Figure 5 and Table 3 are based on data gathered through the PER update process for FY04, including off-budget spending through public institutions<sup>16</sup>. It should be noted that Figure 5 includes only budgeted figures rather than actual due to the assumptions made regarding off-budget foreign project funding in particular.

**Figure 5 Nominal health sector budgets, FY00 – FY04**



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<sup>15</sup> NB comparison of the US dollar figure over time ignores the effects of shilling depreciation over time. In terms of relationship to the US\$9 target, it is relevant to the extent that inputs to the sector are purchased in US dollars, eg drugs and medical supplies.

<sup>16</sup> NB this excludes payment by the NHIF to public institutions as this would be double-counting.

**Table 3 Total health expenditure in Tanzania, FY99 – FY04 (TSh billion)**

	1998/99		1999/2000		2000/2001		2001/2002		2002/2003		2003/04
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
<b>Recurrent</b>											
AGO	-	-	-	-	-	-	8.97	5.61	6.92	6.55	6.62
MOH	37.25	37.15	39.20	32.39	49.39	44.25	61.60	58.99	82.16	69.90	86.38
Region	9.25	8.68	9.36	9.01	6.21	5.61	7.06	6.58	7.86	7.82	8.83
Local Govt	15.72	16.34	18.69	17.95	36.35	35.67	46.26	46.28	57.66	57.48	66.14
<b>Total rec.</b>	<b>62.21</b>	<b>62.18</b>	<b>67.25</b>	<b>59.34</b>	<b>91.95</b>	<b>85.53</b>	<b>123.89</b>	<b>117.47</b>	<b>154.60</b>	<b>141.75</b>	<b>167.97</b>
<b>Development</b>											
MOH	21.21	17.27	17.75	10.19	20.47	14.84	32.07	21.12	34.07	29.03	27.18
Regions	5.00	0.67	2.57	0.79	4.62	1.39	2.35	1.28	4.99	2.48	3.53
Local Govt	0.62	-	1.18	1.06	1.73	1.52	1.70	1.45	1.75	2.38	2.34
<b>Total devt</b>	<b>26.83</b>	<b>17.94</b>	<b>21.50</b>	<b>12.03</b>	<b>26.81</b>	<b>17.74</b>	<b>36.12</b>	<b>23.86</b>	<b>40.80</b>	<b>33.89</b>	<b>33.05</b>
<b>Total on budget</b>	<b>89.04</b>	<b>80.11</b>	<b>88.75</b>	<b>71.38</b>	<b>118.76</b>	<b>103.27</b>	<b>160.01</b>	<b>141.33</b>	<b>195.40</b>	<b>175.64</b>	<b>201.02</b>
<b>Off budget expenditure</b>											
Cost sharing	-	1.09	-	1.49	-	1.86	-	1.24	-	1.67	1.67
Other foreign funds	35.55	42.76	52.33	60.04	59.41	75.00	66.14	79.37	49.25	59.11	68.99
<b>Total off budget</b>	<b>35.55</b>	<b>43.85</b>	<b>52.33</b>	<b>61.53</b>	<b>59.41</b>	<b>76.86</b>	<b>66.14</b>	<b>80.61</b>	<b>49.25</b>	<b>60.77</b>	<b>70.66</b>
<b>Grand total</b>	<b>124.58</b>	<b>123.96</b>	<b>141.08</b>	<b>132.91</b>	<b>178.18</b>	<b>180.13</b>	<b>226.16</b>	<b>221.94</b>	<b>244.66</b>	<b>236.41</b>	<b>271.68</b>

Source: MOH PER data

Notes: AGO spending on NHIF. Basket funding included under recurrent or development as appropriate

Table 3 and Figure 5 show that total public health spending (ie on- and off-budget) is projected to rise by 11% between FY03 and FY04, which represents a real increase in per capita Tanzania Shilling terms. There are significantly different growth rates in different components of total spending, however, with the main source of the increase being due to the 40% increase in Other foreign funds, ie project spending not captured through the official government budget.

The on-budget element of public health spending is projected to rise, year on year, by 2.9%, ie at the same rate as population growth. This is largely due to a fall in on-budget Development spending by 19%, which is not compensated for by the 8% increase in on-budget recurrent spending<sup>17</sup>.

Again, as for the MOF official figures in Section 2.2.2, additional measures of the total resource envelope for the health sector, ie on and off-budget, are shown in Table 4 below. Data reflect budget figures for successive years rather than actual expenditure.

**Table 4 Additional measures of spending, overall MOH PER data FY01 – FY04**

	FY01	FY02	FY03	FY04
Nominal budget (TSh bn)	178.18	226.16	244.66	271.68
In FY01 prices (TSh bn)	178.18	215.74	223.58	242.67
In US \$ million	213.83	242.13	242.95	257.70
Per capita TSh	5,501	6,773	7,108	7,657
Per capita US\$	6.60	7.25	7.06	7.26
CPI deflator	100	104.8	109.4	112.0
US\$ exchange rate	833	934	1,007	1,054
Population	32,391,792	33,390,850	34,420,722	35,482,358

Once off-budget funding sources are taken into account, the rates of growth are much less dramatic, with a 52% increase in the nominal budget over the three year period, translating to a 36% increase in the real value of the budget in shillings. In US\$ the rate of growth is slower again, at only 21% over the period. This probably reflects the fact that the difference

<sup>17</sup> NB The reallocation of TSh17bn of foreign Development spending to the health sector in September 2003 was probably a response to this somewhat unexpected picture. It has not been possible to determine why this sum was not included in the original estimates, but in any case it has not been included within the PER update as the focus was on original budget compared with previous years' expenditure.

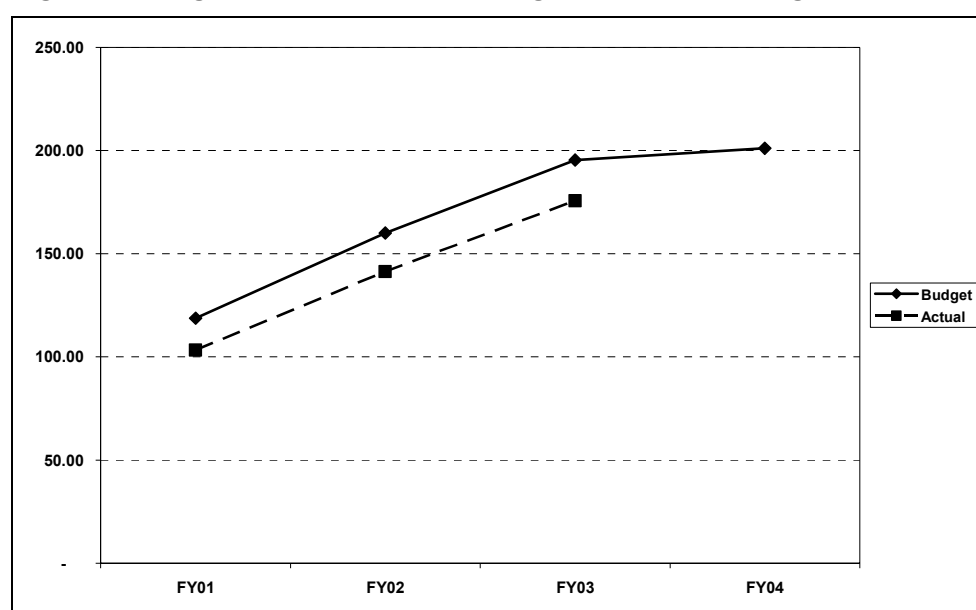
between the two definitions of health spending is largely due to external funding, the total value of which has not grown as fast as the proportion captured within the budget in recent years, in addition to increases in the value of the domestic budget.

The per capita shilling value has increased by 39% over the three year period, and by 8% between FY03 and FY04<sup>18</sup>. In per capita dollar terms, the inclusion of off-budget spending increases the available funds to US\$7.26 per capita in FY04, ie by \$1.99 when compared with Table 2. This value has grown by 10% over the three year period, and the 3% increase between FY03 and FY04 reverses a decline in the previous year.

#### 2.2.4 Recent overall budget performance

Analysis of budget performance, both total and separately for the recurrent and development budget, is undertaken using data collated for the PER update. Comparison of actual expenditure compared with the net approved budgets is presented below in Figure 6.

**Figure 6 Budgeted and actual on-budget health spending, FY01 – FY04**



Note: Budget means Net approved estimates except for FY04 for which original estimates are used.

Figure 6 shows that, although the trend for absolute levels of both budget and expenditure is upwards, total actual expenditure in the health sector has fallen short of the budgeted figure in each of the past three financial years, implying that there is still room for improvement in overall budget performance. Lack of data on releases precludes analysis of the extent to which this reflects performance at the government in meeting budgetary commitments to sectors, or poor absorption capacity at the sectoral level. The degree of shortfall is given in Table 5 below, disaggregated for the recurrent and development budget components of the total.

**Table 5 Budget performance (expenditure/budget), FY01 – FY03**

	FY01	FY02	FY03
Recurrent	93.0%	94.8%	91.7%
Development	66.2%	66.0%	83.1%
<b>Total</b>	<b>87.0%</b>	<b>93.6%</b>	<b>89.9%</b>

<sup>18</sup> The difference in the FY01 figures and the baseline in Table 22 (from the MOH Performance Profile) is due to use of different population figures following publication of the Census data.

Table 5 shows that following an improvement in overall budget performance between FY01 and FY02, the situation has worsened slightly in FY03, with overall expenditure slightly under 90% of final budget estimates. This is down over 3.5% from FY02 performance of almost 94%.

The performance of the Development budget is consistently poorer than that of the Recurrent budget, although ironically there has been improved performance in the Development budget for FY03, up from a position where only two-thirds of expected funds were spent in FY01 and FY02, to achieving over 80% in FY03.

Analysis of variations in budget performance between government and basket funding at MOH headquarters is presented in Section 2.4 below.

## **2.3 Sub-sectoral trends in budget and expenditure**

### **2.3.1 Recurrent and development spending**

The convention in many African countries is that budgets for externally-funded activities are recorded in the Development Budget rather than the Recurrent Budget, regardless of type of expenditure undertaken. This is presumably based on the historical commitment of donors to supporting the development of infrastructure, capacity and systems, rather than of supporting day-to-day operations through the recurrent budget. However, with the recognition that external support to recurrent spending is necessary to ensure a minimum level of service delivery in key sectors such as Health and Education, donor-funded project or programme expenditure is increasingly supplementing the recurrent budget. Arguably, this is one factor in the growth in general budget support.

For those who maintain a (separate or additional) commitment to a given sector, contributions are still recorded in the relevant Development Budget. However, as noted above in Section 2.1, the Government of Tanzania has improved its budget systems for FY04, with one improvement being the extension of GFS coding to the Development Budget, thereby enabling disaggregation and analysis of the Recurrent and Capital elements of total (ie foreign and local) on-budget spending. In the Health sector, the central level Joint Basket was already coded and included in the Integrated Financial Management Information System (IFMIS) as recurrent spending rather than development.

The analysis below is based on the conventional distinction, looking at the shares of recurrent and development spending as recorded in the official Government Estimates, for the purpose of comparison with previous years. Analysis of Recurrent versus Capital spending within the Development budget is presented in Section 2.6.1 below.

**Table 6 Breakdown between recurrent and development spending, FY00 – FY04**

	Budget					Actual			
	FY00	FY01	FY02	FY03	FY04	FY00	FY01	FY02	FY03
Recurrent	76%	77%	77%	79%	84%	83%	83%	83%	81%
Development	24%	23%	23%	21%	16%	17%	17%	17%	19%

Table 6 shows that the relative shares of Recurrent and Development spending in the total budget have remained fairly constant in recent years, with Recurrent averaging 79% of the budgeted figure and 82% of the actual expenditure over the period analysed. For FY04, the Recurrent share has increased from 79% to 84% of the total.

### **2.3.2 Domestic and foreign spending**

With the increasing use of general budget support (GBS) to boost government revenues, discussion of the relative shares of the national budget funded by domestic and foreign

sources becomes more complex. However, even treating the GBS funding as domestic resources, it is still of interest to review the pattern of sectoral funding in these terms, not least as the identifiable foreign funding is often channelled through parallel mechanisms which may reduce the efficiency of their contribution. Table 7 shows the breakdown in total spending between domestic (including GBS) and foreign sources.

**Table 7 Public health spending, by funding type (Billion shillings)**

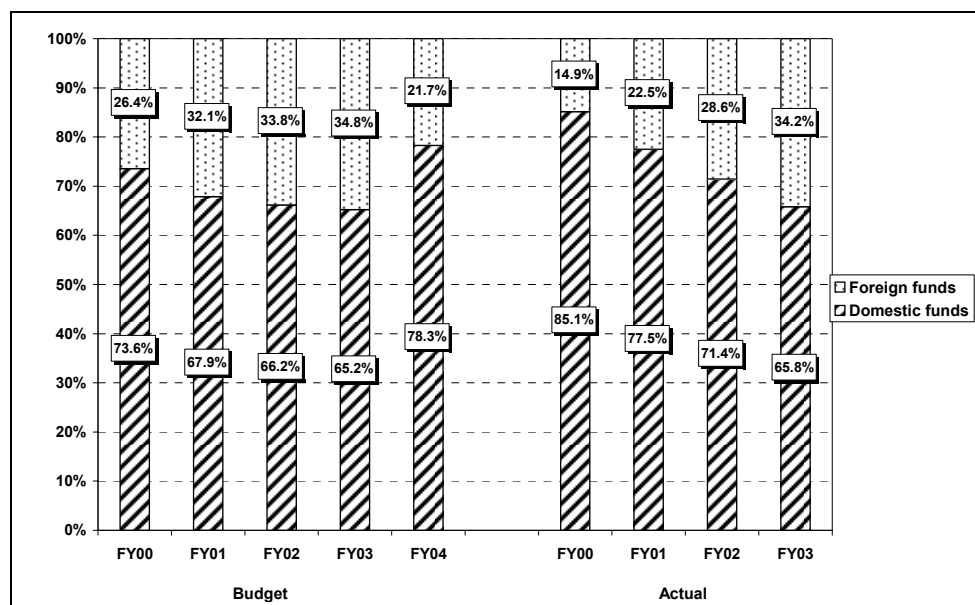
	1998/99		1999/2000		2000/2001		2001/2002		2002/2003		2003/04
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
<b>Recurrent</b>											
Domestic funds	62.21	62.18	60.73	57.98	75.47	74.90	100.60	95.91	121.34	109.47	150.69
Foreign funds	-	-	6.52	1.36	16.48	10.63	23.29	21.57	33.26	32.27	17.28
<b>Total rec.</b>	<b>62.21</b>	<b>62.18</b>	<b>67.25</b>	<b>59.34</b>	<b>91.95</b>	<b>85.53</b>	<b>123.89</b>	<b>117.47</b>	<b>154.60</b>	<b>141.75</b>	<b>167.97</b>
<b>Development</b>											
Domestic funds	2.60	0.92	4.56	2.80	5.14	5.13	5.34	5.04	6.12	6.11	6.61
Foreign funds	24.23	17.01	16.94	9.24	21.67	12.61	30.79	18.82	34.68	27.78	26.42
<b>Total devt</b>	<b>26.83</b>	<b>17.94</b>	<b>21.50</b>	<b>12.03</b>	<b>26.81</b>	<b>17.74</b>	<b>36.12</b>	<b>23.86</b>	<b>40.80</b>	<b>33.89</b>	<b>33.03</b>
<b>Total on budget</b>	<b>89.04</b>	<b>80.11</b>	<b>88.75</b>	<b>71.38</b>	<b>118.76</b>	<b>103.27</b>	<b>160.01</b>	<b>141.33</b>	<b>195.40</b>	<b>175.64</b>	<b>201.00</b>
<b>Off budget expenditure</b>											
Domestic funds	-	1.09	-	1.49	-	1.86	-	1.24	-	1.67	1.67
Foreign funds	35.55	42.76	52.33	60.04	59.41	75.00	66.14	79.37	49.25	59.11	68.99
<b>Total off budget</b>	<b>35.55</b>	<b>43.85</b>	<b>52.33</b>	<b>61.53</b>	<b>59.41</b>	<b>76.86</b>	<b>66.14</b>	<b>80.61</b>	<b>49.25</b>	<b>60.77</b>	<b>70.66</b>
<b>Grand total</b>	<b>124.58</b>	<b>123.96</b>	<b>141.08</b>	<b>132.91</b>	<b>178.18</b>	<b>180.13</b>	<b>226.16</b>	<b>221.94</b>	<b>244.66</b>	<b>236.41</b>	<b>271.66</b>

Source: MOH PER data

Table 7 shows that, as would be expected, domestic funds drive the Recurrent budget, while the Development budget is more heavily influenced by foreign funding. Contrary to previous years, foreign funding of the Development budget is projected to fall in FY04 compared with previous years (although see Footnotes 8 and 11 above). Off-budget funds are predominantly foreign, with the domestic contributions made by cost-sharing schemes in the sector (excluding NHIF) contributing only 2.4% of total projected off-budget resources<sup>19</sup>.

Figure 7 below shows the relative shares of domestic (including GBS) and foreign funding of the health sector in recent years.

**Figure 7 On-budget share of domestic and foreign funding, FY99 – FY03**



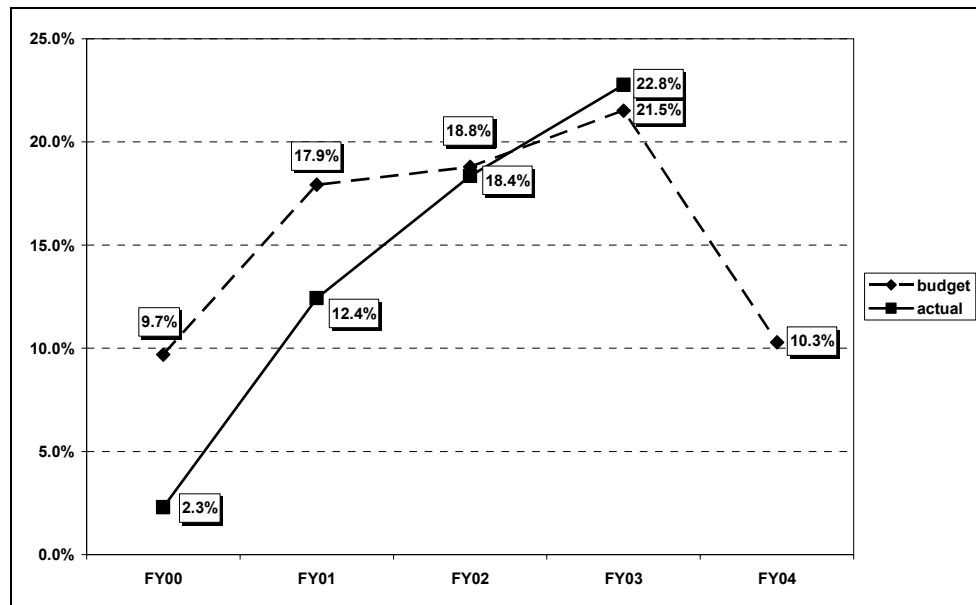
<sup>19</sup> The budgeted level of domestic off-budget funding is held at the level of actual expenditure for the previous year.

Government funds dominate both budgeted and actual expenditures in the health sector, averaging around 70% of the budget in the last five years, but showing a sharply decreasing trend in terms of expenditures since FY00. The budget for FY04 shows a change in trend, from a gradual reduction in the share of government funds to a substantial increase, from 62% to 78%. This largely reflects the move by DFID to from the health basket to GBS.

**Basket funding**

Within foreign funding, basket funding has increasingly played an important role in supporting day-to-day operations within the health sector, both through the recurrent budget support to MOH headquarters, and through the grants to Local Government Authorities (LGAs). Figure 8 below shows the increasing significance of the health basket in the recurrent budget between FY00 and FY03, and the subsequent reduction in FY04<sup>20</sup>.

**Figure 8 Basket funding as a share of recurrent health spending, FY00-FY03**



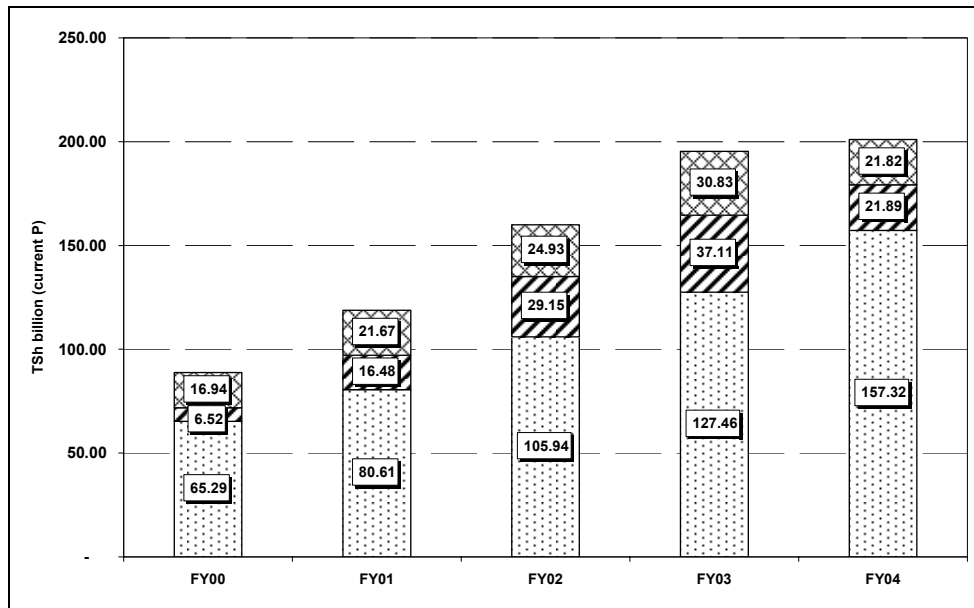
The drop off in the share of the basket for FY04 is due, as mentioned above, to the switch by DFID to GBS, with the total recurrent budget for FY04 seeing a (nominal) increase roughly equivalent to the previous level of DFID funding (ie TSh20bn). In FY04 central level recurrent basket funds have been incorporated into the Development budget, but the recurrent allocations to councils continue and are reflected in the lower figure. In FY05, the central level basket is again expected to be significant, and to be captured in the IFMIS as recurrent spending.

Figure 8 also shows that although in FY02 the budgeted and actual shares of the basket were quite close, at 18.8% and 18.4% respectively, in FY03 the graph diverges again slightly, with the budgeted share at 22.8% and the actual at 21.5%. This reflects poorer budget performance and absorption capacity of basket funds in FY03, explored further in Section 2.4 below.

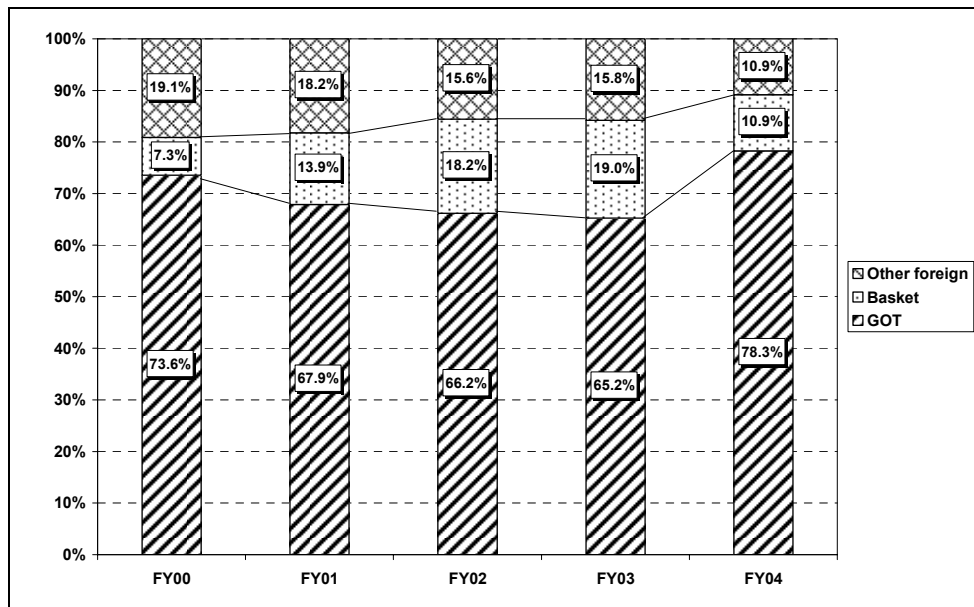
Figures 9 and 10 below show the breakdown in the sectoral budget by type of funding, firstly in nominal terms, and secondly in terms of percentage share. The graphs each distinguish between domestic (including GBS), basket, and other foreign resources.

<sup>20</sup> The differences in both percentages and shape for FY02 and FY03, compared with Figure 4 in the PER update for FY03, are due to the inclusion of the government allocation to the NHIF within the recurrent total.

**Figure 9 Role of foreign funds in increased sectoral budgets, FY99-FY04**



**Figure 10 Health budget, Percentage breakdown by type of funding, FY00 – FY04**



Figures 9 and 10 clearly show the effect of the switch from basket funding to GBS by DFID for FY04, with a reversal of the trend of an increasing share of foreign (basket and other) in the budget. As a result, this type of analysis can no longer be used as a basis for discussion of sustainability of funding, in terms of the high dependency on foreign funds, as the Government of Tanzania budget as a whole is increasingly supported by such foreign resources. However, it does serve to show the extent to which the health sector is still subject to “parallel” funding mechanisms<sup>21</sup>.

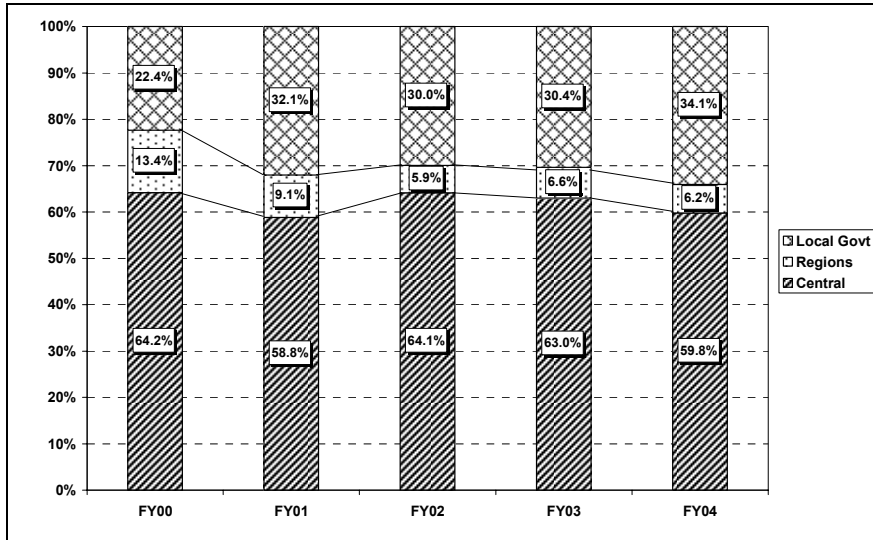
### 2.3.3 Spending by level of the health system

Analysis of the pattern of spending by level of the health system is one of those areas altered by the inclusion of the government allocation to the National Health Insurance Fund. While

<sup>21</sup> While accepting that in many ways, health basket funding is fully integrated within government budgetary and financial management systems.

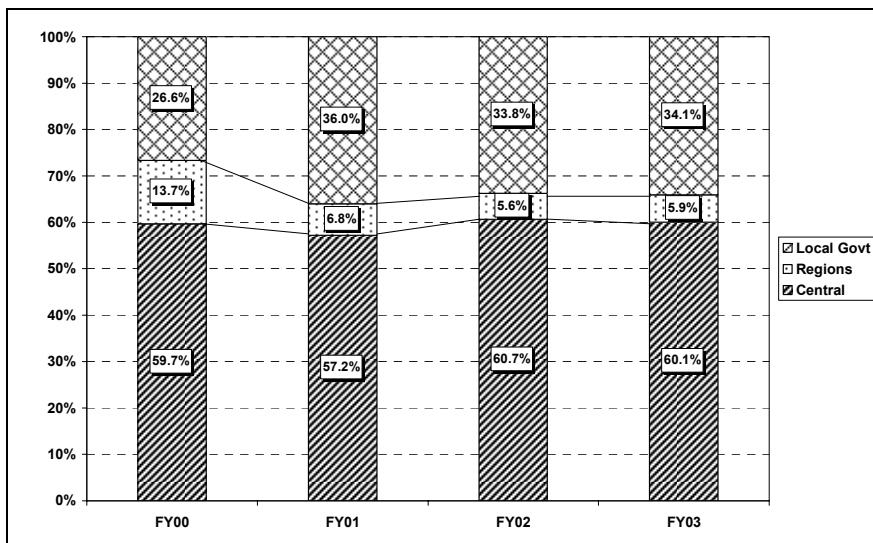
ultimately this is expected to be reflected in benefit payments made to health facilities at all levels of the system, this is captured within the PER as a central level transfer. At present, as noted further below, there is relatively little expenditure by the Fund in relation to income, and therefore analysis of the distribution of actual expenditures by the NHIF contributes little to the picture by level. In future years, this analysis should be included within National Health Accounts, but it may remain a central transfer as far as the PER exercise is concerned.

**Figure 11 Proportion of estimated budget by level, FY99 – FY03**



Note: On-budget only

**Figure 12 Proportion of actual expenditure by level, FY99 – FY02**



Note: On-budget only

In terms of budgets, Figure 11 shows that there was an initial reversal in the trend favouring the Regional and Local government allocations for FY02. This was most likely due to the inclusion of the government allocation to NHIF in the Central level which jumped from 59% to 64% of the total. However, by FY04 the position has almost reverted, with Regional and Local government allocations totalling 40.3% of the total, up from 35.9% in FY02.

In terms of actual spending, the share of central level was broadly static between FY02 and FY03, incurring a fall of 0.6%. This implies that with the shortfall in expenditure over budget, central level has benefited more than proportionately.

It should be borne in mind that Figures 11 and 12 offer a very partial picture of the allocation by level, due to the large volume of spending undertaken at central level on behalf of councils or the regional offices and hospitals. Although an attempt has been made to reflect this in Section 2.3.4 below, this is incomplete, and the sector may benefit from a more detailed tracking study (see Discussion section).

### 2.3.4 Spending by activity type

As in the FY03 update, there is a requirement to estimate the breakdown of sectoral spending between broad categories of activity, ie administrative, preventive and curative. Although distinctions and definitions are in some cases unclear, the analysis is repeated this year in order to provide an updated indicator as per the sector Performance Profile (see Section 4.2 below).

As in the past, this table presents a partial analysis of the recurrent resource envelope, ie of government expenditure, excluding the basket and recurrent spending through the development budget. In the future, it would be useful to undertake a more complete analysis in order to determine the true trend within the sector.

**Table 8 Summary of GOT health spending by level/category, TSh billion**

	FY01			FY02			FY03		
	PE	OC	Total	PE	OC	Total	PE	OC	Total
MOH Admin							3.79	7.95	11.75
NIMR							1.59	0.35	1.95
TFNC							0.66	0.22	0.88
<b>MOH Admin, NIMR and TFNC</b>	<b>2.90</b>	<b>3.69</b>	<b>6.58</b>	<b>3.25</b>	<b>5.24</b>	<b>8.50</b>	<b>6.05</b>	<b>8.52</b>	<b>14.57</b>
<b>Hospitals</b>									
Muhimbili National Hospital	3.79	1.20	4.99	4.78	1.72	6.51	5.36	2.02	7.38
Muhimbili Orthopaedic Institute	0.54	0.30	0.85	0.56	0.38	0.94	1.53	0.93	2.46
Ocean Road Cancer Institute	0.28	0.23	0.51	0.29	0.43	0.72	0.35	0.48	0.83
Bugando Medical Centre	0.71	0.86	1.57	0.72	0.41	1.13	0.94	1.27	2.21
Kilimanjaro Christian Medical Centre	1.20	0.83	2.03	1.33	0.71	2.04	1.48	0.77	2.25
Referral hospitals, MoH *	1.74	4.06	5.81	2.03	0.32	2.35		0.23	0.87
Regional hospitals	4.43	2.07	6.50	5.14	2.40	7.54	5.69	3.27	8.96
District hospitals	3.53	5.06	8.59	5.22	4.39	9.62	6.54	5.34	11.88
Designated District Hospitals	3.07	1.27	4.33	2.94	2.23	5.16	3.43	1.74	5.17
Voluntary Agencies - Hospital	1.91	0.23	2.14	1.94	0.09	2.03	2.32		2.32
<b>Total hospitals</b>	<b>21.20</b>	<b>16.11</b>	<b>37.31</b>	<b>22.93</b>	<b>13.07</b>	<b>38.03</b>	<b>27.65</b>	<b>16.05</b>	<b>43.70</b>
<b>Preventive/Primary health care</b>									
MoH preventive services	0.27	3.55	3.82	0.27	6.01	6.28	0.30	6.21	6.51
Regional preventive services	0.13	0.08	0.21	0.25	0.05	0.30	0.15	0.15	0.30
Council preventive	14.11	12.86	26.97	18.50	17.45	35.95	23.40	17.89	41.29
<b>Total Preventive/Primary</b>	<b>14.51</b>	<b>16.49</b>	<b>31.00</b>	<b>19.02</b>	<b>23.51</b>	<b>42.53</b>	<b>23.85</b>	<b>24.25</b>	<b>48.10</b>
<b>Total Health recurrent</b>			<b>74.90</b>			<b>89.06</b>			<b>106.37</b>

Notes:

- Breakdown of MOH Admin, NIMR and TFNC not available prior to FY03
- Total excludes NHIF contribution which would increase the share of the Administrative category (See Annex D Figure 18)
- PE:OC breakdown for Referral hospitals was not obtained; OCs are drugs and medical supplies only
- No OC information obtained for VAs
- Table exceeds GOT allocation to MOH, Regions and LGAs as spending on kits and hospital drugs and supplies from government funds (TSh 12.8bn) appears to exceed the allocation given in Platinum (TSh 11.0bn), possibly due to known lags in the disbursement process to Medical Stores Department.

As in last year's PER update, data queries remain regarding this table as no attempt has been made to fill gaps from FY01 and FY02. The table includes domestic allocations to the MOH, regions and LGAs, with OC including drugs and medical supply allocations as far as has been possible.

Figure 13 shows the trend in terms of allocation between the three categories for the past four years.

**Figure 13 The trend in allocation by category of spending, FY00 – FY03**

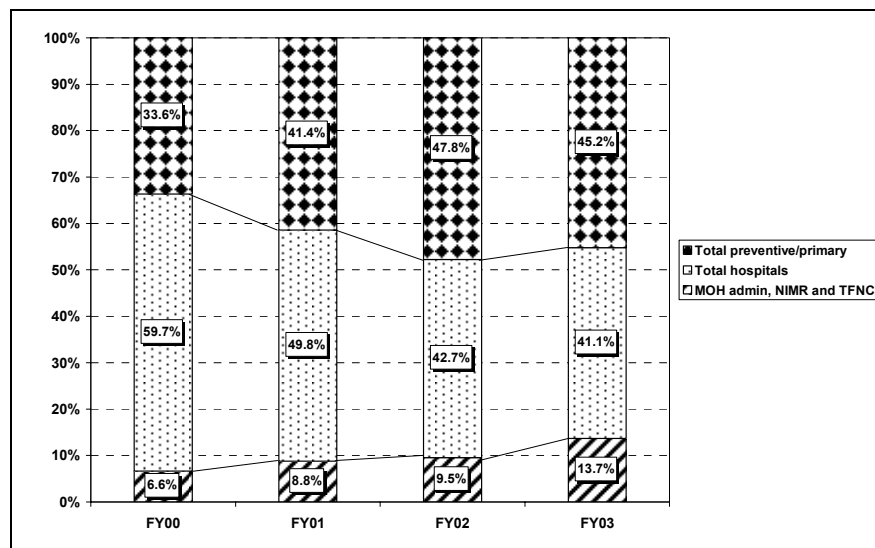


Figure 13 indicates that the positive trend towards Preventive and primary level services reversed slightly between FY02 and FY03, with the share falling from 47.8% to 45.2%, ie by 2.6%. This was entirely due to an increase in the administrative category, ie MOH headquarters together with NIMR and TFNC. The hospital share continued to fall slightly, by 1.6% from 42.7% in FY02.

As was noted last year, it would be preferable to expand this analysis to include both GOT and basket funding, and ideally also the Development budget, but time did not permit such analysis this year. This should be considered when TORs are developed for the FY05 update.

### 2.3.5 On and off-budget spending

The inclusion of the Government contribution to the National Health Insurance Fund in the formal definition of the health sector has an immediate impact on the scale of off-budget domestic funding to the sector. In previous years, NHIF spending has been captured as off-budget actual and projected expenditure only, based on figures given by the NHIF itself. This has resulted in much lower figures for this item in the past. The NHIF is treated in this PER update as on-budget, with the value of the allocation from the Account-General's Office included retrospectively as both budget and actual from FY02 when the Fund began operating. The fact that very little of this "spending" is currently funding health services is discussed in Annex E.

The other components of domestic off-budget spending in the health sector also arise through established cost-sharing mechanisms:

- The Health Service Fund (HSF), which covers contributions and expenditures from user fees at government hospitals around the country; and
- The Community Health Fund, which is a World Bank-supported, community-based prepayment scheme which was operational in 37 councils at the end of FY03, with a further 17 councils having received orientation during the course of the financial year<sup>22</sup> (MOH).

These two sources both grew in nominal terms between FY03 and FY04, the HSF by 39% and the CHF by 2%. The data available indicate that the CHF expenditure remains

<sup>22</sup> MOH (2003). *Annual implementation report (Physical and financial) for July 1<sup>st</sup> 2002 – June 30<sup>th</sup> 2003*, p 156.

substantially below that achieved in FY02 despite having shown a small improvement on the previous year, but it is difficult to comment further as the data are incomplete. Nevertheless, it can be concluded that expenditure from cost-sharing revenues within public institutions (ie hospitals and councils) remains relatively insignificant in the total picture.

In the absence of complete and up-to-date information on revenues generated by the CHF around the country, estimates were obtained by proxy through MOH headquarters accounts showing the payment of matching grants, ie the World Bank project funds which are provided to councils on a one-to-one basis with membership fees once certain conditions are met. However, this is unsatisfactory for a number of reasons:

- Matching grants represent revenue rather than expenditure. The 2001 assessment of the CHF in one district<sup>23</sup> found considerable unspent balances in most wards/facilities;
- Only nine councils meeting qualifying conditions for matching grants were included in the financial report provided by the CHF coordination office at MOH headquarters, therefore under-estimating the actual value of membership fees raised in the 37 councils;
- The majority of revenues raised (and presumably spent) in CHF councils are actually generated by user fees rather than membership fees. In 2002 and 2003 in Hanang, the ratio of revenues generated was around 85% from user fees and 15% from CHF membership dues<sup>24</sup>.

## **2.4 Analysis of MOH headquarters' recurrent spending**

Ideally, we would be able to analyse actual spending performance for each 'component' of the health sector, ie central, regional and local. However, analysis is presented here for the MOH central level only. Detailed appropriation accounts were not obtained from PORALG for Regional spending, although summary data was made available. At the LGA level, arguably the most significant in terms of health service delivery, no expenditure data was available at the time of the PER update, and this is a major drawback in terms of the sectoral PER. It is recognised that efforts to extent IFMIS throughout government are underway and take time. However, the need to explore other means of assessing performance in this area is discussed further in Section 6.

In theory, the inclusion of both government and basket funds in the IFMIS and the availability of the Itemised Daily Balances in Excel should have substantially simplified the task of analysing recurrent expenditure at MOH headquarters. However, problems remain within the MOH both in terms of the accuracy of the data, and in terms of the institutionalisation of its use as an activity within PER preparation. For example, the analysis below, of budget performance and absorption capacity within MOH HQ, could be undertaken as early as July, as could analysis of the allocation of recurrent expenditures between Departments or between items of expenditure. However, in practice this is not done, and the task of data analysis at the time of the PER becomes greater.

Table 9 below shows the breakdown of both government and basket funds by department in FY03. By comparing (i) releases to approved estimates and (ii) actual expenditure to releases, we obtain a measure of budget performance and absorption capacity respectively. A similar breakdown for FY02 is given as **Table x** in Annex D for comparison. Ideally, either

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<sup>23</sup> G Chee, K Smith and A Kapinga (2002). *Assessment of Community Health Fund in Hanang District, Tanzania*. The Partnerships for Health Reformplus Project. Abt Associates Inc. Bethesda, MD: July 2002

<sup>24</sup> S Musau (2004). *The Community Health Fund: Assessing implementation of new management procedures in Hanang District, Tanzania*. The Partnerships for Health Reformplus Project. Abt Associates Inc. Bethesda, MD: January 2004

first quarter or half year performance for FY04 would have been included in the report but time did not permit this.

**Table 9 MOH recurrent expenditure: budget and capacity performance FY03**

Department	Source	Budget	Release	Expd	Release/ budget	Expd/ release	Expd/ budget
1001 Admin & General	Govt	1,833,978,500	1,743,149,266	1,581,406,542	95.0%	90.7%	86.2%
	Basket	387,463,739	387,463,739	370,731,872	100.0%	95.7%	95.7%
	<b>Total</b>	<b>2,221,442,239</b>	<b>2,130,613,005</b>	<b>1,952,138,415</b>	<b>95.9%</b>	<b>91.6%</b>	<b>87.9%</b>
1002 Finance & Accounts	Govt	232,216,000	217,195,718	205,272,924	93.5%	94.5%	88.4%
	Basket	105,017,000	105,017,000	103,235,000	100.0%	98.3%	98.3%
	<b>Total</b>	<b>337,233,000</b>	<b>322,212,718</b>	<b>308,507,924</b>	<b>95.5%</b>	<b>95.7%</b>	<b>91.5%</b>
1003 Policy & Planning	Govt	482,207,700	474,984,455	403,031,949	98.5%	84.9%	83.6%
	Basket	137,279,000	137,279,000	127,232,611	100.0%	92.7%	92.7%
	<b>Total</b>	<b>619,486,700</b>	<b>612,263,455</b>	<b>530,264,560</b>	<b>98.8%</b>	<b>86.6%</b>	<b>85.6%</b>
2001 Curative (Hospital)	Govt	46,572,162,186	38,849,365,575	38,797,644,629	83.4%	99.9%	83.3%
	Basket	11,694,516,320	11,694,516,320	11,297,889,446	100.0%	96.6%	96.6%
	<b>Total</b>	<b>58,266,678,506</b>	<b>50,543,881,895</b>	<b>50,095,534,075</b>	<b>86.7%</b>	<b>99.1%</b>	<b>86.0%</b>
2002 Chemical Laboratory	Govt	597,737,100	548,066,216	548,066,216	91.7%	100.0%	91.7%
	Basket	137,633,000	137,633,000	98,173,000	100.0%	71.3%	71.3%
	<b>Total</b>	<b>735,370,100</b>	<b>685,699,216</b>	<b>646,239,216</b>	<b>93.2%</b>	<b>94.2%</b>	<b>87.9%</b>
2003 Chief Medical Officer	Govt	243,950,100	134,848,494	127,940,618	55.3%	94.9%	52.4%
	Basket	26,096,000	26,096,000	23,387,950	100.0%	89.6%	89.6%
	<b>Total</b>	<b>270,046,100</b>	<b>160,944,494</b>	<b>151,328,568</b>	<b>59.6%</b>	<b>94.0%</b>	<b>56.0%</b>
3001 Preventive	Govt	9,588,503,790	9,105,937,211	8,820,606,806	95.0%	96.9%	92.0%
	Basket	6,249,483,378	6,249,483,478	5,803,665,342	100.0%	92.9%	92.9%
	<b>Total</b>	<b>15,837,987,168</b>	<b>15,355,420,689</b>	<b>14,624,272,148</b>	<b>97.0%</b>	<b>95.2%</b>	<b>92.3%</b>
4001 TUKUTA	Govt	223,219,300	214,739,189	184,730,698	96.2%	86.0%	82.8%
	Basket	35,845,000	35,845,000	32,607,096	100.0%	91.0%	91.0%
	<b>Total</b>	<b>259,064,300</b>	<b>250,584,189</b>	<b>217,337,794</b>	<b>96.7%</b>	<b>86.7%</b>	<b>83.9%</b>
5001 Human Resource Devt	Govt	3,108,369,200	3,019,046,619	3,010,029,955	97.1%	99.7%	96.8%
	Basket	505,474,000	505,474,000	487,338,060	100.0%	96.4%	96.4%
	<b>Total</b>	<b>3,613,843,200</b>	<b>3,524,520,619</b>	<b>3,497,368,015</b>	<b>97.5%</b>	<b>99.2%</b>	<b>96.8%</b>
<b>Total MOH headquarters</b>	Govt	62,882,343,876	54,307,332,742	53,678,730,336	86.4%	98.8%	85.4%
	Basket	19,278,807,437	19,278,807,537	18,344,260,378	100.0%	95.2%	95.2%
		<b>82,161,151,313</b>	<b>73,586,140,279</b>	<b>72,022,990,714</b>	<b>89.6%</b>	<b>97.9%</b>	<b>87.7%</b>

Comparison of Table 9 and Annex D **Table y** shows firstly that the recurrent budget increased substantially at MOH headquarters between FY02 and FY03, from TSh62bn to TSh82bn. This is due to an increase in both domestic resources (including GBS) and the health basket.

However, total budget performance and absorption capacity have deteriorated slightly. In a reversal of the pattern seen in FY02, budget performance of the basket improved from 83.2% to 100.0% in FY03, while release of government funds fell in relation to budget, from 98.5% to 86.4%. As in FY02, the poorest performer in terms of percentages was the Chief Medical Officer's department, with only 55.3% of budgeted funds being released. In absolute terms, the release of only 83.4% of the Curative/Hospital Services Department, ie a shortfall of TSh7.7bn, contributed most to the overall MOH shortfall. No explanation has been obtained for these poor releases.

In part the good performance of the basket is artificial, as the original budget estimates were subject to the MOF's formula for adjusting projected foreign funding in the development budget on the basis of past performance. Total pledges to the basket at the time of the April Joint Sector Review were substantially higher than the original TSh17bn official allocation to MOH HQ, but MOF concerns were to some extent borne out during the course of the year when the World Bank revised its contribution downwards<sup>25</sup>.

Absorption capacity, although poorer for both sources of funding in FY03 than FY02, was better for government funds than for basket funding, which is probably due to release of basket funds late in the financial year. Unlike government funds, these can be carried over

<sup>25</sup> See Table 33 in Annex D for comparison of pledges and releases by Basket partners.

into the following financial year, hence there is an incentive to first utilise government funds which would otherwise be lost to the sector.

The poorest performer in terms of spending was the Department of Policy and Planning, spending only 86.6% of funds released, with most of the shortfall due to underspend of government resources. TUKUTA also performed poorly, and in the FY05 PER update more effort should be allocated to determining the causes of such failures to absorb in order to improve the budget process and address any problems highlighted. Improving absorption capacity within the MOH would clearly strengthen the case for an increased allocation.

## **2.5 Analysis of particular recurrent expenditure categories**

This section first presents more detailed analysis of some areas of recurrent spending in FY03. As in previous years, this includes an analysis of spending on drugs and supplies, although some data problems still remain in this area.

### **2.5.1 Drugs and supplies**

#### **By central MOH department**

Drugs and supplies are an important area of spending in several departments of the MOH, and continue to benefit from both government and basket funding. Table 10 below shows the breakdown for FY02 and FY03 of actual expenditure by MOH Department. A more detailed table, showing the breakdown by sub-item (ie by type of medical supply) is given in Annex F.

**Table 10 Spending by MOH department on drugs and supplies, FY02 and FY03**

	FY02		FY03	
	GOT	Basket	GOT	Basket
2001 Curative/Hospital services	11,270,002,202	2,905,668,252	10,508,002,081	8,208,070,000
2002 Chief Government Chemist	2,600,000	-	2,600,000	33,000,000
3001 Preventive services	1,614,111,333	4,038,815,780	2,658,904,503	2,634,493,707
4001 Tukuta	30,514,634	580,000	7,370,000	1,349,000
5001 Human Resource Devt	-	-	6,300,000	
<b>Total MOH Departments</b>	<b>12,917,228,169</b>	<b>6,945,064,032</b>	<b>13,183,176,584</b>	<b>10,876,912,707</b>

Table 10 shows that the total expenditure on drugs and medical supplies at central level increased substantially between FY02 and FY03, from a total of TSh19.9bn to TSh24.1bn, or by 21%, with a further 20% increase budgeted for FY04 as shown in Table 11 below. It is worth noting that the increase in FY03 was almost entirely due to an increase in the basket allocation towards medical supplies and services, with GOT funding increasing only marginally by 2.1%.

Table 10 also shows that, unsurprisingly, the Hospital Services Department (HSD) continues to be the largest consumer of drugs and supplies, as the Department responsible for channelling funding for the majority of drug supplies at all levels, ie districts, and regional, referral and national hospitals.

In terms of the share of the MOH and sectoral expenditures/budgets on this important expenditure item, it can be seen from Table 11 below that the picture is slightly improved in for FY04, assuming that final expenditures reflect the initial budget.

**Table 11 Drugs and medical supplies as a share of MOH/sector spending, FY02 – FY04**

	<b>FY02 Actual</b>	<b>FY03 Actual</b>	<b>FY04 Budget</b>
<b>MOH HQ recurrent spend on Drugs and Medical supplies</b>	<b>19,862,292,201</b>	<b>24,060,089,291</b>	<b>28,934,757,568</b>
MOH OC expenditure	55,511,793,930	67,905,923,523	80,889,203,486
MOH recurrent spending	58,992,704,669	72,021,538,913	86,383,123,331
Sectoral recurrent expenditure	117,472,785,437	141,746,343,832	167,966,219,945
<i>MOH 2604 as % MOH OC</i>	<i>35.8%</i>	<i>35.4%</i>	<i>35.8%</i>
<i>MOH 2604 as % MOH recurrent</i>	<i>33.7%</i>	<i>33.4%</i>	<i>33.5%</i>
<i>MOH 2604 as % sector recurrent</i>	<i>16.9%</i>	<i>17.0%</i>	<i>17.2%</i>
Population	33,390,850	34,420,722	35,482,358
Average exchange rate US\$1: TSh	934	1,007	1,054
Spend in US\$ per capita	0.64	0.69	0.77

Note: the FY04 figure excludes at least TSh1.2bn which is included in the MOH Development budget possibly in the absence of the central recurrent basket this year (figures not entirely clear because of the use of 260409 for all HIV/AIDS activity).

Table 11 shows that in per capita US dollar figures, the trend is in the desired direction, with the FY04 budget representing \$0.77 per capita, up from \$0.64 in FY02. This figure underestimates the total budget for drugs and supplies in the public sector, however, as it excludes spending through the Development budget and by LGAs and regions directly, in addition to any spending on drugs and supplies for public sector facilities which is not captured on-budget. Further work to quantify this under-estimate should be undertaken either (preferably) through a separate more detailed study of drug financing in advance of the FY05 PER update, or as a particular issue to be followed up in the next PER update.

### **By level of the health care system**

In order to determine whether the allocation of drugs and supplies is in accordance with PRS priorities, an attempt has been made to determine the distribution according to various levels of the health care system, and crudely in terms of preventive and curative services, as shown in Table 12 below. The definitions used are those from previous PER updates, and the table is based solely on data provided by the Chief Pharmacist.

**Table 12 Drugs and supplies allocation by level and type**

<b>MoH spend on drugs (Tshs)</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>	<b>FY03</b>
Muhimbili National Hospital	291,727,000	277,960,000	340,000,000	443,275,451
MOI and ORCI	136,889,700	114,800,000	257,500,000	314,756,124
Bugando and KCMC	373,854,600	247,020,000	400,000,000	538,533,735
DDHs and other VAs (hospitals)	779,993,800	463,000,000	837,000,000	886,457,502
3 Referral hospitals	404,968,099	259,130,000	317,500,000	392,140,945
Regional hospitals	1,473,967,900	892,250,000	1,252,000,000	2,425,971,083
District hospitals	2,492,731,700	1,533,560,000	2,545,750,000	4,677,392,922
TPDF hospitals and JKT	109,710,000	101,810,000	141,250,000	162,495,381
<b>Total hospitals</b>	<b>6,063,842,799</b>	<b>3,889,530,000</b>	<b>6,091,000,000</b>	<b>9,841,023,143</b>
Primary health care kits	5,746,494,000	4,624,782,000	7,633,278,419	9,218,304,000
MoH preventive & HQ dispensary	88,294,000	254,800,000	43,064,000	33,687,921
MoH vertical programmes	284,567,000	220,260,000	79,986,623	140,572,468
MoH emergency / reserve accounts	177,607,000	103,410,000	109,041,177	140,572,468
<b>Total preventive</b>	<b>6,296,962,000</b>	<b>5,203,252,000</b>	<b>7,865,370,219</b>	<b>9,533,136,857</b>
<b>Total MoH spend on drugs</b>	<b>12,360,804,799</b>	<b>9,092,782,000</b>	<b>13,956,370,219</b>	<b>19,374,160,000</b>

Various queries remain regarding the data in this table. It is not clear whether previous years have included funding under the DANIDA HSPS<sup>26</sup>, why the MOH preventive/dispensary allocation has fallen in the past two years, and why the total does not tally with data from the IFMIS<sup>27</sup>. In addition, the table is believed to exclude spending on drugs and supplies through the Development budget and through off-budget external support to vertical programmes, which is likely to be substantial. As mentioned above, these issues require a more in-depth study of drug financing within the public sector than is possible as part of the PER process.

Table 12 shows that there has been a 39% increase overall in drug spending between FY02 and FY03 according to this data. However, this has been driven more by increased allocations to Hospital drug supplies than to the Preventive sub-sector, with growth rates of 62% and 21% respectively. However, future analysis might perhaps more usefully distinguish between drugs and supplies to District health services (in line with the new Strategic Plan) and to higher level hospitals, given the acknowledged role of district hospitals within a district health system, and the priority placed on all facilities at that level within the PRS.

Table 13 below shows the allocation of drugs between government (and designated voluntary) hospitals by level of the health care system, and shows the priority given to district level facilities within the hospital sub-sector. It excludes the military hospitals which are also supported through MOH allocations due to volume of civilian patients also treated in such facilities.

**Table 13 MOH hospital drug allocations by level/hospital type, FY02 and FY03**

	FY02	FY03
District hospitals, DDHs, and other VAs	3,382,750,000	5,563,850,424
Regional hospitals	1,252,000,000	2,425,971,083
National/referral/specialist hospitals	1,315,000,000	1,688,706,255
<b>Total</b>	<b>5,949,750,000</b>	<b>9,678,527,762</b>

The allocation of hospital drugs by level of the health system has remained broadly similar between FY02 and FY03, with the exception of a slight shift from the national and referral hospitals to regional hospitals. In both years, district level hospitals account for 57% of the total hospital drug budget, while the share of Regional hospitals has risen slightly from 21% in FY02 to 25% in FY03.

### **By geographical area**

There appears to have been some improvement in the way in which funds for drugs are allocated since last year. The files obtained from the Chief Pharmacist indicate that for the first quarter of FY03 allocations to hospitals were based on flat rates dependent on the type of hospital. For example, allocations to RMOs (presumably for Regional Hospitals) were generally TSh12m, while most district hospitals were allocated TSh7m.

For subsequent quarters of FY03, allocations were based on population, with the total budget for drugs, medical supplies, dental supplies etc multiplied by the facility catchment population share of a total population figure. Details of the formula for both council allocations and referral hospital allocations are given in Annex F. Use of this formula is worthy of discussion, particularly in the light of the introduction of a formula for the allocation of OCs more generally (see Section 3.2), and further modifications are probably recommended. Substantial variations persist in the per capita allocation of hospital drugs around the country,

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<sup>26</sup> Drug kits for one quarter are funded through this Development project.

<sup>27</sup> Although the issue of some drugs spend being captured in the Development budget rather than the recurrent is the probable cause of part of this discrepancy.

as shown in Figure 14 below. However, comparison with a similar graph for FY02 indicates that there has been some reduction in this variation since the introduction of the formula.

**Figure 14 Variations in per capita hospital drug and medical supply allocations by region, FY03**

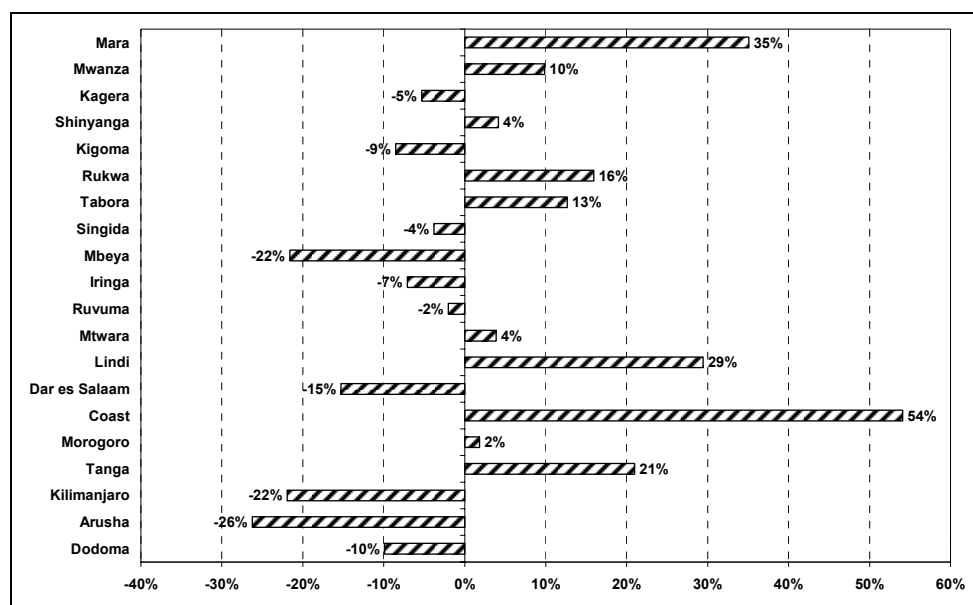


Figure 14 shows regional variations in the level of per capita drug allocations to hospitals, including both GOT and basket funded drugs at district and regional hospitals. The graph shows that there is still a significant variation between regions in the per capita allocation of drugs to district and regional hospitals. For example, Coast region received 150% of the mean allocation in FY03 which, although an improvement on FY02 when it was over 200%, still merits some explanation. While some variation in need is likely due to different epidemiological profiles, it is unlikely that this fully explains this situation, and further analysis is therefore recommended.

### 2.5.2 HIV/AIDS spending

As in FY03, the TORs for the FY04 PER update included an analysis of HIV/AIDS spending. Since last year, there has been an effort within government to simplify the recording of HIV/AIDS expenditure across sectors, through use of the sub-item code 260409. For the second year, a detailed cross-sectoral PER has been undertaken to track spending on HIV/AIDS related activities in other MDAs, and this report therefore provides only a brief summary of spending within the MOH and LGAs.

#### Central level

Table 14 below shows the level and location of MOH headquarters spending on HIV/AIDS-related activities in the past three financial years<sup>28</sup>. This also includes spending under the Development project 5492 HIV/AIDS Control as the actual items of expenditure in both FY03 and FY04 are all recurrent<sup>29</sup>.

<sup>28</sup> There was almost certainly Curative spending in FY02, along the same lines as in FY03 and FY04. However, it was not included in last year's PER update due to time constraints and it has not been possible to complete the table this year for the same reasons.

<sup>29</sup> 260408 Specialised supplies in FY03 (source: IFMIS) and 2604 Medical supplies and equipment in FY04 (Kitabu cha Nne, although this could again just reflect the use of 260409 for HIV/AIDS).

**Table 14 HIV/AIDS spending, Central MOH (TSh)**

Year	Dept	Source	Funds		
			Budget	Released	Total Expenditure
FY02	Preventive	Govt	1,511,962,600	1,511,962,600	1,511,962,600
		Basket	15,000,000	15,000,000	15,000,000
		<b>Total</b>	<b>1,526,962,600</b>	<b>1,526,962,600</b>	<b>1,526,962,600</b>
FY03	Preventive	Govt	1,567,676,000	1,567,676,000	1,567,676,000
		Basket	247,645,857	247,645,857	247,645,857
		<b>Total</b>	<b>1,815,321,857</b>	<b>1,815,321,857</b>	<b>1,815,321,857</b>
	Curative	Govt	0		
		Basket	2,007,175,000	1,132,912,174	1,010,033,108
		<b>Total</b>	<b>2,007,175,000</b>	<b>1,132,912,174</b>	<b>1,010,033,108</b>
	Devt	Other foreign	4,460,472,800	4,460,472,800	4,460,472,800
<b>Total FY03</b>		<b>8,282,969,657</b>	<b>7,408,706,831</b>	<b>7,285,827,765</b>	
FY04*	Preventive	Govt	2,500,000,000	724,582,070	724,582,070
		Other foreign	111,762,000	65,402,000	18,740,750
	Curative	Other foreign	3,875,395,539		
		TFNC	500,000,000	250,000,000	
	Devt	Other foreign	1,646,530,600		
	<b>Total FY04</b>		<b>8,633,688,139</b>	<b>1,039,984,070</b>	<b>743,322,820</b>

Notes: \* Release and expenditure to 31 December 2003

Gaps imply lack of information rather than failure to release and/or spend

Devt – Development project 5492 HIV/AIDS Control

TFNC – Tanzania Food and Nutrition Centre

Table 14 shows that the level of budgeted spending on HIV/AIDS at MOH headquarters has risen slightly between FY03 and FY04<sup>30</sup>, from TSh 8.2bn to TSh 8.6bn, or by 4%. The majority of this spending is from external sources, either basket and through other foreign funding of the development budget. However, the figures are undoubtedly an underestimate of the contribution of the sector to HIV/AIDS-related activity, not least as they exclude various sources of project funding (eg the Global Fund for AIDS, Tuberculosis and Malaria, which is expected to contribute US\$87m over five years). In addition, the significant proportion of routine clinical care provided to HIV/AIDS patients in health facilities is not reflected.

As in the FY03 PER update, the Preventive spending represents all activities under the National AIDS Control Programme in the MOH, while the Curative spending covers activities related to safe blood, PMTCT, and (in FY03) workplace interventions, Technical AIDS Committee costs, and support to hospital provision of a continuum of care for AIDS patients, as reflected in the respective MTEF documents. It is not clear what activities are supported by the Development project.

### **Local government level**

Part of what is procured and planned at the central level is undoubtedly implemented at council level. However, councils also spend directly on HIV/AIDS-related activities which from FY04 are reflected using the same sub-item code 260409 following the extension of GFS coding to the local government level. Table 15 shows budgeted spending at the LGA level since FY02. The absence of any expenditure data from councils means that no assessment of budget performance is possible.

**Table 15 HIV/AIDS spending, Local Government Authorities**

	HIV/AIDS	Health OC	%
<b>FY02</b>	150,791,200	11,749,499,000	1.28%
<b>FY03</b>	297,447,700	13,739,092,700	2.16%
<b>FY04</b>	428,326,200	16,804,401,200	2.55%

<sup>30</sup> No comparison is made with FY02 as the level of Curative spending within the MTEF was not calculated.

Table 15 shows that there has been another small increase in the share of Health OCs allocated towards HIV/AIDS-related activities, from 2.16% of the total to 2.55%. Although apparently small in relation to the nature of the problem, it should be borne in mind that these expenditures supplement substantial central level spending. As with drugs and supplies, the majority of which are procured at central level and later distributed to councils, it would be interesting to undertake further analysis to determine the extent to which centrally incurred HIV/AIDS-related health sector spending actually funds operational level activities. For example, one of the Hospital Service Department activities in the MOH MTEF for FY03 was “*Support to Level 1, level 2 and level 3 hospitals to provide a continuum of facility and home based care for AIDS patients and Persons Living with HIV/AIDS*”. Ideally, it would be possible to identify the share of this subsidy which was allocated to Level 1 hospitals in order to obtain a more complete picture of spending at the LGA level.

It was notable that whereas almost all LGAs had allocated some funds, albeit small in many cases, towards item 1716 HIV/AIDS plans in FY02 and FY03, in line with stated PRS policy, in FY04 eight councils (4 in Coast Region, Mtwara DC, Handeni DC, and Ilala and Temeke municipal councils), had not budgeted under sub-item 260409 for FY04.

## **2.6 Analysis of the sectoral Development Budget**

The TORs specify that analysis should be undertaken of development spending within the sector, in order to distinguish between capital investment and activities that are recurrent in nature. Like last year, an attempt has been made to analyse externally financed projects from the MOF database as well as locally funded development projects. Analysis of the official Development budget distinguishes between levels of the health system.

### **2.6.1 Health sector Development budget**

A breakdown has recently been provided of PRS Priority projects within the Development Budget for each sector. For Health, these are identified as follows:

- Construction and rehabilitation of health facilities at the local government level (ie dispensaries, health centres and district hospitals) in accordance with the identification of this level as a Priority item within the Recurrent budget;
- Child and Mother Survival Programmes, supported by UNICEF, which are implemented both at the LGA and Regional level (sometimes being incorporated within the Administration sub-votes rather than Health);
- At the MOH HQ, the District Health Support Project (assumed to be the DANIDA HSPS); Control of Communicable Diseases; support to the National Institute of Medical Research and the Tanzania Food and Nutrition Centre; and the World Bank-supported Health Sector Development Programme
- Within PORALG, the Rehabilitation of Health Infrastructure project, which is Health basket-funded, and the Health Sector Programme (basket funding for Councils).

#### **Central level**

MTEF targets for the year FY03 were similar to FY02, both aimed at contributing to achievement of the national development Vision 2025 and the PRS. The MOH has continued to implement sectoral reforms with the objective of improving efficiency, effectiveness and quality of services at all levels. In order to achieve this there are number of projects implemented under the Ministry.

The Health Plans and Management Programme principally dealt in FY03 with supervision and monitoring of development projects, and capacity building. The Health Sector Programme Support supports Councils, Departments and other Institutions to undertake

Health Sector Reforms and SWAp activities, as well as including the DANIDA contribution to the Basket Fund.

Other projects are focused on more traditional development activities, such as construction, rehabilitation and purchase of equipments. Examples include the First Health Rehabilitation Project, funded by various donors and GOT, which has been strengthening and extending Muhimbili National Hospital (MNH) and Dar Urban Health facilities. Funds allocated to the project for Strengthening of referral hospitals have been used for replacement of equipments, and rehabilitation of hospitals such as Mbeya Referral hospital, the Psychiatric village, and Isanga Hospital. In addition, efforts have been made to finalise the construction of a new Paediatric ward complex at MNH.

Funds allocated to the Ocean Road Cancer Institute (ORCI), Chief Government Chemist (CGC), Tanzania Food and Nutrition Centre (TFNC), National Institute for Medical Research (NIMR) have been used mainly for development activities like construction of radiation rooms, purchase of new equipments and machines, maintenance of equipments, rehabilitation and construction of offices and buildings.

Funds allocated to the Control of Communicable Disease project have been used for more recurrent type operations, notably improvement of the availability of anti-TB and Leprosy drugs throughout the country, undertaking immunisation campaigns, and the introduction and expansion of Hepatitis B vaccine within the immunisation schedule, and of services for the Integrated Management of Childhood Illness. Malaria control activities have been conducted especially social marketing and community participation. MOH has also continued to take a leading role in the implementation of sectoral HIV/AIDS interventions, as identified in the National Policy on HIV/AIDS. Major areas of intervention have continued to be around care, treatment, support and prevention, including the expansion of Prevention of Mother to Child Transmission (PMTCT) and counselling services. In addition, there is growing MOH and donor collaboration in supporting an increase in accessibility to Highly Active Anti-Retroviral Therapy (HAART).

Funds allocated for Health Sector Development Programme have been used for National Health Insurance Fund, Cost sharing, Drug revolving Fund, CHF, PER, and NHA activities. Part was used as counterpart funds and others for consultancy works. In addition, part of the funds were used for capacity building for short and long term courses,

Funds allocated for Strengthening of National Health Training Institutions were used for the construction and rehabilitation of buildings in the 27 health training institutions under the Ministry of Health.

From the above it can be seen that the MOH still has a number of Development projects which are not considered "priority" in relation to the PRSP, notably relating to referral and special hospitals, and urban health facilities. This is taken up further in Section 4.1 below.

### **Regional level**

As can be seen in the MOF External financing database, projects can be financed and implemented at central level, or in the regions or councils. Projects included within the Regional budget are funded by both government and donors, with the latter being the main financing agents of Development projects at the regional level. In FY03 about 80% of the actual expenditures for development projects in the regions came from donors, while the remaining 20% was funded internally.

This picture is consistent also with regard to the FY04 estimates, where again donors contribute an estimated 80% compared to the local contribution of 20%. One of the major

projects at regional level is the UNICEF-supported Child Survival and Protection project, although this is believed to incorporate substantial recurrent activities.

Other activities as shown in the Budget books are rehabilitation, construction of buildings and purchase of equipments. These activities are mainly financed by the Government and other donors eg Japan is financing Morogoro Urban rehabilitation project.

**Council level**

The council level development budget, as presented in the Kitabu cha Nne, differs from the central and regional levels as it presents estimates of local (ie Government of Tanzania) planned spending only. This undoubtedly underestimates the true picture given the extent of donor involvement at local government level. With the further development of capacity and systems at the local government level, an improved picture of the extent and nature of external funding of health services at this level should be possible in the future and should be attempted in future PER updates, or through the proposed tracking study.

At the Council level, the majority of projects are infrastructural – construction, rehabilitation or strengthening - and therefore represent capital investment, in either Health Centres and Dispensaries, or the District hospital. Some councils also have UNICEF-funded projects in the areas of mother and child health (Kuendeleza mama na mtoto) and/or child survival (Uhai, ulinzi na maendeleo ya mtoto). In line with the definition of expenditure categories in Section 2.3.4 above, a very crude attempt has been made to split these along preventive and curative lines in order to see the trend, shown in Figure 15 below. The Curative category comprises all projects related to the District hospital, while Preventive refers to all other projects in the council development budget. All Development spending at LGA level is considered Priority however.

**Figure 15 Preventive-curative split in LGA Development Budget, FY01 – FY04**

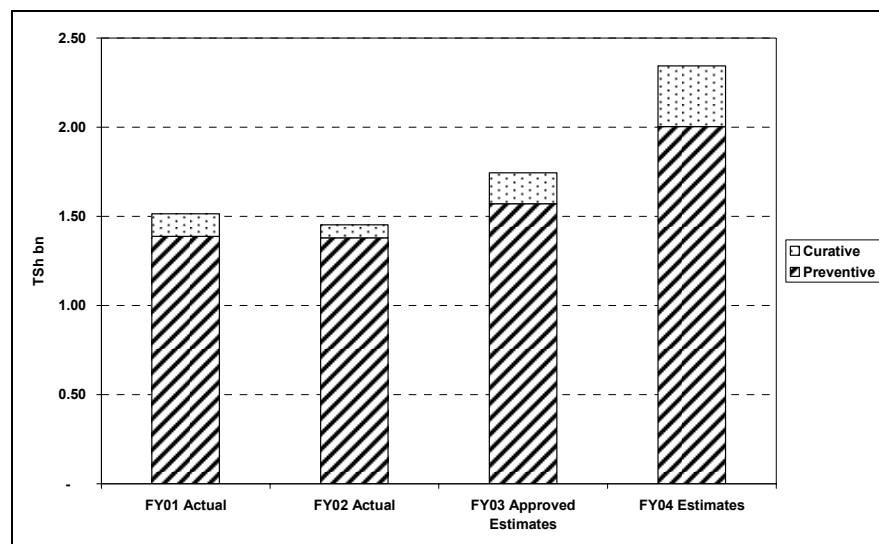


Figure 15 shows that the level of planned spending in the council development budget has been rising in recent years, up from TSh 1.45bn in FY02 to a budgeted TSh2.34bn in FY04. At the same time, the curative share of total spending (planned or actual) has risen, from 5% in FY02 to 14.5% in FY03.

**Recurrent-capital split within Development projects**

Conventionally, in many developing countries, externally-funded projects are included within the Development budget even when they support recurrent activities. This is due largely to the historic tendency of donors to support infrastructural or capacity building activities rather recurrent cost items (although drugs and vaccines have always been substantially externally

financed). In recent years, this split has become more artificial, and the TORs therefore included an analysis of the extent to which current projects<sup>31</sup> listed in the MOH Development budget are actually funding recurrent items. The extension of GFS coding to the Development budget has simplified this task, and the findings are presented in Table 16.

**Table 16 Share of recurrent spending within Development project budgets, FY04**

Code	Project name	% recurrent
6271	Health Sector Plan and Management Project	71.1%
6273	Health Sector Programme Support	99.2%
5402	First Health Rehabilitation Project	13.2%
5406	Strengthening of referral hospitals	0%
5486	Paediatric Ward Complex (MNH)	0%
5487	Muhimbili Orthopaedic Inst.	0%
5494	Chief Government Chemist Agency	0%
5407	Control of Communicable Diseases	51.9%
5485	Health Sector Development Programme	88.5%
5492	HIV/AIDS	100.0%
5496	Tanzania Food and Nutrition Center	60.3%

This analysis is rather crude as it looks at individual sub-item codes rather than assessing whether actual activities are recurrent or capital, and a more sophisticated analysis could be undertaken in the future if felt useful, following agreement on how different activities might be classified. In addition, it might be interesting to look in the future at the extent to which loan funding supports the Development budget, and in particular the extent to which such funding is supporting non-priority items within the budget. As a minimum, spending on drugs and medical supplies through the Development budget (at Regional and LGA level) should be quantified and incorporated in the analysis of spending on such items.

### **2.6.2 The MOF database of externally funded projects**

In the PER update for FY03, some analysis was undertaken of the database of externally funded projects, compiled by the MOF External Finance Department. Although the current version of the database was obtained from MOF, unfortunately the data do not permit updating of some of the analysis, notably the extent to which identified projects fall on or off budget, but also the projections over the MTEF period.

One feature worthy of note is that although the total commitment for FY04 as captured in the database is TSh95bn, a figure for “expected outturn” for the year was given as TSh203bn, ie over 100% higher than the commitment. It would be useful to have some explanation of this variance.

As happened last year, time did not permit a reconciliation of projects within the sectoral development budget and those recorded in the database. On the assumption that everything in the official sectoral Development budget at central, regional and local government level is captured in the database, the difference between the total planned funding and the foreign component of the Development budget has been taken as the off-budget value of external financing of the sector in earlier sections. Time also did not permit an analysis of the extent to which projects included within the database represent largely investment activities as opposed to supporting the routine operations of the health sector. This should be carried forward to the next PER update, assuming that MOF will continue to produce the database.

<sup>31</sup> other than the health basket which has been treated differently in previous PERs, and is included in Recurrent in the MOF CGE tables..

### 3 Local government budgets, allocations and spending

According to the PRS, local government spending in priority sectors represents a substantial component of the allocation towards pro-poor activities. In the health sector, the local government level comprises four sub-votes, all of which are included in the PRS priority level, and which correspond to the District Health Services level identified as a priority component within the new Health Sector Strategic Plan. These are:

- 510 Curative services
- 511 Preventive services
- 512 Health centres
- 513 Dispensaries and clinics

The Curative sub-vote is treated in the PER as broadly corresponding to the district hospital level, as shown in Table 6 above. In those LGAs where district hospital services are provided by a regional or referral hospital, there is generally no reflection of the Curative Budget at the LGA. This results in some under-estimation of actual provision of District-type Health Services

#### 3.1 Local government health sector spending

During FY03, there is some evidence of the continued Government commitment to the devolution of resources and responsibilities to local authorities, both overall<sup>32</sup>, and specifically within the health sector. However, urban councils tend to benefit more than proportionally from increased allocations as shown in the sub-sections below.

##### 3.1.1 Overall level and share of government subventions to LGAs

Government subventions through the block grant, covering both PEs and OCs, are the primary source of revenue at the LGA level. Table 17 below shows the nominal value of health sector allocations through the block grant over the past three years together with the current budget, disaggregated between urban and rural status, and for PEs and OCs.

**Table 17: Government subventions to LGAs, FY01-FY04 (Billion shillings)**

	FY01 Approved estimates			FY02 Approved estimates			FY03 Estimates			FY04 Estimates		
	PE	OC	Total	PE	OC	Total	PE	OC	Total	PE	OC	Total
Urban	4.47	1.57	6.04	4.90	2.16	7.06	5.71	2.53	8.23	6.59	3.29	9.89
District	16.58	6.47	23.05	18.83	9.59	28.42	21.41	11.07	32.48	25.00	13.51	38.51
<b>Total</b>	<b>21.05</b>	<b>8.04</b>	<b>29.09</b>	<b>23.73</b>	<b>11.75</b>	<b>35.48</b>	<b>27.12</b>	<b>13.59</b>	<b>40.71</b>	<b>31.59</b>	<b>16.80</b>	<b>48.40</b>

Table 17 shows that between FY03 and FY04, there was an overall increase in the nominal value of the block grant allocation to LGAs of almost 20% which is very encouraging, and provides evidence of the government's commitment to devolution.

The increase was slightly higher for urban councils (20%) than for rural district councils (19%), reflecting a substantially larger increase in the OC allocation to Urban councils (30% compared with 22%)<sup>33</sup>. PEs grew slightly more slowly in urban than rural councils. This continues a trend seen also in the previous year, when the overall rate of growth was slightly lower (15%) but was again in favour of urban councils. This is contrary to the stated objective of allocating resources in favour of the generally poorer rural district councils, and reasons for this should be explored further.

<sup>32</sup> Find ref from PRSP progress report 2003

<sup>33</sup> See Annex D Table 32 for more detailed figures on the rate of growth of LGA allocations.

The issue of separating out PEs and OCs within the block grant is under review, as ideally with continued devolution, decisions between expenditure on different inputs, ie personnel versus the other complementary inputs, would take place at the council level. For FY04, the PE and OC components of the block grant remain specified at the time of budget and disbursement however.

Figure 16 shows the split between PEs and OCs at the local government level for the past 3 financial years together with the current year. This shows a gradual reduction in the share allocated to PEs over the four year period, from 72% to 65%. This varies slightly between urban and district councils, as seen in the graph. Further analysis is merited to determine the extent to which this reflects a deliberate move to increase the OC budget and thus improve the mix of inputs at the LGA level, or whether it reflects reductions in the wage bill arising from past hiring freezes.

**Figure 16: PE:OC split at LG level**

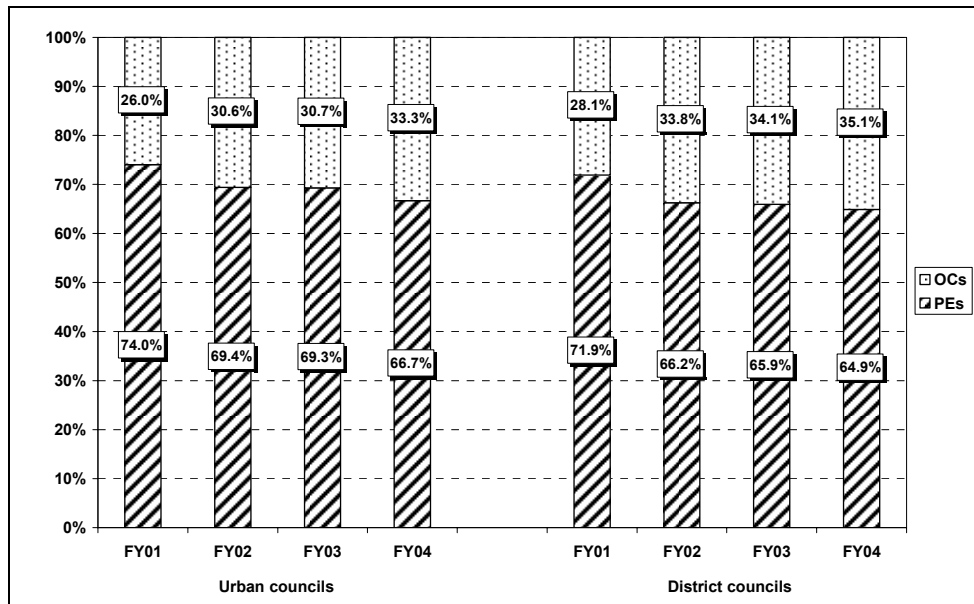


Figure 16 shows that PEs account for the majority of funds released to urban and district councils. However, as mentioned above, further work to separate out the share of medical supplies and services procured centrally on behalf of the LGAs, would improve the OC share of total available resources at that level.

### 3.1.2 Releases in relation to budget

Information provided to the Team by the Budget section within MOF indicates that 100% of all planned OC block grants for health was released to each council by the end of the financial year, thereby indicating that the PRS commitment to funding the Primary Health sub-sector was met in FY03. PE figures exceeded the original estimates due to salary increases during the course of the year.

The figures show that there were substantial variations in the quarterly releases of OCs in relation to budgeted amounts. This is due to the release of more than 25% of the annual total to the Education sector in the first quarter due to examination expenses which has a knock-on effect for all other sectors<sup>34</sup>. Without some indication of planned cash flow, it is impossible to state whether this has had implications for planned activities in the health sector.

<sup>34</sup> Personal communication, Mr Mwampeta, Assistant Commissioner of Budget, MOF

However, as the level of funding through the block grant is acknowledged to be small in relation to requirements, and as much spending at the LGA level supports the routine day-to-day activities required to deliver services, it is likely that this uneven flow does have some adverse effect. Table 18 shows the variation in quarterly cash flow for a selection of LGAs.

**Table 18 Variation in flow of LGA OC funds by quarter, FY03**

	Lowest		Highest		Urban average	District average
	Council	%	Council	%	%	%
Q1	Shinyanga MC	9.3%	Karagwe DC	52.1%	21.7%	21.8%
Q2	Shinyanga MC	9.3%	Kigoma TC	55.1%	22.9%	25.5%
Q3	Shinyanga MC	9.3%	Njombe	25.9%	21.7%	21.2%
Q4	Kongwa DC	13.9%	Shinyanga MC	72.1%	33.8%	31.6%

To date no explanation has been given for these figures, and they are therefore presented for information only.

### 3.1.3 Geographical variation

The PER update for FY03 included some analysis of the geographical variation in per capita allocations of funds to the LGA level. This has not been possible this year due to time constraints, but the analysis should be undertaken in the future in order to identify any improvements arising from the introduction of the needs-based resource allocation formula (see below), and in order to ascertain whether funds are being allocated in line with PRS objectives, ie clearly in favour of poorer geographical areas.

## 3.2 Fiscal decentralisation and allocation formulae

The MOH has finalised its discussions on a new formula for allocation of LGA resources since the PER update last year. The new formula is based on the version developed in-house in the MOH, with consultation with the team from Georgia State University who have been supporting similar activities government-wide under the auspices of the Local Government Reform Programme<sup>35</sup>.

The new health sector formula has four components, described and weighted as follows<sup>36</sup>:

- Population (70%) – based on 2002 Census data, this reflects “*the importance of the individual as the main client-recipient of health care services*”;
- Mileage (10%) – mileage travelled by health sector vehicles within the district, in order to reflect the higher costs of service delivery in rural areas;
- Poverty level (10%) – this uses the basic needs poverty line<sup>37</sup>, weighted for council population;
- Under-five mortality (10%) – measuring health need, this uses district-based information from the 2002 Census, weighted for population. Under-five mortality was selected rather than infant mortality as it reflects better the major causes of the Tanzanian disease

<sup>35</sup> Andrew Young School of Policy Studies, Georgia State University. *Developing a system of intergovernmental grants in Tanzania*. Study prepared for the Local Government Reform Programme. Draft of 11 December 2002. Information is also available on the website: <http://isp-aysps.gsu.edu/projects/tanzania>

<sup>36</sup> Health Sector Reform Secretariat (2003). *Resources allocation formula for Health basket fund*. Final Draft, October 2003

<sup>37</sup> defined as “*an absolute line defining poverty in terms of the exogenous measurement of basic non-food needs expenditure required to provide a defined level of living*”. URT (2002). *Poverty and Human Development Report*.

burden, including HIV/AIDS. Until the Census 2002 data becomes available, this is based on information from the Tanzania Reproductive and Child Health Survey of 1999.

In the absence of district-specific data for poverty, regional data were used as a temporary proxy. The intention is to update data annually, while reviewing the formula periodically every three years.

The formula was approved by the Health sector Basket Finance Committee in October 2003, and came into effect for basket funding to councils from January 2004. It has since been approved by Cabinet in February 2004, and will therefore be applied to both to the block grants (covering both PE and OC) and the council basket funding from July 2004. This is in line with broader government policy to strengthen equitable allocation of resources by geographical area, following recognition that the allocation of block grants lacked transparency, was supply-oriented, and tended to favour better-off councils. Formulae are also being applied to Education sector block grants in FY05, and are scheduled for introduction in Agriculture, Roads, Water and Local administration for FY06.

In order to ensure that no council receives either too large an increase thereby hindering absorption, nor suffers a cut in the level of its funding compared to last year, a principle of "holding harmless" has been adopted (as per recommendations in the Georgia State University doc). As this results in a figure exceeding that allocated to the council health basket, which continues to be based on a flat rate of \$0.50 per capita, approximately TSh524m has been allocated from central level basket funds (under the Development budget) to ensure that the council commitments can be made during the period January to June 2004. Once the formula is introduced to the block grant, phasing will also apply, with no council receiving an allocation more than 25% higher than in 2003 in order to reduce potential problems with absorption capacity.

## 4 Sectoral performance

### 4.1 Health sector performance in relation to the PRS

#### 4.1.1 Health as a priority sector

Discussion of the allocation to Health as a Priority sector is covered in Section 2.2.1 which indicated that the sector has received a reduced share of the total budget for FY04 compared to actual levels of expenditure in past years. This is taken up again in Section 6.

#### 4.1.2 Primary health as a priority item

For the FY 04 work has been undertaken by the Ministry of Finance to clarify the position regarding definition of priority sectors and priority items. For the health sector, this has involved the distinction between items falling within Health as opposed to HIV/AIDS, and the restating of items classified as Primary Health. This redefinition means that there is an effective break in series between FY03 and FY04 in reporting on budget and expenditure on health sector priority items, as the HIV/AIDS spending within the health sector is now included under HIV/AIDS<sup>38</sup>. This includes spending by the Preventive Services Department of both the MOH headquarters and the Regions, together with the HIV/AIDS budget line (260409) at the local government level.

Unfortunately, time constraints and failure to obtain details of spending on sub-item 260409 at the Regional level mean that it has not been possible to provide a complete analysis of spending on the priority item according to this new definition. Table 19 shows an attempt to present the trend in spending on PRS priority items in recent years as far as is possible. Given the small contribution from Preventive Services at the Regional level, the failure to deduct HIV/AIDS spending is unlikely to significantly alter the overall picture. However, the analysis still lacks clarity regarding the allocation of funds for centrally procured drugs for the LGA level as it is not possible at present to separate this out within the MTEF, and the figure identified by MOF for FY04 does not tally with data made available to the PER Task Team (more details are given in Annex C).

**Table 19 Recurrent spending on PRS priority items, FY02 to FY04 (TSh million)**

	<b>FY02</b>	<b>FY03</b>	<b>FY04</b>
Total subvention to LGAs	35,393	43,250	48,856
Preventive service subvote at RAS	302	304	310
LGA drugs budgeted under MOH	9,108	12,478	15,000
MOH HQ Preventive services subvote	7,574	7,253	15,187
<b>Total Health Priority items</b>	<b>52,376</b>	<b>63,285</b>	<b>79,353</b>
Total Priority sector spend/budget	117,473	141,746	167,966
<i>Priority items as % sectoral spend</i>	45%	45%	47%

Table 19 shows that there has been an increase in the nominal level of spending on Priority items within the Health sector in recent years, up by 21% between FY02 and FY03, and a further 25% in FY04. In terms of the share of overall Health spending (according to the MOF definition of the Priority sector), there has also been a slight improvement with the FY04 budget, with the share increasing from 45% of the total in FY02 and FY03 to 47% in FY04. This means that over half the sectoral budget is allocated to non-priority items however, which could presumably still be improved upon.

<sup>38</sup> A further change is the explicit inclusion of PE spending within priority sub-votes. The original table in the PRS included OCs only.

One shortcoming of this analysis is the failure to include other sources of funds such as the health basket funds, and the value of directly procured drugs for activities at local government level. Future PERs will obviously need to follow the official government definitions for the priority sectors and items, but it would be worth undertaking a more in-depth analysis of all sector funds in terms the defined priorities.

#### **4.1.3 Analysis of the MOH HQ Development budget in terms of PRS priorities**

Particular projects have been identified as PRS priorities within the sectoral Development budget. Time did not permit an analysis of all categories of Development spending (ie by PORALG, Regions and LGAs) but a cursory analysis of the MOH HQ Development budget indicated that substantial on-budget development spending goes towards non-PRS priority projects. Table 20 shows the analysis by type of funding.

**Table 20 MOH HQ Development spending on PRS priorities, FY04**

	Local	Foreign (Basket)	Foreign (Non-basket)	Total
PRS Priority	237,039,000	1,347,276,230	17,863,225,428	19,447,540,658
Non-priority	3,315,409,200	3,784,508,870	1,153,836,072	8,253,754,142
<b>Total</b>	<b>3,552,448,200</b>	<b>5,131,785,100</b>	<b>19,017,061,500</b>	<b>27,701,294,800</b>
% Priority	6.7%	26.3%	93.9%	70.2%

Table 20 shows that overall over two-thirds of planned on-budget development spending for FY04 is in line with PRS priorities, but there is substantial variation in this figure according to the funding sources. GOT funding, although less than 13% of the total Development budget, is primarily targeted at non-PRS priority projects. These are largely infrastructural in nature and related to tertiary institutions such as the Muhimbili National Hospital and the Ocean Road Cancer Institute.

The share of Foreign basket development funding allocated to PRS priorities is surprisingly low at only just over a quarter, although it should be borne in mind that this represents only part of the total basket, with the council basket funding all included as supporting the PRS. Equally surprising is the high share, almost 94%, of foreign non-basket funding which supports PRS priority projects. This could be interpreted as an effective divergence in the priorities of the external partners and of the MOH itself, as basket funding is allocated in line with ministry priorities, while foreign non-basket funding could be claimed to support "donor" priorities, although in this case it is interesting that these are more in line with overall stated GOT policy as articulated in the PRS.

#### **4.2 Health sector financing performance indicators**

As in previous years, the PER provides the opportunity to update selected performance indicators for the health sector as a whole. There are five indicators related to financing issues, although unfortunately it has not been possible to update each aspect of all of these due to time and data constraints. Table 21 shows the updated figures, in Tanzania shillings (current prices), for three of the indicators, and the percentage share of LGA allocations budgeted for health in the coming year. The cost-sharing indicator has not been updated and is discussed further below.

**Table 21 Finance-related health sector performance indicators**

Indicator	Level	Baseline	FY03		FY04
			Budget	Actual	Budget
1 Total GOT public allocation to health per capita (central, regional, and district)	Central	1,245	2,139	1,782	2,721
	Regional	172	244	242	270
	District	848	1,320	1,334	1,443
2 GOT and donor allocation (budget and off-budget) to health per capita	National average	5,100	7,108	6,868	7,656
3 Per capita GOT recurrent expenditure broken down by level (central, hospital services, preventive services)	Central	190		423	
	Hospital	1,077		1,270	
	Preventive	894		1,397	
7 % of GOT funds available for budgeted and actual district health activities against the total overall funds available for district activities	Budget	18%	17.7%		16.6%
	Actual	15%			
12 Cost-sharing fees collected by public health facilities in year x as a proportion of the 1998 targets	National average	0.46		n/a	

Note: Figures in Tanzania shillings unless otherwise indicated.

Indicator 3 is taken from Table 6 and as such does not include the NHIF allocation. When this is included, the central level figure changes to TSh 613 per capita.

Table 22 below provides US dollar values for indicators 1 to 3, in order to facilitate comparison with other countries and with the figure of US\$9 which is frequently referred to in discussions about the costs of the sector<sup>39</sup>.

**Table 22 Selected finance-related health sector performance indicators, in US dollars**

Indicator	Level	Baseline FY01	FY03		FY04
			Budget	Actual	Budget
1 Total GOT public allocation to health per capita (central, regional, and district)	Central	1.49	2.12	1.77	2.58
	Regional	0.21	0.24	0.24	0.26
	District	1.02	1.31	1.33	1.37
2 GOT and donor allocation (budget and off-budget) to health per capita	National average	6.12	7.28	7.04	7.26
3 Per capita GOT recurrent expenditure broken down by level (central, hospital services, preventive services)	Central	0.23		0.42	
	Hospital	1.29		1.26	
	Preventive	1.07		1.39	

Notes:

- Exchange rate used is the mean of Bank of Tanzania rates for September, December, March and June (as per Economic Report Feb 04).
- Central level value for Indicator 3 **including** NHIF is \$0.61

Indicator 1 monitors the GOT commitment to health sector spending at each level of the health system. Table 21 shows some improvement in nominal Tanzania shilling per capita budget and spending, with an increase in GOT allocations to all levels. This is most noticeable at the central level, where the budgeted figure for FY04 has increased by 27% over FY03. At the regional level the increase is 14% while at the LGA level the increase is only 9%. These figures cannot be directly compared with last year as the indicators in Table 17 of last year's PER update excluded NHIF. However, they can be compared with the baseline data from FY01 (actual expenditure values taken from the MOH Performance Profile), which shows that the total GOT contribution (central + regional + council) has increased by 48% over the period, from TSh 2,265 to TSh 3,365 per capita.

Table 22 shows that in US dollar terms, the picture is less encouraging, with a total overall increase in actual expenditures of 23%, from a baseline of US\$2.72 in FY01 to US\$ 3.33 in FY04. The district level benefited more than proportionally over this period, up by 30% from US\$1.02 to US\$1.33. The annual budget increase on FY03 is 14% with the largest increase at the central level, up 21% from a budgeted US\$2.12 in FY03 to US\$2.58 in FY04. The

<sup>39</sup> Though see Footnote x.

overall levels however are very low, even when taking into account that they only represent GOT spending.

Indicator 2 measures total resources per capita for health spending, including off-budget funds. As such, the actual figures need to be treated with caution in the absence of improved information from MOF on off-budget external expenditure in the sector as this is currently based on a crude assumption. However, budget figures can be compared, and show an 8% increase from FY03 to FY04.

Indicator 7 shows the level of government commitment to health service implementation at the LGA level, monitoring the share of overall GOT allocations to the council level which is assigned to health. Unfortunately, for the second year running, this shows a slight fall in the budgeted amount, both in terms of year on year allocations which have fallen from 17.7% in FY03 to 16.6% in FY04, and from the baseline figure of 18%. Although councils also benefit from allocations through the basket, this decline in the GOT share is worrying and must be addressed by the sector as it is a further indication that external funding is being allowed to replace rather than supplement sectoral funding.

Unfortunately, as happened last year, it was not possible to provide a figure for the actual share of expenditure due to failure to obtain the final figures for total LGA allocations. The whole area of strengthening information on actual expenditures at LGA level is one in which substantial work remains, although it should be possible to include at least an estimate of this figure in the future. This has long been recognised, and indeed the MOH Performance Profile 2001 suggests that *“a regular tracking study [on the area of council spending] be included in the annual Health Sector PER exercise”* (p24). Either this should be flagged as an area for increased attention in the next PER update, or a separate tracking study should be undertaken prior to the PER update.

Indicator 12 was not updated, as queries regarding its definition and meaning, as were raised last year, have not yet been answered. Agreement on this before next year's PER update would be useful.

Data do allow some analysis of cost-sharing revenues, at least through the Health Services Fund data collated by the MOH and included in the Appropriation Accounts, although this is subject to concerns about reliability and completeness. Table 23 below shows four potential indicators for hospital cost-sharing. The first shows expenditures from HSF revenues as a percentage of balances brought forward plus revenues collected during the financial year (ie total HSF resources available to the facility), which could be interpreted as a measure of absorption capacity at the facility level. As noted in Section 2.3.5, an assessment of the CHF in Hanang found large unspent balances, which contradict the original objective of cost-sharing as revenue-raising in order to improve quality of service<sup>40</sup>. Where the value is zero, this is due to lack of information on actual expenditures, possibly due to their having been none, but more likely due to failure to submit the necessary information, itself an indicator of poor performance.

The second and third indicators relate HSF resources to the drug expenditures mentioned in Section 2.5.1 (and included in Table 12) in order to give an idea of the contribution (or potential contribution) of such revenues. The second indicator shows Revenues as a % of Drug expenditures (GOT and basket), indicating possible annual contribution, while the third puts unspent resources in perspective by showing the balance carried forward as % of Drug expenditures. Finally, the catchment populations used to allocate the drug budget are used to calculate per capita revenues raised<sup>41</sup>. The analysis is presented for one region

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<sup>40</sup> Find ref for C-S objectives (WDP report)

<sup>41</sup> although the questions regarding these catchment population figures remain.

(Arusha/Manyara) and for referral hospitals only due to time constraints, but illustrates the potential value of further such analysis.

**Table 23 Potential HSF cost-sharing indicators, FY03**

DESCRIPTION	Expd/ (Balance BF + Rev)	Rev/ Drug expd	Bal CF/ Drug expd	pc Revenues (TSh)
Muhimbili National Hospital	13%	54%	75%	97
Mbeya referral hospital	0%	7%	68%	15
Mirembe referral hospital	0%	0%	6%	-
Kibongoto referral hospital	34%	7%	10%	16
Arusha regional hospital	11%	53%	98%	113
Mbulu district hospital	39%	33%	48%	74
Monduli district hospital	8%	14%	90%	32
Babati district hospital	108%	12%	-1%	25
Kiteto district hospital	0%	0%	5%	-
Arumeru district hospital	66%	24%	12%	50
Karatu district hospital	0%	0%	3%	1

Although the reliability of the data on which Table 23 is based cannot be guaranteed, the data suggest two important points:

- a) that the revenues generated could make a substantial contribution to daily running expenses within a given facility, with revenues reaching 50% of drug expenditures in a couple of facilities; and
- b) that there is substantial variation in both revenue-generation (from TSh1 per capita to TSh 113 per capita) and absorption (from 8% to 66%<sup>42</sup>) of such revenues between hospitals.

Clearly, more analysis would need to be undertaken in order to ensure that data are accurate, and that revenue generation is not at the expense of financial access to poorer members of the population. Further exploration of reasons for large unspent balances would also be worthwhile. However, as the policy of cost-sharing is in place, it is regrettable that no useful indicator is currently monitored on an annual basis, and this section serves to illustrate some possibilities.

<sup>42</sup> The 108% recorded by Babati Hospital is excluded due to likely error.

## 5 Future costs and revenues

As in past years one of the requirements of the PER Macro Working Group for the sector PER studies was that a costing of priority expenditure programmes and activities should be undertaken (see the TOR in Annex A). However, as pointed out in successive PER update reports, the nature of such a costing requires a separate study as it would involve a considerable investment of both time and resources. To date, no decision has been taken as to whether this would be worthwhile, and no progress has been made in developing more detailed TORs for the task.

### 5.1 Future costs

The PER includes an assessment of future costs of the sector in order to assist in the preparation of the budget and MTEF for the coming period. Ideally, as per the TORs for the PER, the preparation of input to the annual Budget Guidelines would be part of the same process, ie based on an analysis of the previous year's expenditure and current priorities and costs. However, this has not been the case in the health sector in recent years due to delays in the PER process. This year, as last year, the section on Future costs is based on work undertaken in the MOH prior to the PER exercise, and the decision has been made here to include an early version of the costs, Table 25 below, as this has clear justification attached for its figures.

**Table 24 Detailed costing/justification for priority items**

MOH Recurrent, Priority Items							
Notes	FY 2003/4 Budget			FY 2004/5 Requirement			
	Local	Foreign	Total	Local	Foreign	Total	
1	Drugs & Medical Supplies	29.47	2.93	32.40	33.40	3.00	36.40
2	Subvention to DDH	4.90	-	4.90	6.30	-	6.30
3	Subvention to VA	2.40	-	2.40	4.80	-	4.80
	DHR sub vote						
	Human resources development	4.76		4.76	10.50		10.50
4	DPS sub-vote	17.53	38.22	55.75	60.20	62.00	120.10
5	- Immunisations	3.95	8.93	12.88	35.50	10.00	45.50
	- Reproductive & Child Health						
6	incl IMCI	2.40	5.53	7.93	3.50	11.00	14.50
7	- TB & Leprosy Control	1.15	1.04	2.19	1.50	4.50	6.00
8	- Malaria prevention and control	1.05	7.40	8.45	3.20	7.70	10.90
9	- Sector response to HIV/AIDS	3.14	8.05	11.19	7.90	20.50	28.40
10	- Nutrition	1.28	0.13	1.41	3.50	0.30	1.80
	- Environmental Health, Hygiene and Sanitation	0.13	0.10	0.23	0.39	0.30	0.59
11	- Other preventive programmes	4.43	7.04	11.47	4.71	7.70	12.41

Local Government Health Services							
Notes	FY 2003/4 Budget			FY 2004/5 Requirement			
	Local	Foreign	Total	Local	Foreign	Total	
	PE	34.44	-	34.44	35.00	-	35.00
	OC	14.42		14.42	18.21		18.21
	Council Health Basket		17.85	17.85		25.85	25.85
12	Development (local)	2.35		2.35	7.00		7.00
	<b>LGA Health Services Total</b>	<b>51.20</b>	<b>17.85</b>	<b>69.05</b>	<b>60.21</b>	<b>25.85</b>	<b>86.06</b>

**Notes**

- 1 All drugs & medical supplies except EPI, TB, HIV, RCHS
- 2 Actual requirement for DDH full grant as per MTEF 2003/4
- 3 Bed grant for VA has been increased from 7,500/= to 15,000/=
- 4 Major sources of increase are HIV and Immunisation
- 5 Assumes introduction of HIB & HepB vaccines; if not. Low case scenario approx. 25bn
- 6 03/4 under-estimated off-budget components
- 7 03/4 omitted elements (Global TB drug facility) off-budget. Full financing requirement 6bn
- 8 Covers ITN programme, + scaling up of communications, home-treatment & M&E
- 9 NB: requirement rises to 45bn next year as sectoral strategy is scaled up.
- 10 Incremental increase on previous year. NB does this cover Vitamin A?
- 11 includes disease surveillance, oncho, eye care, vector control, community health, school health, health education, NIMR, port health, etc.
- 12 Significant increase required for primary services infrastructure rehabilitation

The MOH is still using a figure of \$9 per capita as a stated target for spending in the sector, based on a 1998 costing undertaken in country. This has been substantially re-valued with the work of the WHO Commission on Macroeconomics and Health, which estimated the costs of delivering a package of cost-effective interventions in a low income country with a similar epidemiological profile at between US\$34 and US\$41<sup>43</sup>. Tanzania is facing increasing costs from new first line malaria treatment, the introduction of new vaccines, the expansion of services such as VCT and TB prophylaxis, and the introduction of ARV treatment for AIDS. These contribute to a substantial increase in overall sector costs arising from interventions which were not reflected in the WDR costing.

The PRS is to be updated in FY04, and the decision regarding whether or not to undertake a costing for the sector, to be included in the new PRS, should be made sooner rather than later in order to allow sufficient time for any such exercise, if indeed it is not already too late. A crude costing is advisable in the face of the potentially substantial new inflows of funding, particularly for HIV/AIDS care and treatment.

## 5.2 Future revenues

### 5.2.1 Government funding (including GBS)

Estimates of future GOT funding for FY05 and beyond are available through the Budget Guidelines which were issued in January<sup>44</sup>. Summary figures – real values in absolute terms and annual increases - of the projected budget of the sector are shown in Table 25 below. Nominal and per capita values are given in Annex D Tables .

**Table 25 Real estimates of future sectoral funding, FY04 – FY07 (TSh m)**

	FY04	FY05	FY06	FY07
<b>Real values (FY04 P)</b>				
<i>Discount factor (assumes 4% inflation)</i>		0.9615	0.9246	0.8890
Total health sector	210,480	273,967	267,798	261,279
Recurrent - total	158,798	158,436	155,828	152,665
Priority recurrent	73,480	88,350	71,431	69,279
Non-priority recurrent	34,476	34,348	33,515	32,505
Total local funding	165,500	164,880	162,688	160,000
Development - total	51,682	115,531	111,970	108,614
Development - foreign	44,979	109,087	105,110	101,279
Basket funding	25,281	46,587	47,911	47,911
Other (non-basket foreign) devt	19,698	62,673	57,200	53,369
<b>Annual growth rates (real)</b>				
Total health sector		30.2%	-2.3%	-2.4%
Recurrent - total		-0.2%	-1.6%	-2.0%
Priority recurrent		20.2%	-19.1%	-3.0%
Non-priority recurrent		-0.4%	-2.4%	-3.0%
Total local funding		-0.4%	-1.3%	-1.7%
Development - total		123.5%	-3.1%	-3.0%
Development - foreign		142.5%	-3.6%	-3.6%
Basket funding		84.3%	2.8%	0.0%
Other (non-basket foreign) devt		218.2%	-8.7%	-6.7%

Table 25 shows that although the total real allocation to the sector is projected to rise by 24% over the three year period, total domestic funding, including GBS, is projected to fall each year resulting in a total drop of slightly over 3%. This raises questions regarding the extent

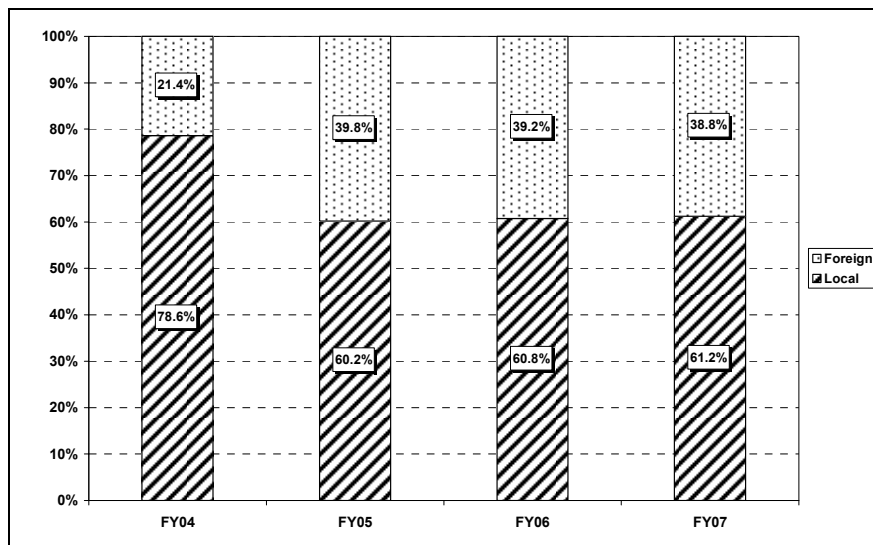
<sup>43</sup> WHO CMH report (op cit, footnote 7), Table a2.4 on p166.

<sup>44</sup> Normally, the PER process would be complete prior to issuing of the Budget Guidelines as the findings are expected to feed into development of the same guidelines.

to which external funding is merely replacing domestic funding in the sector, particularly in the light of DFID's recent move to GBS.

The table also shows that the increase is entirely due to a large (218%) increase in foreign, non-basket funding to the sector in FY05, with subsequent years showing a fall in the allocation. The effect of this increase is shown more clearly in Figure 17 below, which indicates very small increases in the share of local funding as a proportion of the total for FY06 and FY07. No explanation is given in the Budget Guidelines as to what the source of such funding might be although it is likely to include the Global Fund for AIDS, Tuberculosis and Malaria. To the extent that it represents project funding and is channelled through parallel mechanisms, this may reduce the efficiency and transparency of funding within the sector. Efforts should be made to clarify the actual sources and to ensure that as far as possible they are reflected in the MTEF and budgetary documents.

**Figure 17 Projected share of local and foreign funding, FY04 – FY07**



### 5.2.2 Sectoral basket estimates

The Budget Guidelines include an estimate for the basket (both central and LGA) of TSh 48,450 million in FY05. However, although possibly correct at the time of the submission from MOH, this now understates the contribution of the basket for the coming year due to increased pledges from the World Bank. Table 26 below gives health basket estimates for FY05, as included in the Side Agreement signed by basket partners at the Joint Health Sector Review held in mid-March 2004.

**Table 26 Indicative basket estimates, FY05**

Partner	Own currency	2004/05			
		Amount (M)	R of Ex	USD (M)	TSh (M)
DANIDA - council	DKK	45.3		7.4	8,443
DANIDA - rehabilitation	DKK	6.5		1.1	1,255
Germany - KfW	Euro	2.5	1.20	3.0	3,423
Ireland	Euro	3.1	1.20	3.8	4,279
Netherlands	Euro	3.1	1.20	3.7	4,245
SDC	CHF	5.0	0.66	3.3	3,765
UNFPA	USD	0.3	1.00	0.3	342
World Bank	USD	35.0	1.00	35.0	39,935
<b>Total</b>				<b>57.6</b>	<b>65,687</b>

Note: Exchange rate used US\$1: Tsh 1,141

The increase in the size of the potential basket for FY05 is substantial, due largely to the large contribution from the World Bank under their new Health Sector Development Programme. This will boost the central level recurrent basket, which will again presumably be incorporated as JD funds into Platinum. Given the concerns raised with the Platinum system and its reporting outputs for FY03, it is critical that the shortcomings in the system be addressed before the channelling of such substantial basket flows takes place.

### **5.2.3 External project funding**

The External Finance Department of the Ministry of Finance has continued to update its database on the current and future flows of external funding through donor project and basket funding. However, the version obtained for the current year lacks information on potential future funding flows over the MTEF period although this was included last year.

Future flows of funding to the public health sector are expected to be significant, notably due to the success of the recent application to the Global Fund for HIV/AIDS, Tuberculosis and Malaria, which will bring in an estimated US\$87m over five years, and also to the extent that funding is successfully solicited to support the ambitious HIV/AIDS Care and Treatment plan developed in 2003 with the assistance of the Clinton Foundation.

## **6 Discussion, recommendations and next steps**

### **6.1 Key issues and recommendations**

#### **6.1.1 Overall sectoral spending**

The data in Section 2 show a mixed picture of the trend in health sector budgets and expenditures, depending on which particular measure is used. MOF values for both nominal and real spending (budgeted and actual) show a substantial increase in the past three years, by 96% and 75% respectively. In nominal per capita terms, growth has been similarly impressive at 79% over the period. However, most of these gains were made in the early years of the PRSP, with real growth from FY03 to FY04<sup>45</sup> only 2.5%, ie less than inflation, while the real figure was 0.2%. In US dollar terms, the year on year increase is less than 1%, and the per capita US \$ figure is actually lower in FY04, at US\$5.27 compared with US\$5.39.

While more money is welcomed, the increase is far outstripped by the increase in costs of delivering a basic package of services to the Tanzanian population. Although not quantified, comparison with earlier international cost estimates, and cost increases due to introduction of new critical interventions, or changes in technology and the cost of inputs, has put serious upward pressure on the health budget, and challenges the capacity of the sector to deliver on its MDG and PRSP goals within the available resources.

While there is some positive news regarding absolute values of health budget and expenditure, the picture is more gloomy regarding the government commitment to the sector in terms of share of overall budget. The apparent decline in the share of the health sector (Figure 2) from 10.4% of total government expenditure excluding CFS in FY03, to 9.2% of budget excluding CFS in FY04 (both values including health-related HIV/AIDS spending) is low, both in relation to initial targets and to international commitments such as the Abuja declaration.

It is hoped that the Joint Health Finance Committee will take forward this issue, although the failure of the health sector to activate this high level committee earlier, as agreed at last year's Review, is disappointing and perhaps represents a lost opportunity to follow up some of the PER findings and recommendations with a view to securing a more satisfactory budget allocation in FY05.

#### **6.1.2 Sub-sectoral spending: meeting priorities**

The change in definition of the priority sector and item led to some difficulties in calculation due to non-availability of information on HIV/AIDS spending at the Regional level. However, Table 20 indicates a slight increase in the share of Priority Items between FY03 and FY04, reflecting a 25% increase in the nominal level. This is encouraging.

The analysis of spending by level and by category (Preventive vs Hospital) performance could be strengthened by inclusion of basket funding and those elements of the Development budget which contribute to recurrent spending (eg drugs and supplies purchases under the DANIDA-funded HSPS and through the Communicable Disease Control programme at central level). Further work would be required to disaggregate central spending on behalf of LGAs, but would be useful in terms of obtaining a more accurate measure of resource availability at that level. Council Health Plans generally include an estimate of "in-kind" resources reflecting nominal drug allocations, which could be used in such an analysis.

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<sup>45</sup> Itself TSh20bn less than budgeted, so that the growth rate should have been higher.

Efforts are made at the Budget Guidelines preparation stage to identify required resources for priority health programmes within the sector, eg EPI, Reproductive and Child Health, Malaria. These are important in terms of the sector's progress in tackling major causes of early mortality in targeted vulnerable population groups. However, no check is undertaken on total resources available (recognising that the MTEF is still incomplete in terms of external support to these areas), and no follow-up is currently undertaken of actual expenditures in relation to budgets. It is therefore recommended that the FY05 update include analysis of spending in at least two such programmatic areas, to be defined in advance. This should include both a central and LGA analysis.

### **6.1.3 Budget performance and absorption capacity**

Analysis of budget performance and absorption capacity is incomplete. IFMIS permits comparison both of releases against budget, and of expenditure against release, thereby enabling comparison both of performance by GOT (and partners) in meeting their stated budgetary commitments, and of the spending agency in using resources. However, currently this is undertaken for MOH HQ only due to lack of detailed expenditure data at the Regional level, and of any at LGA level. Overall sector performance assumes releases at the LGA level are equivalent to actual expenditures, which was shown not to be the case in the 2001 Pro-poor expenditure tracking study.

Figure 6 shows that for the past 3 years, actual expenditures have been consistently less than budgets. IFMIS data at MOH HQ level show that, with the exception of the release of budgeted basket funds which is itself artificial (see Section 2.4), budget performance and absorption capacity were both lower in FY03 than FY02.

### **6.1.4 Local government financing issues**

The nominal level of funds allocated to the council level has increased between FY03 and FY04. However, Indicator 7 in the Health Sector Performance Profile shows that the budgeted health sector share of LGA funds has been falling in recent years, from an initial baseline of 18% to 16.6% in FY04. It is not possible to say whether this is due to the presence of the council basket funds, although it is a possibility given that these substantially raise the nominal OC budget for health at the council level. However, as with the central level, an increase in the value of the indicator was presumably intended, in which case there is an additional issue for MOH to take forward with MOF.

The allocation between urban and rural councils raises some queries, as the growth both PEs and OC allocations is higher for urban councils. Time did not permit the updating of analysis of the geographical distribution of basket and/or block grant funding between Regions, but it is expected that the introduction of the new needs-based formula will improve the objectivity and equity of such allocation. The PER FY05 update could update this analysis, using the FY03 data as a baseline.

Unfortunately, IFMIS has not yet been extended to the council level, and to date it has not been possible to obtain actual expenditure data from LGAs. Although the existing council physical and financial reports are of very mixed quality, these are in theory a good source of detailed information on receipts of government funds (local and external) and councils' own resources, but are not used consistently. Time during the PER process did not permit the level of work required to locate and analyse these reports, and it is therefore recommended that a separate tracking study be undertaken of local government funding, along the lines of the 2001 Pro-poor expenditure tracking study. This should be undertaken prior to the FY05 PER update process in order for the results to be used, and should cover both PE and OC funding Ministry of Finance through to end users as far as possible, including the basket funding in order to determine both the (minimum) level of public funding and timing/effective availability of funds at the council level

### **6.1.5 Cost-sharing**

The original objectives of the cost-sharing policy in Tanzania were to raise revenues to supplement those from Government and cooperating partners. However, this PER update indicates that the contribution to the overall sectoral resource envelope is still limited, while at the same time there are concerns that existing cost-sharing schemes are creating barriers to access for the poorest<sup>46</sup>, contrary to the objectives of overall development policy as articulated in the PRSP.

The cost-sharing indicator selected for the MOH health performance profile has not been updated for two years due to lack of clarity regarding its definition and purpose. However, other sample indicators in Table 24 show that funds raised under the Health Services Fund (ie user fees at public hospitals) have the potential to contribute substantially to non-wage running costs within the facility (total costs of service delivery are not available) yet unspent balances are often significant. No information is available at the central level regarding the source of such funds (ie whether registration, drugs and supplies, laboratory charges etc), nor of how they are actually used within the facility. The FY03 PER update raised the issue of lack of reporting in this area, but little action appears to have been taken.

The information on the Community Health Fund made available to the PER Task Team is very limited, and conclusions cannot therefore be drawn on its contribution within those councils where it is currently functional. This should be addressed in the future. Concerns have however been articulated elsewhere regarding its design, in respect of low membership, high service use by members, and of failure to protect the poor while charging fees to non-members. The increasing coverage by the National Health Insurance Fund which covers public sector workers is also believed to have reduced demand for CHF membership.

The NHIF, itself a form of cost-sharing, raises additional questions. Further thought is merited on how to take account of the fact that much is not being spent in the initial years. There is also need to recognise that there are (apparently) no incentives in this Fund to ensure cost-effective or equitable use of health services, and therefore the extent to which it might ultimately be considered pro-poor is questionable.

### **6.1.6 Drugs and supplies**

There was an encouraging increase in total on-budget spending on drugs and supplies at MOH HQ of 21% between FY02 and FY03, with a further 20% increase budgeted for FY04. Off-budget allocations mean that the per capita figures is undoubtedly above the US0.77 indicated in Table 12. Queries remain in the allocation of these funds, both by level of the health system and geographically, but data constraints preclude further comment at present.

The whole area of spending on drugs and supplies within the sector merits a more detailed study. Notwithstanding the difficulties in obtaining data, which must be addressed, it is clear that the actual information made available is incomplete. Large volumes (and values) of drugs and supplies remain off-budget (some are captured within the MTEF but not all), and the basis for geographical differences in allocation remain unclear.

Given the importance of drug and supply availability in both perceptions of and actual service quality, in terms of its share of sectoral spending, and the retention of drugs budgets at the central level on behalf of LGAs and hospitals, it is recommended that a specific tracking study be undertaken in this area. Such a study could cover:

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<sup>46</sup> See for example M Mamdani and M Bangser (2004) *Poor people's experiences of health services in Tanzania: a literature review*. Women's Dignity Project. Dar es Salaam: March 2004. Also REPOA (2004).

- quantification of total drugs and supplies budget within sector, ie including purchases by projects and programmes etc direct, analysis by level, and tracking (in terms of both timing and level) of drug supplies to the periphery. This would include a mapping of funding and physical flows from government (central and local), donors, NGOs (if possible) and councils/facilities' own resources to end user facilities;
- analysis of centrally procured items, or those captured within the central level budget which should ideally be included within the Regional or Local Govt components of the allocation by level of care (Section 2.3.4);
- closer examination of the geographical allocation of drugs and supplies in order to comment on the existing formula and justify any difference with that used for block grants and basket funding for councils.

#### **6.1.7 Other weaknesses and gaps in information (systems)**

A major problem has been between inconsistency in budget and expenditure information collected through the sectoral PER and MOF data. In addition, changing definitions of priority sectors and items complicate calculations of time series data. It would be helpful if MOF clearly indicated sources of data (eg budget estimates as per a specific date, in recognition that they change at different stages of the budget approval process). For the revision of the PRS, it is recommended that definitions of priority sectors and items are clearly stated, together with targeted allocations, in order to give a basis for comparison in future PER updates.

Problems with the IFMIS within the MOH were a particular problem for this PER update, both delaying proceedings and necessitating repeat analysis of the same items. Both sector and general budget support uses government systems for financial reporting in order to minimise the different sources of funding and the reporting and accounting burden they represent. Failings in the MOH use of such systems potentially jeopardises future funding as it can undermine partner confidence in the system, and it is critical that the problems encountered in FY03 are not repeated, particularly in the face of large inflows of funds through the central level recurrent basket fin FY05.

In some areas, eg pharmaceuticals and to some extent Accounts, there are insufficient staff conversant with the information required. When, as often happens, only one person is knowledgeable in an area, delays in accessing basic information or obtaining clarification occur when that person happens to be out on safari or leave.

The multiplicity of different formats, not all of which are consistent or complete, complicates the task of the PER team. Some of the different formats used within GOT for presentation of plans and budgets are either inconsistent and/or incomplete. Examples this year included the Daily Cash Flow, Platinum reports, LGA physical and financial implementation reports. Data within the Annual Physical and Financial Implementation Report of MOH HQ was also, incomplete, particularly with respect to information on the Development budget and off-budget external funds which had been included in the previous year's MTEF document. This was unfortunate as the area of off-budget actual foreign expenditure is particularly weak, with actual expenditure having been based on a very crude assumption for several years now. This needs to be firmed up with information from either MOF, eg actual out-turns based on the information in the External Finance database, and/or (ideally) MOH.

#### **6.1.8 The PER process**

The health sector PER still does not serve its original purpose, which is to provide a largely retrospective analysis of spending in relation to budget and to priorities on which to base the forthcoming budget. Problems have been encountered in sectoral PER execution for the past few years, with limitations both in the data and the availability of Task Team members. The MOH argument that capacity is limited is doubtless genuine, and the burden of

undertaking the PER is undisputed. Many countries do not undertake an annual PER, partly due to recognition of this fact. However, the issue is also one of priority which appears, at least to some extent, to be a function of relative incentives between sectoral activities.

The role of the external consultant requires clarification, particularly regarding whether there is to be a capacity-building role, which in turn depends on clarification of whether it is realistic for the process of undertaking the PER is to be institutionalised, as is intended by MOF. An alternative would be to adopt the approach of the HIV/AIDS Per update and to contract out more of the process to consultants (ideally a combination of external and local).

Data constraints were greater this year than last year, despite the hope that familiarity with the process and its requirements would simplify the task. Despite the PER being a government exercise, and forming part of the budget process, substantial delays were incurred in accessing data due to other government departments requiring letters of request from the MOH before releasing information, or insisting that data could be given only in hard copy form, thereby necessitating retyping by Task Team members. This seems unnecessary, and the MOH should raise the issue with the overall PER Working Group in order to avoid this delay in the future.

## **6.2 Immediate next steps**

The most critical follow-up activity, to be undertaken as soon as possible, is the (re-) activation of the Joint Health Finance Committee agreed in the 2003 Joint Health Sector Review, in order to take forward some of the issues raised in successive PER updates, but most immediately the issue of the share of the budget allocated to health overall, and at the local government level.

On the assumption that a PER update will be undertaken in some form for FY05, preparation should begin as early as possible in order to avoid the problems encountered this year. In addition to the report itself, two further outputs are planned from this process: firstly, a full listing of the information required to complete the PER (according to the current TORs), together with their location and potential availability; and secondly, a proposed workplan based on the availability of data, with completion targeted by end of November for submission of the Budget Guidelines input<sup>47</sup>.

In addition, the PER coordinator and others (to be decided) should arrange to meet with key partners who provide information for the PER – such as Medical Stores Department and NHIF - in order to discuss what is required and when, on a routine basis. A meeting should also be held with the Chief or Deputy Chief Accountant of the MOH, as some additional summarising or analysis of IFMIS data could be done prior to export to Excel. Formats could be prepared for quarterly updates so that annual reporting does not become such a burden.

The Director of Policy and Planning should follow-up with the Director of Hospital Services to ensure that information on the drugs budget and its distribution is made available to the PER Task Team at the time of budget preparation in order to enable comparison between planned and actual distribution, and to facilitate more analysis of spending by geographical area within the PER.

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<sup>47</sup> This assumes that the overall timeframe for the BG submission process remains the same this year. The end date can of course be brought forward if not.

## **7 Annexes**

### **Annex A Terms of Reference for the FY04 Health Sector PER update**

#### **Purpose and Key Objectives**

Since FY98, the Government of Tanzania working in partnership with development partners/donors and local stakeholders, has undertaken Public Expenditure Reviews, which have greatly influenced pertinent public policy formulation and budget management. As previous Public Expenditure Reviews (PERs), PER FY04 will continue to consolidate and build on the achievements realized so far. The main objectives of PER FY04 will be:

1. strengthen Government ownership and sector participation in the PER process as well as improve quality and timing of PER outputs,
2. improve ex-ante coverage of program support and donor-funded projects in the Government budget, as well as ex-ante projection of the wage bill including the provisions for a systematic implementation of the medium term pay reform,
3. provide support to the implementation and monitoring of the Tanzania Poverty Reduction Strategy, with particular attention to (a) ensuring that updating and coverage of costing sector interventions and activities is complete to feed into the Budget Guidelines and preparation of MTEF for all the priority sectors and activities (b) aligning sector development programs (SDPs) to the achievement of poverty reduction strategy (PRS) targets and related millennium development goals (MDGs),
4. make decentralization more effective through strengthening the capacity of the Local Authorities to prepare and implement poverty-focused MTEFs, and
5. undertake pieces of analytic work to inform fiscal policy dialogue on Tanzania's revenue effort, tracking expenditure and service delivery, coherence of the development budget with PRS priorities, and fiscal risks associated with the drive towards more budget support.
6. In achieving these objectives, all priority sectors are required to undertake PER update work to (a) immediately feed into the preparation of the Budget Guidelines before December 2003 and (b) inform the PER FY04 consultative meeting.

#### **Background for the Health PER**

The role of the PER in the health sector is to provide the Ministry of Health and other key stakeholders in the sector with a medium term view of budgetary allocations across the sector, and to review how they match with the stated strategic objectives. The purpose is to ensure efficient and effective use of scarce resources by strengthening the planning, budgeting and allocation 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.

The scope of the "health sector" for the purpose of this PER includes health expenditures at central, regional and local government levels, and should indicate – to the extent possible – all actual and anticipated sources of financing, including GOT, basket, project support, user fees, NHIF, etc.

In Tanzania, health sector priorities are identified in the MTEF for the MOH, the Tanzania PRSP, and in the health plans of local councils and regional administrations. A new Medium Term Health Sector Strategic Plan (HSSP) 2003 – 2008 has been developed with the objective of delivering quality health services and client satisfaction. The MOH, Regional Administrations and Local Councils will be jointly responsible for the development of operational plans and budgets on a year-to-year.

### **Outputs of the Health Sector PER**

The PER must provide key outputs in time to feed in to the budget guidelines in December described under section 1 below. A full draft report should then be prepared, including outputs under section 2. The final draft of the report must be completed not later than November 2003.

#### **Section 1: Outputs to feed into the preparation of MOF's Budget Guidelines, deadline by the end of November 2003.**

- a) Describe health sector strategic objectives, priority areas for financing in the medium term and implications for budget allocation
- b) Provide estimates to feed in to budget guidelines including:
  - i) Estimated resource envelope (all sources of financing on/off-budget, including revenues collected & retained in the health sector), high and medium scenarios.
  - ii) Undertake/refine costing of priority interventions<sup>48</sup> over the medium term and their impact on PRS targets. Compare the financial requirements for meeting PRS targets to projected resource availability for the sector (see b(i) above) and present options for restructuring expenditure to meet the targets. This should also take account of the "residual" required to cover normal running costs. Spell out the implications of these options and recommendations (e.g. scaling back targets, improving efficiency, mobilization of additional resources, etc).

#### **Section 2: Complete Sector PER Report, deadline by the end of November 2003**

##### **Specific Tasks**

1. Review PER FY03 findings and actions taken by the sector in response to those findings indicating unaccomplished/pending actions and reasons as well as implications and the way forward. Identify follow-up actions planned in FY04.
2. Analyze the recurrent and development budget performance for the past three years (aggregate actuals vs budgets).
3. Show clearly the trends in expenditures at sectoral and sub-sectoral level including central-local government split. This should include doing an analysis of priority areas/items of expenditure highlighted in the PRS.
  - (i). Assess whether and how far these trends reflect policy objectives.
  - (ii). Review deviations in overall budget performance (budgeted vs. actual expenditure) indicating clear justifications for such deviations and factors constraining the allocation of resources and supervision/control of expenditure.
  - (iii). Assess planned versus actual resource allocation in FY02/03 at sectoral and sub-sectoral levels highlighting any notable new developments and their relationship with the FY03/04 budget.

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<sup>48</sup> Refer to listing of priority areas provided by MOH. Estimate must include justified figures for Malaria, HIV/AIDS, EPI, Reproductive & Child Health, TB/Leprosy, essential drugs, etc.

- (iv). Analyze non wage expenditures (OC) by major expenditure items over the past three years and assess the relationship between budgeted and actual expenditures for at least five largest budget items. Also assess the appropriateness of the current composition of OC expenditures with respect to achieving the objectives of the sector. This analysis should use the same (re-) classification of expenditures used in the previous Health Sector PER (FY 01, 02 and 03).
  - (v). Analyze drugs and medical supplies budget vs actual expenditure and distribution by level (i.e. referral hospitals, regional and district hospitals, health centers, national programmes/projects like TB/Leprosy, etc.)
  - (vi). Detailed analysis of development expenditures to distinguish between capita investment and those which are recurrent in nature.
  - (vi) Document which expenditure items have benefited most from increased budget allocations and actual expenditures of the sector, indicating amounts (percent) that went to OC and to PE, and if there was prioritization to specific expenditure items, e.g. maintenance, transport, training, etc.)
  - (vii) Review the latest report of the Controller and Auditor General on MOH and the External Audit of the Central Basket, actions taken by the sector to address the major queries raised on systemic fiscal issues, and assess adequacy of the actions taken.
5. Review existing plans and strategies for the sector (including prioritization), with a view to harmonize the PRS, sector policies/objectives and MTEF. This will include, among others, re-aligning the sector priorities and articulating the links between the inputs and outputs identified in the MTEF and sector /PRS objectives.
  6. Undertake/refine costing of priority interventions<sup>49</sup> over the medium term and their impact on PRS targets. Compare the financial requirements for meeting PRS targets to projected resource availability for the sector and present options for restructuring expenditure to meet the targets. This should also take account of the “residual” required to cover normal running costs. Spell out the implications of these options and recommendations (e.g. scaling back targets, improving efficiency, mobilization of additional resources etc).
  7. Identify the key performance indicators that will be used to monitor progress, with reference to the PRS indicators, the PRS Progress Report and the Health Sector Performance Profile. These should include annual indicators and more medium term impact measures. These should relate to the PRS and information being collected through the poverty monitoring process. Also use these indicators to review sector performance and progress toward meeting PRS targets and MDGs.
  8. Identify HIV-related activities and costing to be included in the 2004/05 Budget and MTEF FY04-06, drawing upon the preliminary costing of Health Sector Strategy for HIV/AIDS. Also assess status of HIV/AIDS budget execution for FY02 and FY03 and identify any major impediments.

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<sup>49</sup> Refer to listing of priority areas provided by MOH. Estimate must include justified figures for Malaria, HIV/AIDS, EPI, Reproductive & Child Health, TB/Leprosy, essential drugs, etc.

### **Reporting Requirements**

- 1) Outputs to feed in to the budget guidelines must be made available by the end of November 2003.
- 2) A full draft PER report, including annexes, tables and figures should be submitted by October 2003 in electronic form (MS-Word and MS-Excel)
- 3) The finalized report, taking account of comments/recommended amendments should be submitted in electronic form as mentioned in number 2 above.
- 4) The report will have a maximum of 40 pages, excluding appendices. It must include an accessible summary on the principal conclusions, policy implications and recommendations for wider distribution to the public (maximum 5 pages).

### **Programme of Work**

#### **Health Sector PER TaskTeam**

In order to undertake the Health Sector PER, 2004, a task team is required, with members from all parts of the health sector, as well as those responsible for collecting and assimilating financial data for the sector. The PER task team for 2004, consist of the following members (**t.b.c**):

Mr Richard Mkumbo	Economist, Directorate of Policy & Planning, MoH (Co-ordinator)
Regina Kikuli	Economist, Head, Planning and Budget Section, MoH
Mariam Ally	Economist, Directorate of Policy & Planning, MoH
Nainkwa Mnzava	Economist, Directorate of Policy & Planning, MoH
Joyce Chitalika	Statistician, DPP
Maganga M.	Directorate of Local Government, PoRALG
Richard Shankango	Accountant, Ministry of Health
Charles Kibaya	Budget Officer, Ministry of Finance
Valeria Mamkwe	Budget Officer, Ministry of Finance
A. E. Msangi	Accountant General Office, Ministry of Finance
Anna Matowo	Planning and Privatization, President's Office

In addition, an external consultant will provide technical assistance to the sector to support the PER task team to undertake the PER 2004. The consultant will bear sole responsibility for the completion of the PER draft and final report.

#### **Health Sector PER Working Group**

The PER Working group will oversee and provide guidance in the implementation of the Health PER will review the draft report, and will be responsible for signing off the final draft for transmission to the PER Steering Committee (MOF).

Mr E.W.M Manumbu	Director Policy and Planning – Chairman
Ms. Regina Kikuli	Head, Budget Section, DPP – Alternate Chair
Mr R Mkumbo	Economist, DPP – Secretary
Dr. F. N. Njau	Head, HSRs, DPP.
Ms J Mahon	SDC – Donor Rep.
Mr P Smithson	DFID – Donor Rep.
Ms M Bangser	Women's Dignity Project – Civil Society Rep.
Dr A Kimambo	TPHA – Civil Society Rep.

#### **Timetable of activities**

The activities required to undertake the Health Sector PER, 2003, can be summarised as follows:

<b>Activity</b>	<b>Dates</b>	<b>Responsibility</b>
<b>Formal Agreement on TOR</b>	July-Aug.	PER Working Group
<b>Collect core data:</b> MoH, MoF, PORALG, local councils, development partners	Aug.-Sept.	PER task team
<b>Collect additional data:</b> Councils, MSD, MoH, MoF, BFC, CHF, parastatals	Aug.-Sept.	Consultant and PER task team
<b>Preparation of draft report:</b> Input data onto computer	Oct.	Consultant and PER task team
Data analysis training and compilation of draft report	Oct.	Consultant and PER task team
Presentation of data/outputs required for Budget Guidelines	Oct.	Consultant and PER task team
Compile draft report	Oct.	Consultant and PER task team
<b>Feedback and final report:</b> Present PER results	Late Oct.	Consultant and PER task team
Amend draft report	November	Consultant
Disseminate final report	November	Ministry of Health
<b>Note:</b>	Timetable will be finalized in our Technical Sub Committee meetings	

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## **Annex B Sources of information, key assumptions and other notes**

Data for all tables and figures are included in a single accompanying file, **\PER tables FY04**, and the various “tabs” within this worksheet are, it is hoped, self-explanatory. However, much of the data in this file has been copied in from other working files, and has been copied as values rather than showing the various formulae or more detailed source data. The description of sources below therefore refers to the original source documents within the working files in folder **\PER FY04\Data**, rather than the relevant tabs within **\PER tables FY04**, although these also generally specify the source data.

### **PER Master Table (Annex B)**

Several of the figures and tables below are based on data within the PER Master Table given in Annex B. The data for this are taken from several sources, as far as possible noted within the Table in the form of comments. All data from previous years is used as it was, with the exception that NHIF data has been added to FY02 and FY03. This was provided by the Accountant General’s Office **<<check>>**.

MOH recurrent budget data for FY04 is drawn from *Volume II Estimates of Public Expenditure (Consolidated Funds Services (Section 1) and Supply Votes (Ministerial) for the year 1 July 2003 to 30 June 2004 as submitted to the National Assembly*. Revised estimates and actual Recurrent expenditure data for FY03 were taken from an electronic (Excel) version of the Itemised Daily Balance report produced by the Accounts Department in Platinum, in file **\(Revised) Itemised Daily Balances.xlsJune03**, tab “all” and summarised in tab “**PER summary**”.

Regional recurrent budget data is taken from *Volume III estimates of public expenditure Supply Votes (Regional) for the year 1 July 2002 to 30 June 2003 as submitted to the National Assembly*, and recurrent expenditure data is taken from an electronic version of the *Regional Appropriation Accounts* summary provided by PORALG. Note. These distinguish between Preventive and Curative sub-votes only, with no information on sub-items. The data can be found in file **\Regional data FY04**.

Estimates and Approved Estimates for local government recurrent budget figures are taken from *Volume III Estimates of Public Expenditure Supply Votes (Regional), Details on Urban and District Council Grants and Subventions for the year from 1st July, 2003 to 30th June, 2004 as submitted to the National Assembly* for FY04 and FY03 respectively. Data on actual expenditure lags by two years, and is taken for FY02 from the same volume. Data on actual OC and PE releases for FY03 were obtained from the Budget Department, MOF.

Actual Basket funding figures for MOH headquarters for FY03 were taken from two sources. Final budgeted Basket figures came from the MOH Basket income and expenditure account prepared by the MOH Accounts Department<sup>50</sup>, while releases and actual expenditure data came from the file **\(Revised) Itemised Daily Balances.xlsJune03**, tab “all”.

Basket data for councils for FY04 was drawn from information provided by the MOH Health Sector Reform Secretariat and Basket Finance Committee, while for FY03 it was extrapolated from the file used in the PER update for FY03 on the grounds that all funds were released. This was confirmed in a PORALG report on the 82 Phase 1 and Phase 2 councils. Source data is contained in file **\LG Basket FY04**, tabs “**LG basket FY03**” and “**LG basket FY04**”.

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<sup>50</sup> MOH (2003) *Health basket funds: Income and expenditure account for the year ended 30<sup>th</sup> June 2003*

Budgeted development spending for FY04 is taken from the various volumes of Kitabu cha Nne according to whether it is central, regional or local government. Actual expenditure for MOH HQ in FY03 was taken from the MOH Health Basket: Income and expenditure report for basket funds, and the ministry Appropriation Accounts. Actual development expenditures for regional and local government were taken from PORALG Appropriation Accounts.

Health Services Fund data on hospital cost-sharing is included within the MOH Appropriation Accounts and was provided by the Accounts Department. Information on the Community Health Fund was provided by the project Accountant. Data on estimates of off-budget external financing are taken from the database maintained by the External Finance Department of the Ministry of Finance. No information was available on actual expenditures, which have been assumed at 120% of budget. This assumption needs to be reviewed.

## **Figures**

### ***Figure 1 Sectoral spending as a proportion of the total GOT budget, FY99 – FY04***

This graph uses Ministry of Finance data on Central Government Expenditure 1998/99 – 2003/04. The original data are located in the file **\PER FY04\Data\Overall government FY04, tab “CGE official”**, while the manipulations are in **tab “health analysis”** in the same file.

### ***Figure 2 Fall in Health sector budget as share of total for FY04, various definitions***

Data for Health #1 in Figure 2 is taken from the same MOF data on Central Government Expenditure (CGE) as in Figure 1, using actual for FY03 and Budget for FY04. The definition Health #2 includes budgeted MOH HIV/AIDS spending (Vote 52) which is taken from additional (ie disaggregated) data from MOF which supports the figures in the CGE table, and which is located in **\Overall government FY04, tab “additional info”**. Similarly, total HIV/AIDS spending is taken from the original table in **\Overall government FY04, tab “CGE official”** (and shown in disaggregated form in **tab “additional info”**). Communication with MOF officials indicates that prior to FY04, HIV/AIDS spending was included in Health, and that therefore the direct comparison would be between FY03 Health #1 and FY04 Health #2. The additions are to be found in **file \PER tables FY04, tab “CGE Health” (cells A55:c58)**.

### ***Figure 3 Health budget as share of original GOT budget estimates, FY01 – FY04***

Figure 3 reflects original budget figures, with the total GOT budget taken from successive budget speeches (July 2000 to July 2003), as given in Table 30 and in **file \PER table FY04\Overall govt – budget v actual**. The FY04 Health budget is taken from the MOF data on CGE as above, while Health budget figures for the other years are taken from successive years' PER updates (eg PER update FY03 for the FY03 budget). In FY02 and FY03, the allocation to the NHIF has been added. Calculations are shown in **\PER tables FY04, tab “budgets”**.

### ***Figure 4 Nominal on-budget health spending and rate of growth, FY99 – FY04***

Data on nominal spending/budget is taken from the MOF file on CGE as in Figure 1, **tab CGE official (Row 21)**. The rate of growth in nominal spending is calculated from these data in can be found in **file \PER tables FY04, tab “CGE Health” (cells A13:G16)**.

### ***Figure 5 Nominal health sector budgets, FY00 – FY04***

Data for Figure 5 are taken from the data collated for the FY04 PER update, and therefore differ from those in the Figures above, both due to data differences and as they include off-budget funds in addition to those captured through the government systems. Data is taken from the **file \PER tables FY04, tab “Master table and manipulations”, row 42**, and is also reflected in Table 3 in the PER report and Annex B. Actual expenditures have been

excluded due to the considerable doubt which remains over their reliability, as they are based on incomplete information and assumption.

**Figure 6 Budgeted and actual on-budget health spending, FY01 – FY04**

Data for Figure 6 are taken from the PER Master Table (Annex B and file \PER tables FY04, tab “Master table and manipulations”), and reflect on-budget figures for budgeted and actual expenditure as shown in row 35. Please see above for sources.

**Figure 7 On-budget share of domestic and foreign funding, FY99 – FY03**

Figure 7 data are taken from the PER Master Table (file \PER tables FY04, tab “Master table and manipulations”). Domestic includes government spending at AGO, MOH, regional and council level, while Foreign includes basket funding (recurrent and development, central and council) and on-budget non-basket foreign spending in the development budget (central and regional).

**Figure 8 Basket funding as a share of recurrent health spending, FY00-FY03**

Data for Figure 8 are taken from the PER Master Table (file \PER tables FY04, tab “Master table and manipulations”). Recurrent Basket funding includes both MOH HQ and council basket funding (rows 11, 16 and 19), and total recurrent reflects the total on-budget recurrent spending (row 20).

**Figure 9 Role of foreign funds in increased sectoral budgets, FY99-FY04**

**Figure 10 Health budget, Percentage breakdown by type of funding, FY00 – FY04**

The data on which Figures 9 and 10 are based are taken from the PER Master Table (file \PER tables FY04, tab “Master table and manipulations”). Basket includes both recurrent and development, while Other foreign reflects non-basket, on-budget foreign spending at any level.

**Figure 11 Proportion of estimated budget by level, FY99 – FY03**

**Figure 12 Proportion of actual expenditure by level, FY99 – FY02**

Data for Figures 11 and 12 is also drawn from the PER Master Table. Central level includes both MOH and AGO. Figures include on-budget recurrent and development spending.

**Figure 13 The trend in allocation by category of spending, FY00 – FY03**

Figure 13 is based on the data and definitions from Table 8 in the PER report. MOH/Admin includes MOH spending not captured under Hospitals or Preventive, together with allocations to the National Institute of Medical Research and the Tanzania Food and Nutrition Centre. Figure 13 excludes the allocation to the National Health Insurance Fund, although this is shown in Figure 18 in Annex D. Within the hospitals category, data for district hospitals are proxied by subvote 510 (Curative) at the LGA level. PEs are summed across all LGAs (file \Local government FY04, tab “by item FY03”) while OCs are taken from the same source plus the drugs allocation from the Chief Pharmacist’s data (file \Drugs\Drug allocation info FY03, tab “hospitals – GOT”). Regional hospitals are proxied by the Curative subvote in the same way, with PE and non-drug OC data from file \Regional data FY04, tab “Health recurrent PE:OC”. Data for the higher level hospitals are taken from a combination of the MTEF, Platinum reports in IFMIS, and information from the Hospital Services Department accountant on the split between PE and OC for the various institutions, together with the drug information from the Chief Pharmacist. No PE:OC split was undertaken for referral hospitals as the PE data were net rather than gross, as salaries are paid direct by the MOH rather than transferred in a single subvention as for higher level hospitals. The Preventive/Primary data reflect subvotes 511, 512 and 513 (Preventive, Health Centre and Dispensary) at LGA level, Preventive at Regional level, and the balance of Preventive services at MOH HQ after deduction of NIMR and TFNC. Drug data is added accordingly.

**Figure 14 Variations in per capita hospital drug and medical supply allocations by region, FY03**

Data for Figure 14 were provided by the Chief Pharmacist, and included in file \Drugs\Drug allocation info FY03. The total allocation includes both drugs and medical supplies, and covers both GOT and basket funding, summed for all hospitals up to Regional level within a given region. These have been combined in tab “regions” with population data from the website [www.tanzania.go.tz/populationf.htm](http://www.tanzania.go.tz/populationf.htm), calculated for FY03 as the mean of 2002 and 2003, as shown in file \PER tables FY04, tab “other data”.

**Figure 15 Preventive-curative split in LGA Development Budget, FY01 – FY04**

Figure 15 shows a crude split between curative projects in the LGA Development budget, as taken from the Kitabu cha Nne for FY04, defined as anything related to the district hospital, and Preventive, which covers all other projects at that level. All funding is local as no foreign funds are reflected in the official council development budget estimates.

**Figure 16: PE:OC split at LG level**

Data on the PE:OC split for councils is taken from successive budget and expenditure estimates, as entered in file \Local government FY04, tab “sectoral estimates”.

**Figure 17 Projected share of local and foreign funding, FY04 – FY07**

The data on which Figure 17 is based are taken from Table 4, p21 in the second version of the Budget Guidelines for FY05<sup>51</sup>, which is reproduced in file \PER tables FY04, tab “Future rev”. The calculations can be found in cells F96:J98.

**Figure 18 Allocation of GOT recurrent funding including NHIF contribution, FY00-FY03**

Data are as for Figure 13, but include the allocation to the NHIF within the MOH/Admin category as the data on actual spending are only a small proportion of the allocation. In the future, this might be split between hospitals (on the assumption that most spending actually takes place at the hospital level rather than the primary level) and Admin.

## **Tables**

**Table 2 Additional measures of spending, MOF on-budget data FY01 – FY04**

The data in Table 2 are based on the nominal values of health sector budgets and expenditure as presented in the MOF file on Central Government Expenditure, located in file \Overall government FY04, tab “CGE official”. Real valued were obtained by deflating by the Consumer Price Index, with FY01 as the base year, given in \PER tables FY04, tab “Other data”. Per capita figures were obtained using population data from the website [www.tanzania.go.tz/populationf.htm](http://www.tanzania.go.tz/populationf.htm), with the financial year population calculated as the mean of two calendar years. US dollar figures were obtained using an annual exchange rate calculated as the mean of the Bank of Tanzania rates for September, December, March and June (the first two only for FY04), and again shown in \PER tables FY04, tab “Other data”.

**Table 3 Total health expenditure in Tanzania, FY99 – FY04 (TSh billion)**

Table 3 is a condensed version of the PER Master Table (Annex B), with sources as above. Values have been divided by one billion.

**Table 4 Additional measures of spending, overall MOH PER data FY01 – FY04**

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<sup>51</sup> PO-PP/MOF, *Guidelines for the preparation of the medium term plan and budget framework for 2004/05 – 2006/07*, Working draft, Dar es Salaam: January 2004, as in Word file \Guidelines January 2004

Table 4 uses similar data for obtaining real, US dollar and per capita values as Table 2, but is based on the total budgeted spending for the health sector, including both on- and off-budget sources, as calculated by successive PER exercises.

**Table 5 Budget performance (expenditure/budget), FY01 – FY03**

Overall budget performance figures are taken from the PER Master Table. The table shows expenditure as a percentage of budget for on-budget recurrent, development, and total spending.

**Table 6 Breakdown between recurrent and development spending, FY00 – FY04**

Table 6 data are taken from the PER Master Table, and reflect on-budget figures only.

**Table 7 Public health spending, by funding type (Billion shillings)**

Data for Table 7 are taken from the PER Master Table. On-budget domestic funds include GOT and general budget support. Off-budget domestic funds include resources from cost-sharing, ie the Health Services Fund and Community Health Fund monies. On-budget foreign funding includes basket and other foreign spending recorded in the official development budget, while the off-budget foreign is taken from the MOF External Finance database.

**Table 8 Summary of GOT health spending by level/category, TSh billion**

The data in Table 8 are the same as those in Figure 13 above. Please refer.

**Table 9 MOH recurrent expenditure: budget and capacity performance FY03**

Table 9 is a summary of data from the Integrated Financial Management System, and is based on two sources. Information on Government funding (budget, release and expenditure) is taken from file **\\(Revised) Itemised Daily Balances.xlsJune03**, as is release and expenditure data for the basket. The final budget figures for the basket however are taken from the Basket Income and Expenditure account (see reference under PER Master Table).

**Table 10 Spending by MOH department on drugs and supplies, FY02 and FY03**

Data for this table are taken from the MOH Platinum reports, and represent actual expenditure. Data from FY02 are copied from the PER data for the previous year, while the FY03 data are copied in from calculations in the relevant tabs in file **\\Platinum files\\(Revised) Itemised daily balances**.

**Table 11 Drugs and medical supplies as a share of MOH/sector spending, FY02 – FY04**

The data on drugs and supplies budget/expenditure in Table 11 are taken from the Platinum reports for the respective years. FY04 data are found in file **\\Platinum\\IFMIS FY04 Q1+2**. MOH OC is calculated by taking the total of GOT and Basket recurrent funding less PEs and is taken from Platinum files. MOH Recurrent includes PEs and is taken from PER data included in the PER Master Table. Sector recurrent is defined as the on-budget recurrent total, and is also taken from the PER Master Table. Population figures are taken from the website [www.tanzania.go.tz/populationf.htm](http://www.tanzania.go.tz/populationf.htm), with the financial year calculated as the mean of successive calendar year projections. The exchange rate is taken from the mean of the BOT mid-rates for September, December, March and June (first half year only for FY04) as per the Economic Report of January 2004, and located in file **\\PER tables FY04, tab “Other data”**.

**Table 12 Drugs and supplies allocation by level and type**

Data in Table 12 are based on calculations using information provided by the Chief Pharmacist. Early years were copied in from previous PER files, while the FY03 data are located in file **\\Drugs\\Drug allocation info FY03**. The data include spending both by GOT and basket, and also through the DANIDA-funded Health Sector Support Programme as they

fund the first quarter kit supply to councils. As pointed out in the text, there are problems with this table as the figures are not consistent between sources of information and definitions remain to be clarified.

**Table 13 MOH hospital drug allocations by level/hospital type, FY02 and FY03**

Data in Table 13 are similarly drawn from the information provided by the Chief Pharmacist, and have been summarised from PER Table 12. Original data are located in file \Drugs\Drug allocation info FY03.

**Table 14 HIV/AIDS spending, Central MOH (TSh)**

Data on HIV/AIDS spending at central MOH level are taken from Platinum reports. Preventive spend is defined as spending by the National AIDS Control Programme, identified as sub-item 260409 within sub-vote 3001. Curative spend is defined in terms of specific activities within Hospital/Curative Services Department, as outlined in the successive MTEF documents, namely safe blood, PMTCT, and (in FY03) workplace interventions, Technical AIDS Committee costs, and support to hospital provision of a continuum of care for AIDS patients. In FY04, HIV/AIDS-related spending on TFNC is identified by sub-item 260409, and Development spending is for project 5492 in Kitabu cha Nne. No activities are specified.

**Table 15 HIV/AIDS spending, Local Government Authorities**

HIV/AIDS spending at the LGA level is taken from the detailed budgets as contained in *Volume III Estimates of Public Expenditure Supply Votes (Regional), Details on Urban and District Council Grants and Subventions for the year from 1st July, 2003 to 30th June, 2004 as submitted to the National Assembly*. It covers spending on sub-item 260409, and can be found and reproduced in file \Local government FY04, tab "By item FY04". Total LG spending on OCs is taken from the summary tables at start of the Appendices to Volume III Estimates FY04, reproduced in the same file, tab "LG total", column G.

**Table 16 Share of recurrent spending within Development project budgets, FY04**

The share of recurrent spending within the development budget is a very crude calculation undertaken by project for FY04 by summing the sub-items beginning with the recurrent classifier 2xxxxx and calculating the percentage of total spending on that project. The original source is Kitabu cha Nne, and the data are located in file \Ministry of Health FY04, tab "Development – specific".

**Table 17: Government subventions to LGAs, FY01-FY04 (Billion shillings)**

Data in Table 17 are taken from file \Local government FY04, tab "sectoral estimates", rows 147 - 150.

**Table 18: Variation in flow of LGA OC funds by quarter, FY03**

Data in Table 18 are based on information provided by Mr Mwampeta in the Budget Department of MOF regarding release of OCs to local councils. The data are in file \LG releases – Hazina original.

**Table 19 Recurrent spending on PRS priority items, FY02 to FY04 (TSh million)**

The data in Table 19 reflect a mix of MOF data and those gathered as part of the PER process. For FY04, the data are taken directly from additional data provided by the MOF to support their Central Government Expenditure table. These are located in the file \Overall government FY04, tab "additional info". For FY02 and FY03, the figures have been calculated using PER data. LGA subventions are calculated as total actual expenditure in district and urban councils as per the Master Table, less the budgeted total HIV/AIDS figures reflected in Table 15. The LGA drugs budget is calculated from the data in Table 12, as District hospital + DDH/VA + 75% of Primary health care kits (to reflect the fact that one quarter is paid for under the DANIDA-funded HSPS). MOH Preventive Department spend was calculated using the IFMIS files for each year, and reflects total expenditure less 260409

(HIV/AIDS Epidemics). Regional figures do not exclude HIV/AIDS spending as we were unable to locate sub-item data, but the inclusion is expected to be minor.

***Table 20 MOH HQ Development spending on PRS priorities, FY04***

The calculations in Table 20 are taken from the MOH Development budget as included in Kitabu cha Nne for FY04, and reproduced in file \Ministry of Health FY04, tab “Development – aggregate”. The definition of priority development projects is taken from documentation provided as part of the EC Budget Review of November 2003.

***Table 21 Finance-related health sector performance indicators***

The indicators in Table 21 are calculated from various sources of PER data. Indicators 1 and 2 are taken from data in the PER Master Table, while Indicator 3 is based on Table 8 and Figure 13 data (please see above). Indicator 7 is calculated using information from file \Local government FY04 tabs “sectoral estimates” and “LG total”.

***Table 22 Selected finance-related health sector performance indicators, in US dollars***

Table 22 reproduces information from Table 21 for Indicators 1, 2 and 3, but dividing by the exchange rate as defined for Table 2.

***Table 23 Potential HSF cost-sharing indicators, FY03***

Information in Table 23 is calculated using data provided by the MOH Accounts Department on the Health Services Fund, and located in file \cost-sharing\HSF, tab “FY03”. This was combined with the information on drug expenditure for the hospitals selected as per Table 12.

***Table 24 Detailed costing/justification for priority items***

Table 24 is taken from an early budget submission by the MOH to Ministry of Finance. The original is found in Word file \Bguidelines submission – old.

***Table 25 Real estimates of future sectoral funding, FY04 – FY07 (TSh m)***

Data for Table 25 are taken from the second version of the Budget Guidelines (see reference for Figure 17), reproduced in \PER tables FY04, tab “future rev”. The real values are calculated using an estimated inflation rate of 4% per annum over the period.

***Table 26 Possible basket estimates, FY05***

The basket estimates in Table 26 are taken from the Side Agreement signed following the 2004 Joint Health Sector Review, representing pledges by basket partners for the coming year.

***Table 27 Discrepancies between MOH and MOF data, as at end March 2004***

Table 27 highlights the differences between data contained within the MOF file on Central Government Expenditure (in file \Overall government FY04, tab “CGE official”), and estimates of sectoral spending gathered through the PER process in recent years.

***Table 28 Definition of Health as a priority sector, and budget breakdown, FY04***

Table 28 was provided by the MOF and shows the definition of health as a priority sector as currently defined for PRSP monitoring purposes.

***Table 29 Health performance relative to other PRS sectors, FY04***

The calculations on which Table 29 is based are taken from the MOF data in file \Overall government FY04, tab “CGE official”, and “manipulations”.

***Table 30 Original Health and Total budget figures, FY01 – FY04***

Original health budget data comes from successive PERs up to FY04 which is taken from the MOF data on Central Government Expenditure. The total government budget figures are

original estimates, taken from successive budget speeches, and located in file \Overall govt – budget v actual.

***Table 31 Budget, release and expenditure by MOH Department, FY02***

Table 31 is taken from the PER update for FY03, and is located in \PER FY03\Data\Platinum\IFMIS FY02

***Table 32 Rate of growth in LGA block grant allocations to Health***

Table 32 is taken from the same source as Table 17. The original sources are previous PER tables (for FY01 and FY02), Ministry of Finance Budget section for FY03, and Volume III Estimates (Regional) Urban and District Councils (for FY04).

***Table 33 Planned and actual basket funding, FY03***

Information in Table 33 is taken from the Side agreement to the report of the 2003 Joint Health Sector Review for planned figures, and from the Income and Expenditure Account for the basket for actual releases to the holding account.

***Table 34 Nominal values of projected future spending, FY04 – FY07***

***Table 35 Real per capita values of projected future spending, FY04 – FY07***

Data in Tables 34 and 35 are drawn from the revised Budget Guidelines document, as for Table 25 above. Population data used in Table 35 are those taken from the website referred to under Table 2, and found in \PER tables FY04, tab “Other data”.

***Table 36 Actual health spending by NHIF***

Data on the actual spending by the National Health Insurance Fund was provided by the Fund itself. The data for FY02 differ from that given in their Audit Report.

***Table 37 Spending on Item 2604 Medical Supplies and Services, FY02 and FY03***

Table 37 is an expanded version of Table 10 and the sources are the same.

***Table 38 Allocations for drug kits by source, FY03***

The information in Table 38 is taken from the files provided by the Chief Pharmacist, located in file \Drugs\Drug allocation info FY03, tab “Kit totals”.

**Final Version**  
**Health Sector PER Update FY04**

**Annex C PER Master table**

	1999/2000		2000/2001		2001/2002		2002/2003		2003/04
	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
<b>Recurrent</b>									
Accountant General's Office									
National Health Insurance Fund					8,972,544,500	5,612,062,399	6,915,980,248	6,546,305,881	6,616,460,542
Ministry of Health									
Government funds	33,771,197,537	32,055,992,068	40,146,725,500	39,885,344,271	49,087,814,200	48,165,359,880	62,882,343,876	51,554,396,979	86,383,123,331
Donor basket fund	5,424,913,671	334,588,662	9,245,017,030	4,364,216,238	12,509,980,444	10,827,344,789	19,278,807,437	18,344,250,378	
Regional Administration									
Government funds	9,363,412,405	9,008,206,554	6,206,326,511	5,614,804,137	7,062,588,748	6,584,825,460	7,864,022,725	7,824,023,250	8,829,819,608
Urban councils									
Government funds	5,045,401,204	4,489,209,418	6,038,363,000	6,067,256,194	7,215,534,300	7,166,663,655	8,860,711,200	8,770,916,400	9,692,668,800
Donor basket fund	452,823,200	418,196,000	2,060,190,187	1,635,792,491	2,476,963,415	2,472,793,397	2,763,096,113	2,747,033,593	2,961,911,914
District councils									
Government funds	12,548,841,000	12,429,340,225	23,073,974,900	23,333,303,942	28,262,447,400	28,377,319,802	34,814,714,100	34,776,743,600	39,163,565,600
Donor basket fund	640,605,300	608,943,000	5,178,497,029	4,632,995,861	8,301,693,509	8,266,416,055	11,222,194,068	11,182,673,751	14,318,670,149
<b>Total recurrent</b>	<b>67,247,194,317</b>	<b>59,344,475,926</b>	<b>91,949,094,157</b>	<b>85,533,713,134</b>	<b>123,889,566,515</b>	<b>117,472,785,437</b>	<b>154,601,869,766</b>	<b>141,746,343,832</b>	<b>167,966,219,945</b>
<b>Development</b>									
Ministry of Health									
Government funds	3,177,000,000	1,912,000,000	3,245,000,000	3,253,939,506	3,245,000,000	3,197,327,926	3,843,728,200	3,236,004,165	3,552,448,200
Donor basket fund					5,856,811,717	4,615,471,717	3,841,820,500	3,644,903,594	4,607,625,422
Foreign (non-basket)	14,575,086,329	8,281,183,077	17,226,052,570	11,583,576,639	22,966,181,000	13,309,109,927	26,383,612,500	22,145,113,823	19,017,061,500
Regional Administration									
Government funds	400,487,000	28,987,586	372,312,000	361,419,503	389,332,000	389,169,060	535,986,500	491,986,173	733,313,400
Foreign (non-basket)	2,166,066,000	757,095,717	4,242,770,000	1,024,583,643	1,962,380,000	892,908,611	4,449,580,400	1,990,505,266	2,799,671,000
Urban councils									
Government funds	215,662,000	181,046,000	349,898,000	355,028,000	359,669,000	267,914,000	333,828,700	392,986,173	456,106,200
Foreign (non-basket)	200,000,000	200,000,000	200,000,000						
District councils									
Government funds	765,578,000	673,975,000	1,176,751,000	1,160,314,000	1,344,211,000	1,185,182,000	1,411,232,600	1,990,505,266	1,887,680,400
<b>Total development</b>	<b>21,499,879,329</b>	<b>12,034,287,380</b>	<b>26,812,783,570</b>	<b>17,738,861,291</b>	<b>36,123,584,717</b>	<b>23,857,083,241</b>	<b>40,799,789,400</b>	<b>33,892,004,460</b>	<b>33,053,906,122</b>
<b>Total on budget</b>	<b>88,747,073,646</b>	<b>71,378,763,307</b>	<b>118,761,877,727</b>	<b>103,272,574,426</b>	<b>160,013,151,232</b>	<b>141,329,868,678</b>	<b>195,401,659,166</b>	<b>175,638,348,292</b>	<b>201,020,126,067</b>
<b>Off budget expenditure</b>									
Cost sharing									
Health Services Fund – Hospital		1,404,865,561		1,421,254,371		1,082,642,718		1,509,458,307	1,509,458,307
Community Health Fund – PHC		87,146,973		438,258,582		155,262,177		158,670,763	158,670,763
Other foreign funds	52,332,895,965	60,035,769,500	59,414,377,872	75,000,000,000	66,142,394,763	79,370,873,716	49,254,970,437	59,105,964,525	68,992,700,922
<b>Total off budget</b>	<b>52,332,895,965</b>	<b>61,527,782,034</b>	<b>59,414,377,872</b>	<b>76,859,512,952</b>	<b>66,142,394,763</b>	<b>80,608,778,610</b>	<b>49,254,970,437</b>	<b>60,774,093,594</b>	<b>70,660,829,992</b>
<b>Grand total</b>	<b>141,079,969,611</b>	<b>132,906,545,340</b>	<b>178,176,255,599</b>	<b>180,132,087,378</b>	<b>226,155,545,995</b>	<b>221,938,647,288</b>	<b>244,656,629,603</b>	<b>236,412,441,886</b>	<b>271,660,956,059</b>

**Annex D Miscellaneous additional tables and figures**

**Table 27 Discrepancies between MOH and MOF data, as at end March 2004**

TSh bn	FY99 actual	FY00 actual	FY01 actual	FY02 actual	FY03 actual	FY04 budget
<b>MOF CGE data</b>						
Recurrent	50.7	53.9	70.3	90.9	149.1	177.6
Development	21.9	27.3	30.4	51.2	37.6	19.6
	<b>72.6</b>	<b>81.2</b>	<b>100.7</b>	<b>142.1</b>	<b>186.7</b>	<b>197.2</b>
<b>MOH PER data</b>						
Recurrent	62.2	59.34	85.53	117.47	139.47	167.97
Development	17.9	12.03	17.74	23.86	53.89	33.03
	<b>80.1</b>	<b>71.4</b>	<b>103.3</b>	<b>141.3</b>	<b>193.4</b>	<b>201.0</b>
MOH - MOF	7.5	-9.8	2.6	-0.8	6.7	3.8
% MOF data	10%	-12%	3%	-1%	4%	2%

**Table 28 Definition of Health as a priority sector, and budget breakdown, FY04**

Breakdown of Health budget FY04	OC	PE	PE parastatal	Total recurrent	Local dev	Foreign devt	Total Devt	TOTAL
<b>Total of Health Sector Expenditure</b>	<b>83,061</b>	<b>46,743</b>	<b>18,543</b>	<b>148,347</b>	<b>6,537</b>	<b>42,385</b>	<b>48,922</b>	<b>197,269</b>
Health Insurance Fund	6,616	-	-	6,616	-	-	-	6,616
Ministry of Health	59,885	5,494	18,543	83,922	3,552	22,002	<b>25,554</b>	109,476
Pres. Office: Reg,Admin & L. Govt.	-	-	-	-	20	17,850	<b>17,870</b>	17,870
Regions	2,143	6,810	-	8,953	617	2,533	<b>3,150</b>	<b>12,103</b>
Local Government	14,417	34,439	-	48,856	2,348	-	<b>2,348</b>	51,204
<b>o/w Total of Primary Health Expenditure</b>	<b>44,345</b>	<b>35,008</b>	<b>-</b>	<b>79,353</b>	<b>3,305</b>	<b>35,579</b>	<b>38,884</b>	<b>118,237</b>

**Table 29 Health performance relative to other PRS sectors, FY04**

	TSh bn		% Total Expd		% change in share
	FY03 actual	FY04 budget	FY03	FY04	
<b>Total expenditure (excluding CFS)</b>	<b>1,787.4</b>	<b>2,198.6</b>	<b>100.0%</b>	<b>100.0%</b>	
<b>Total expenditure in priority sectors</b>	<b>973.7</b>	<b>1,128.0</b>	<b>54.5%</b>	<b>51.3%</b>	<b>-5.8%</b>
Health	186.7	197.3	10.4%	9.0%	-14.1%
<i>Health including reallocation</i>	186.7	214.3	10.4%	9.7%	-6.7%
Education	436.2	502.3	24.4%	22.8%	-6.4%
Water	51.9	64.4	2.9%	2.9%	0.8%
Agriculture	60.2	91.1	3.4%	4.1%	23.0%

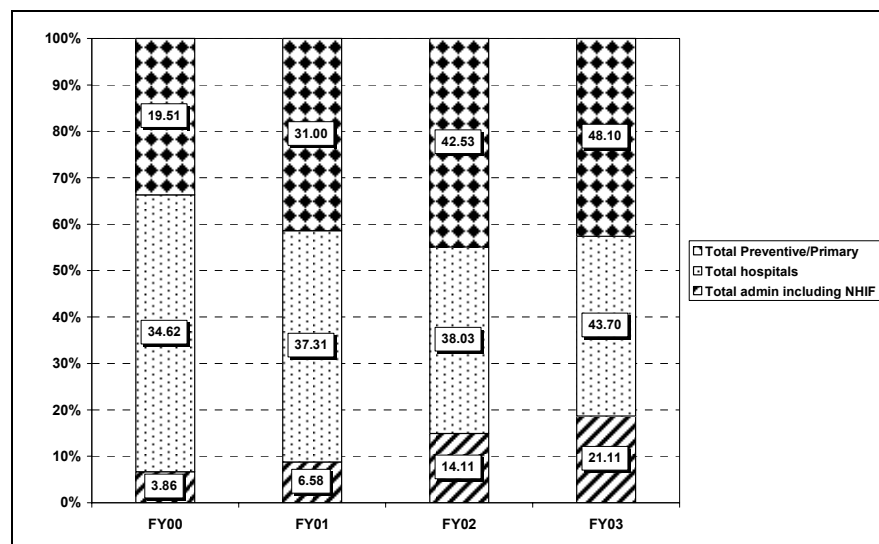
**Table 30 Original Health and Total budget figures, FY01 – FY04**

	FY01	FY02	FY03	FY04
Health	117.97	153.11	199.69	197.20
Total budget, incl CFS	1,394.59	1,764.74	2,219.21	2,607.20
Total budget, excl CFS	1,100.83	1,432.15	1,895.69	2,198.60

**Table 31 Budget, release and expenditure by MOH Department, FY02**

Dept	Source	Budget	Release	Expd	Release/ budget	Expd/ release	Expd/ budget
1001 Admin & General	Govt	1,720,363,771	1,683,538,832	1,539,681,014	97.9%	91.5%	89.5%
	Basket	442,471,000	198,511,800	121,667,888	44.9%	61.3%	27.5%
	<b>Total</b>	<b>2,162,834,771</b>	<b>1,882,050,632</b>	<b>1,661,348,902</b>	<b>87.0%</b>	<b>88.3%</b>	<b>76.8%</b>
1002 Finance & Accts	Govt	191,664,091	190,681,933	183,598,621	99.5%	96.3%	95.8%
	Basket	73,534,796	67,900,796	63,748,042	92.3%	93.9%	86.7%
	<b>Total</b>	<b>265,198,887</b>	<b>258,582,729</b>	<b>247,346,663</b>	<b>97.5%</b>	<b>95.7%</b>	<b>93.3%</b>
1003 Policy & Planning	Govt	303,966,150	303,210,562	257,256,012	99.8%	84.8%	84.6%
	Basket	1,396,332,362	820,064,610	1,664,607,791	58.7%	203.0%	119.2%
	<b>Total</b>	<b>1,700,298,512</b>	<b>1,123,275,172</b>	<b>1,921,863,803</b>	<b>66.1%</b>	<b>171.1%</b>	<b>113.0%</b>
2001 Curative (Hospital)	Govt	33,733,517,123	33,224,685,969	33,391,493,053	98.5%	100.5%	99.0%
	Basket	3,917,647,868	3,858,948,388	3,821,381,199	98.5%	99.0%	97.5%
	<b>Total</b>	<b>37,651,164,991</b>	<b>37,083,634,357</b>	<b>37,212,874,252</b>	<b>98.5%</b>	<b>100.3%</b>	<b>98.8%</b>
2002 Chief Govt Chemist	Govt	526,708,373	525,172,265	524,961,226	99.7%	100.0%	99.7%
	Basket	150,000,000	47,155,003	29,047,940	31.4%	61.6%	19.4%
	<b>Total</b>	<b>676,708,373</b>	<b>572,327,268</b>	<b>554,009,166</b>	<b>84.6%</b>	<b>96.8%</b>	<b>81.9%</b>
2003 Chief Medical Officer	Govt	195,728,003	118,690,609	105,262,445	60.6%	88.7%	53.8%
	Basket	224,048,511	151,173,376	131,230,020	67.5%	86.8%	58.6%
	<b>Total</b>	<b>419,776,514</b>	<b>269,863,985</b>	<b>236,492,465</b>	<b>64.3%</b>	<b>87.6%</b>	<b>56.3%</b>
3001 Preventive	Govt	9,214,807,857	9,168,202,751	9,085,533,007	99.5%	99.1%	98.6%
	Basket	5,992,019,030	5,015,133,256	4,757,150,383	83.7%	94.9%	79.4%
	<b>Total</b>	<b>15,206,826,887</b>	<b>14,183,336,007</b>	<b>13,842,683,390</b>	<b>93.3%</b>	<b>97.6%</b>	<b>91.0%</b>
4001 Tukuta	Govt	225,456,429	225,379,147	201,722,243	100.0%	89.5%	89.5%
	Basket	40,000,000	23,278,800	23,171,400	58.2%	99.5%	57.9%
	<b>Total</b>	<b>265,456,429</b>	<b>248,657,947</b>	<b>224,893,643</b>	<b>93.7%</b>	<b>90.4%</b>	<b>84.7%</b>
5001 Human Res Devt	Govt	2,975,602,421	2,934,065,818	2,875,852,258	98.6%	98.0%	96.6%
	Basket	273,946,877	220,487,127	215,963,127	80.5%	97.9%	78.8%
	<b>Total</b>	<b>3,249,549,298</b>	<b>3,154,552,945</b>	<b>3,091,815,385</b>	<b>97.1%</b>	<b>98.0%</b>	<b>95.1%</b>
<b>Sub-total</b>	<b>Govt</b>	<b>49,087,814,218</b>	<b>48,373,627,887</b>	<b>48,165,359,879</b>	<b>98.5%</b>	<b>99.6%</b>	<b>98.1%</b>
	<b>Basket</b>	<b>12,510,000,444</b>	<b>10,402,653,156</b>	<b>10,827,967,789</b>	<b>83.2%</b>	<b>104.1%</b>	<b>86.6%</b>
<b>TOTAL</b>		<b>61,597,814,662</b>	<b>58,776,281,043</b>	<b>58,993,327,669</b>	<b>95.4%</b>	<b>100.4%</b>	<b>95.8%</b>

**Figure 18 Allocation of GOT recurrent funding including NHIF contribution, FY00-FY03**



**Table 32 Rate of growth in LGA block grant allocations to Health**

	PEs			OCs			Total		
	FY02	FY03	FY04	FY02	FY03	FY04	FY02	FY03	FY04
Urban	10%	16%	16%	38%	17%	30%	17%	17%	20%
District	14%	14%	17%	48%	15%	22%	23%	14%	19%
<b>Total</b>	<b>13%</b>	<b>14%</b>	<b>16%</b>	<b>46%</b>	<b>16%</b>	<b>24%</b>	<b>22%</b>	<b>15%</b>	<b>19%</b>

**Table 33 Planned and actual basket funding, FY03**

Partner	Own currency	Budget	Release	R/B
		USD (M)		%
DFID	£	16.2	13.68	84.4%
DANIDA	DKK	6.0	6.68	111.4%
Germany - KfW	Euro	2.3	2.30	100.0%
Germany - GTZ	Euro	0.3	0.32	109.2%
Ireland	Euro	3.1	3.10	100.0%
Netherlands	Euro	1.3	1.30	100.0%
SDC	CHF	2.5	2.50	100.0%
World Bank	USD	10.0	6.32	63.2%
<b>Total</b>		<b>41.69</b>	<b>36.19</b>	<b>86.8%</b>

**Table 34 Nominal values of projected future spending, FY04 – FY07**

	FY04	FY05	FY06	FY07
<b>Nominal values (current P)</b>				
Total health sector	210,480	284,926	289,650	293,904
Recurrent - total	158,798	164,773	168,544	171,727
Priority recurrent	73,480	91,884	77,260	77,929
Non-priority recurrent	34,476	35,722	36,250	36,563
Total local funding	165,500	171,476	175,963	179,978
Development - total	51,682	120,152	121,107	122,176
Development - foreign	44,979	113,450	113,687	113,926
Basket funding	25,281	48,450	51,820	53,893
Other (non-basket foreign) devt	19,698	65,180	61,867	60,033
<b>Annual growth rates (nominal)</b>				
Total health sector		35%	2%	1%
Recurrent - total		4%	2%	2%
Priority recurrent		25%	-16%	1%
Non-priority recurrent		4%	1%	1%
Total local funding		4%	3%	2%
Development - total		132%	1%	1%
Development - foreign		152%	0%	0%
Basket funding		92%	7%	4%
Other (non-basket foreign) devt		231%	-5%	-3%

**Table 35 Real per capita values of projected future spending, FY04 – FY07**

**Final Version**  
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	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>
<b>Real values (per capita)</b>				
<i>Population</i>	34,931,498	35,944,514	36,986,947	38,059,611
Total health sector	6,025	7,622	7,240	6,865
Recurrent - total	4,546	4,408	4,213	4,011
Priority recurrent	2,104	2,458	1,931	1,820
Non-priority recurrent	987	956	906	854
Total local funding	4,738	4,587	4,399	4,204
Development - total	1,480	3,214	3,027	2,854
Development - foreign	1,288	3,035	2,842	2,661
Basket funding	724	1,296	1,295	1,259
Other (non-basket foreign) devt	564	1,744	1,546	1,402
<b>Annual growth rates (real)</b>				
Total health sector		26.5%	-5.0%	-5.2%
Recurrent - total		-3.0%	-4.4%	-4.8%
Priority recurrent		16.8%	-21.4%	-5.7%
Non-priority recurrent		-3.2%	-5.2%	-5.7%
Total local funding		-3.2%	-4.1%	-4.4%
Development - total		117.2%	-5.8%	-5.7%
Development - foreign		135.7%	-6.4%	-6.4%
Basket funding		79.1%	-0.1%	-2.8%
Other (non-basket foreign) devt		209.2%	-11.3%	-9.3%

## Annex E The National Health Insurance Fund and PRS priorities: some issues

Inclusion of the government contribution to the National Health Insurance Fund in the FY04 PER update changes the way that this item is viewed within the PER, ie from monitoring the off-budget actual expenditures on health services by NHIF, to capturing a budgetary transfer at the central level. Although not included within the PRS Priority Item, it is therefore included as part of the on-budget resource envelope for Health as a Priority Sector. Arguably, this should arguably be explored further as the NHIF contribution to the achievement of PRS and MDG objectives is questionable, at least in the immediate future.

The GOT contribution to NHIF on behalf of public servants amounts to 8% of the Other Charges budget for the sector in FY04. Data solicited from NHIF indicate that actual expenditure on health services in FY02 and FY03 was very limited, as would be expected from such a fund in its infancy. The government allocation represents only part of the NHIF income (49% of total Members' contributions in FY02), and is compared with direct expenditure on services in Table x below<sup>52</sup>. Other expenditure categories are advocacy, stationery, depreciation, and administration (the latter being limited to 8% maximum by the NHIF Act (No 8) of 1999).

**Table 36 Actual health spending by NHIF**

	FY02 Actual	FY03 Actual	FY04 Budget
Government contribution (actual)	5,612,062,399	6,546,305,881	6,616,460,542
Benefit payments	247,362,882	1,345,852,460	2,626,406,325
<i>Benefit payments as % Govt contribution</i>	4.4%	20.6%	39.7%

Notes:

- The FY02 figure for benefit payments comes from the NHIF audited accounts. However other data provided by NHIF to the Per Task Team indicates total spending of TSh16.8m, ie 0.3% of the Government contribution
- FY04 Benefit payments are NHIF projections based on performance in the first quarter

In addition, health services reimbursed under the NHIF are predominantly Curative or Hospital services, ie again largely falling outside the Priority Item (with the exception of those services provided by District Hospitals which are proxied by subvote 510 and included in the Local Government category). NHIF provided a breakdown of spending according to their five categories of benefit - registration; outpatient care; basic diagnostic tests; inpatient care; and surgery services – and it was hoped that an analysis of “primary” versus “secondary” services could be made, but unfortunately the data show that a formula was used rather than actual data on expenditures in each of these categories. Such an analysis could, however, presumably be performed in future years if felt to be useful, following discussion with NHIF on MOH information requirements.

NHIF are not yet able to monitor the provenance of their members, although they can monitor expenditure by LGA (based on the facilities within the LGA), but as the majority are formal sector employees and their dependents, they are more likely to be residents of urban areas than rural. Again, this points to a beneficiary group which is not the poorest according to the latest Poverty and Human Development Report.

Health services offered and presumably reimbursed under the NHIF go beyond those included within the Essential Health Package, and therefore may represent a less efficient and cost-effective option in terms of meeting PRS objectives. For example, the Fund has a

<sup>52</sup> This figure differs from that provided by the World Bank in their HSDP project document which indicates expenditure on services of TSh 1.204bn, presumably taken from the NHIF Implementation Report 2002/03 <<**can we get the Report to check?**>>.

detailed grading and costing of operations, many of which would not be considered part of the essential health package, but which presumably represent services for which they are willing to reimburse members.

NHIF are willing and able to generate various reports relating to their activity (as of now). It would be useful for MOH and partners to consider what might be requested on a routine basis in order to monitor the extent to which government contributions to the NHIF are in line with PRS objectives.

## **Annex F: Additional information and comment on spending on Medical supplies and services (GFS item 2604)**

### **Drug spending at MOH central level**

The majority of funding for Medical supplies and services is channelled through Vote 52, the MOH headquarters, and reflected under Item 2604 which currently contains nine sub-items:

- 260401 Vaccines
- 260402 Drugs & medicines
- 260403 Special foods (diet food)
- 260404 Dental supplies
- 260405 Hospital supplies
- 260406 Post mortem supplies
- 260407 Laboratory supplies
- 260408 Specialised supplies
- 260409 HIV/AIDS epidemics

For GOT and basket funds, the breakdown between these items, with the exception of 260409 (see Box 2 below) for the period FY02 – FY03 is shown in Table 34 below. Although data was available in Platinum to enable inclusion of expenditure data for the first half of FY04, time did not permit this analysis, although it should be possible in future years, at least in terms of reporting original budgets<sup>53</sup>.

#### **Box 2 HIV/AIDS spending – sub-item 260409**

In the FY03 PER update, the sub-item 260409, HIV/AIDS epidemics, was used at the central MOH level to cover the whole range of sub-items used in HIV/AIDS-related activities by the National AIDS Control Programme, eg allowances, stationery, travel, computers etc. For FY04, its use has been extended to cover HIV/AIDS related activities at Regional and Local Government level, and in other MDAs. Spending by any Vote on this sub-item is now included within the PRS priority sector HIV/AIDS rather than Health for the purposes of monitoring spending on PRS priorities from FY04 onwards. For the purpose of the PER update, health sector spending on 260409 is generally included except where specifically stated.

It is hoped that for FY05 a new set of objective codes, as proposed in the FY04 PER update for HIV/AIDS, will be introduced throughout government in order to clarify the nature of HIV/AIDS-related activities being undertaken, and to facilitate the monitoring of performance by more clearly relating inputs to outputs.

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<sup>53</sup> Comment on how such data might be made available in more timely fashion is given in Section x. Refer to recommendation to design and request specific reports from Platinum system on regular basis.

**Table 37 Spending on Item 2604 Medical Supplies and Services, FY02 and FY03**

	FY02		FY03	
	GOT	Basket	GOT	Basket
<b>2001 Curative services</b>				
260402 Drugs and Medicines	10,589,007,100	1,600,000,000	10,067,883,667	4,000,000,000
260403 Special foods (diet food)	169,160,000			
260404 Dental supplies	22,437,001	137,563,000	51,103,080	500,000,000
260405 Hospital Supplies	237,398,100	1,168,105,252	176,925,000	1,000,000,000
260406 Post Mortem Expenses	2,000,001			
260407 Laboratory Supplies	250,000,000		97,000,000	500,000,000
260408 Specialised supplies				1,888,070,000
<b>Sub-total Curative</b>	<b>11,270,002,202</b>	<b>2,905,668,252</b>	<b>10,392,911,747</b>	<b>7,888,070,000</b>
<b>2002 Chief Govt Chemist</b>				
260406 Post Mortem Expenses	2,600,000		433,674	
260408 Specialised supplies				33,000,000
<b>Sub-total Chief Govt Chemist</b>	<b>2,600,000</b>	<b>-</b>	<b>433,674</b>	<b>33,000,000</b>
<b>3001 Preventive services</b>				
260401 Vaccines	749,804,939		1,611,756,217	
260402 Drugs and Medicines	84,103,500			2,071,225,000
260405 Hospital Supplies				
160407 Laboratory Supplies				
260408 Specialised supplies	780,202,894	4,038,815,780	1,046,678,286	549,236,139
<b>Sub-total Preventive</b>	<b>1,614,111,333</b>	<b>4,038,815,780</b>	<b>2,658,434,503</b>	<b>2,620,461,139</b>
<b>4001 Tukuta</b>				
260407 Laboratory supplies	30,514,634	580,000	7,370,000	1,210,000
<b>Sub-total Tukuta</b>	<b>30,514,634</b>	<b>580,000</b>	<b>7,370,000</b>	<b>1,210,000</b>
<b>5001 Human Resource Devt</b>				
260407 Laboratory Supplies			6,300,000	
<b>Sub-total Human Resource Devt</b>	<b>-</b>	<b>-</b>	<b>6,300,000</b>	<b>-</b>
<b>Total MOH</b>				
260401 Vaccines	749,804,939	-	1,611,756,217	-
260402 Drugs and Medicines	10,673,110,600	1,600,000,000	10,067,883,667	6,071,225,000
260403 Special foods (diet food)	169,160,000	-	-	-
260404 Dental supplies	22,437,001	137,563,000	51,103,080	500,000,000
260405 Hospital Supplies	237,398,100	1,168,105,252	176,925,000	1,000,000,000
260406 Post Mortem Expenses	4,600,001	-	433,674	-
260407 Laboratory Supplies	280,514,634	580,000	110,670,000	501,210,000
260408 Specialised supplies	780,202,894	4,038,815,780	1,046,678,286	2,470,306,139
<b>Total MOH</b>	<b>12,917,228,169</b>	<b>6,945,064,032</b>	<b>13,065,449,924</b>	<b>10,542,741,139</b>

### Allocations from central level to health facilities

Drugs are provided to health facilities in a number of different forms. For most councils, the majority of the drugs for dispensaries and health centres are supplied in kit form. These are funded by two main sources: the DANIDA-supported Health Sector Programme Support (HSPS) which provides funds for the first quarter of each financial year in order to ensure availability in the event that government funding is delayed (as is often the case), and funds from the MOH recurrent budget (Department of Hospital Services). Due to delays in the system, the final allocation from the MOH may effectively fund the first of the new financial year, as shown in Table 30 below which is taken from a spreadsheet report submitted by Medical Stores Department to the Chief Pharmacist.

**Table 38 Allocations for drug kits by source, FY03**

Period	Funding	Amount	Tab
Jul - Aug 02	MOH Credit 6 of FY02	1,423,544,000	June2002
Sep - Oct 02	HSPS Credit 1 of FY03	1,604,500,000	SEPT2002
Nov 02	HSPS Credit 2 of FY03 and MOH Credit 1	798,070,000	Kits Credits
Dec 02	HSPS Credit 2 of FY03 and MOH Credit 1	798,070,000	Dec2002
Jan - Feb 03	MOH Credit 2 of FY03	1,596,920,000	JAN2003
Mar - Apr 03	MOH Credit 3 of FY03	1,498,600,000	MARCH03
May - Jun 03	MOH Credit 4 of FY03	1,498,600,000	May 03
<b>Total FY2002/03</b>		<b>9,218,304,000</b>	
<i>HSPS contribution</i>		<i>2,402,570,000</i>	
<i>MOH contribution</i>		<i>6,815,734,000</i>	

Note: The final column refers to the Tab within the spreadsheet which covers several financial years. This is an example of a potentially very useful report which is poorly formatted at present and would benefit rethinking by MOH officials.

In a small but increasing number of councils, an indent system is in place as a pilot **<<or is it now being rolled out?>>**, whereby an allocation is given to the council and drugs are requested according to need, ie a “pull” system rather than the “push” system of kits whereby the content is pre-determined and standardised.

The multiple sources of funding for drugs and supplies are captured to a varying degree on the budget, with some falling under the recurrent budget (eg regular GOT OC funds, and Health basket funds), and others in the Development budget (eg under Project 5407 Control of Communicable Diseases which is funded by several donors and the basket – development). Others are provided to technical/vertical programmes directly at the central level and are not captured in the official government budget documents, although they appear – to a variable extent – in the MOH MTEF, and the MOF External Finance database. A limited number are provided to councils direct by donors, again sometimes captured on-budget, but more often not.

*Note: It is not clear where the HSPS credit for drugs appears in the budget as there appears to be no sub-item 260402 in the Development Budget under project 6273, at least for FY04 which is the first for which sub-item codes are available.*

It has not been possible to go into sufficient depth during the PER update exercise to be confident that the figures presented in Section 2.5.1 are complete and accurate. However, this is a critical area in terms of priority spending in the sector, notably as availability of drugs in government facilities is usually the major factor in beneficiary assessment of quality and satisfaction.

In FY03, various formulae were introduced for the allocation of drugs and medical supplies between customers, whether hospitals or councils. For councils, it is assumed that these reflect the actual council population, while for hospitals a formula has been used, as described in Box 3 below.

### **Box 3 Allocation criteria for referral and special hospitals**

Drug allocations to hospitals other than District Hospitals (and DDH) are based on a formula which uses adjusted catchment populations as follows:

- Population up to 1,000,000: use actual population of the region
- Population 1,000,000 to 1,500,000: Multiply the population by 0.75 except Dar es Salaam region. Use Kinondoni population for allocation of funds to the three municipal hospitals
- Population 1,500,000 - 2,000,000: Multiply regional population by 0.70
- Population 2,000,000 - 2,500,000: Multiply regional population by 0.60
- Population over 2,500,000: Multiply by 0.50

Use of this formula merits wider discussion in the MOH and among partners as the basis for adjusting the catchment populations is not clear, and reasons for using a different formula from that recently introduced for local government recurrent basket grants need to be made explicit.