HEALTH SECTOR PUBLIC EXPENDITURE REVIEW 2010/11

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

Prepared by:
Directorate of Policy and Planning
Ministry of Health and Social Welfare
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HEALTH SECTOR
PUBLIC EXPENDITURE REVIEW
2010/11

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ACRONYMS

ADDOs	Accredited Drug Dispensing Outlets
AMO	Assistant Medical Officers
Bn	Billion
CC	City Council
CCHPs	Comprehensive Council Health Plans
CFS	Consolidated Fund Services
CHF	Community Health Fund
CIDA	Canadian International Development Agency
COIA	Commission for Information and Accountability
DC	District Council
DMO	District Medical Officer
DRF	Drug Revolving Fund
FY	Fiscal Year
Global Fund	Global Fund to Fight Aids, Tuberculosis and Malaria
HSDG	Health Sector Development Grant
HSF	Health Service Fund
HSSP	Health Sector Strategic Plan
JRF	Joint Rehabilitation Fund
LDGD	Local Government Development Grant
LGAs	Local Government Authorities
MC	Municipal Council
MDGs	Millennium Development Goals
MMAM	Primary Health Services Development Program
Mn	Million
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTEF	Medium-Term Expenditure Framework
NASA	National Aids Spending Assessments
NCDs	Noncommunicable Diseases
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NSGRP MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (National Strategy for Growth and Reduction of Poverty)

OC	Other Charges
PE	Personal Emoluments
PER	Public Expenditure Review
PFM	Public Financial Management
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
SWAp	Sector-Wide Approach
TB	Tuberculosis
TC	Town Council
TFIRs	Technical and Financial Implementation Reports
TIKA	Tiba kwa Kadi (urban equivalent of the CHF)
TZS	Tanzanian Shilling
USD	U.S. Dollar
WHO	World Health Organization

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EXECUTIVE SUMMARY

1. OBJECTIVES

The main objective of Health Sector Public Expenditure Review for fiscal year (FY) 2011 (PER FY11) was to assess the budgetary allocations and expenditures to inform stakeholders about progress made in key health financing milestones over the 2006/07–2011/12 period. Specifically, the Health Sector PER sets out to provide:

- A review of PER FY10 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions for FY11
- Analysis of the trend of recurrent and development budget and expenditures for the past five FYs
- Analysis of the trends in the sources of funding for the health sector for the past five FYs
- Analysis of budget and expenditure trends for the different sectoral and subsectoral levels including the central-local government split
- Assessment of budget performance (allocation versus actual spending) by classification (development and recurrent), funding sources (government funding and foreign funding), and different levels (central and local)
- Analysis of the core or priority areas/items of expenditure as highlighted in the Health Sector Strategic Plan III (HSSP-III) and the National Strategy for Growth and Reduction of Poverty (MKUKUTA)
- A detailed analysis of income and expenditure at the district level

2. KEY PER 2010/11 HIGHLIGHTS

Public health sector financing has more than doubled over the five-year period under review, but the share of the health budget in the total government budget still remains below the 15 percent recommended under the Abuja Declaration. The health sector budget has increased in nominal terms from TZS520 billion in 2006/07 to TZS1.164 trillion in 2011/12. However, the share of public spending on health out of total government expenditure (excluding Consolidated Fund Services [CFS]) declined from 13.1 percent in 2009/10 to 12.0 percent in 2010/11; while the share of public health allocation in the total government budget (excluding CFS) also declined from 12.3 percent in the 2010/11 budget to 10.0 percent in the 2011/12 budget. This level of expenditure (which includes donor funding) is below the Abuja target, despite the government's stated commitment to increase the share of health allocation in the budget to 15 percent of the total government budget.[1] In 2010/11, public health expenditures were only about 2.7 percent of GDP, while public health budgetary allocations were down to 2.8 percent of GDP in the 2011/12 budget compared to 3.5 percent of GDP in the 2010/11 budget.[2]

Per capita public health allocations have almost doubled in nominal terms between 2006/07 and 2010/11, but the real increase was only modest. Further, per capita health spending is still low, and falls significantly short of the World Health Organization

[1] Equinet has created a definition of how to measure progress toward the Abuja target, as it is just domestic financing. However, mathematically, if the overall financing envelope (domestic + foreign) doesn't meet the "Abuja target" as presented in this PER, then the domestic financing alone will be very far from it.

[2] Based on the available data, government funds to the health sector have oscillated between 1.6–1.9 percent of GDP for actual health spending.

(WHO)-recommended target of USD54 to address health challenges, and is well below the HSSP-III projections of USD15.75 per capita spending by 2009/10. In nominal terms, public health allocations per capita increased by 108 percent from TZS13,785 (USD11) in 2006/07 to TZS28,673 (USD19.80) in 2010/11 before falling (by 7 percent) to TZS26,563 (USD17.30) in 2011/12. Actual per capita health spending increased by 58 percent from TZS13,698 (USD11) in 2006/07 to TZS21,635 (USD14.90) in 2010/11. In real terms, however, per capita allocations for health increased by 70 percent from TZS9,069 (USD7.30) to a peak of TZS15,425 (USD10.60) in 2010/11 before falling to TZS13,348 (USD8.70). Actual public health per capita expenditures rose from TZS9,012 (USD7.20) to a peak of TZS12,818 (USD8.80) in 2009/10, and down to TZS11,639 (USD8) in 2010/11, which is a 10 percent decline.

Government funding remains the dominant source of health sector financing, but the share of foreign financing in health has increased noticeably during the period under review.[3] Government contribution to health expenditures declined from 71 percent in 2006/07, reaching a low of 53 percent in 2010/11, and is estimated at 59 percent of the 2011/12 budget. However, because of much higher execution of local funds in the implementation of the budget, the share of government funds in the actual health spending has always remained above 60 percent throughout the review period. The share of external health financing increased from 29 percent in the 2006/07 budget to a maximum of 47 percent in the 2010/11 budget, and is estimated at 41 percent in the 2011/12 budget. Also, it is worth noting that foreign funding still accounts for a dominant (88.8 percent) share of the development budget in health interventions. This trend points to a potential threat to the sustainability of health sector financing in case of unanticipated declines in donor funding in the sector.

The performance of the health sector budget execution was satisfactory throughout the review period, but it still remains vulnerable to low execution of foreign funds, and persistent challenges in the execution of the development budget, notably the low absorption capacity of spending units, non-release of funds, delays in the release of funds, and lengthy and cumbersome procurement processes. The execution of the health sector budget was generally good throughout the review period, with annual average execution of 91 percent, except for 2010/11 when only 75 percent of the budgeted funds were utilized. The performance of the recurrent budget has been generally higher than the development budget, which recorded a very low execution of 57 percent in 2010/11. Performance of government funds was generally higher than foreign funds for the past three fiscal years. With regard to foreign funds, the execution of basket funds was better than the non-basket funds, which recorded a very low execution of 51 percent in 2010/11. Budget performance continues to be hindered by among other factors: the low absorption capacity of the spending units; delays in the release of funds; non-release of the funds; over-ambitious budgeting (given the past performance); and lengthy and cumbersome procurement processes, which affect particularly the implementation of development projects.

The overall performance of the recurrent budget for the Ministry of Health and Social Welfare (MoHSW) departments is excellent (92.7 percent), except for the Social Welfare and Finance and Accounts Departments that only have average performance, and the Internal Audit Department, which has poor performance with an execution of only about 34 percent. The poor performance of the Audit Department is due to non-release of the allocated funds. Non-release of funds to the Audit Department threatens the functioning of the unit and the entire public financial management (PFM) system of the MoHSW.

Health sector financing continues to be concentrated at the central level, and the pace towards decentralization has slowed in 2011/12. However, there is a significant share of

[3] These findings are different from those reported in the National Health Accounts because private contributions are not included.

health financing that is centrally controlled, but goes to the local level in the form of pharmaceutical and medical supplies. The share of public health financing controlled at the central level has declined generally, from 64 percent in 2006/07 to 60 percent in 2011/12. However, if the pharmaceutical component is excluded from the central spending, the share of health financing controlled at the central level goes down to 37 percent in 2011/12. The share of medicines, which eventually go to the local level, has increased from 15 percent of the health budget in 2006/07 to 28 percent in 2010/11, before declining to a projected 20 percent of the health budget in 2011/12.

The other sources of funding at the local level (which are mostly off-budget) increased from 7 percent in 2009/10 to 14 percent of the council budget in the 2010/2011. Actual expenditure from councils' own resources remained constant at 2 percent, which raises a concern about the sustainability of health interventions should there be a shock to the funds from the central level (government and development partners).

Complementary health financing continues to grow in importance, but only a small proportion of the Tanzanian population (about 14 percent) is currently insured with the National Health Insurance Fund (NHIF) and Community Health Fund (CHF) based on the current estimates from NHIF reports. Between 2007/08 and 2010/11, receipts from the Health Service Fund (HSF) have almost doubled. Although this could be reflecting an increase in population, it is also reflecting the fact that majority of the population is not insured; only 14 percent of Tanzanians are insured (NHIF and CHF combined). Further, the HSF still has unspent balances, which in 2010/11 were equivalent to 20 percent of the receipts, a decline from 26 percent observed in 2009/10. In both 2009/10 and 2010/11, more was spent than collected which resulted in the decrease of the unspent balance. NHIF continues to accumulate huge reserves although compared to 2008/09 figures, they have declined from 63 percent to 59 percent of the total annual income. These funds (HSF and NHIF) should be used to improve health services promptly while maintaining prudent, actuarially determined reserves. Holding very large reserves defeats the whole purpose of collecting these funds.

Following the accreditation of the Drug Dispensing Outlets, and improvements in the procurement of medicines by the Local Government Authorities (LGAs) from the Medical Stores Department (MSD), access to tracer drugs has significantly improved in the LGAs. Access to tracer drugs from the sampled health facilities was found to be high. This reflects efforts made by councils in procuring medicines from the Medical Stores Department but also accrediting Part I Pharmacies and Accredited Drug Dispensing Outlets (ADDOs) to serve the NHIF/CHF clients. These pharmacies and ADDOs are key conduits for making medicine accessible to rural marginalized areas, and more efforts should be made to work with ADDOs. This is also an area where the CHF funds could be used effectively.

Following the improvement in the budget allocation for training and deployment of human resource for health, the overall human resource gap has narrowed to 41 percent in 2010/11 from 65 percent in 2006/07. The improvement in budget allocation for training and deployment of human resources for health has helped in bringing the overall human resource gap down to 41 percent in 2010/11. In terms of cadres, the gap for assistant medical officers (AMOs) has almost closed (73 percent available), followed by laboratory technicians (63 percent available), but the shortage of dentists and pharmacy technicians still persists (only 35 percent and 59 percent available, respectively).

3. RECOMMENDATIONS

1. Despite the government's stated commitment to increase the share of health sector financing in the government budget to at least the 15 percent recommended in the Abuja Declaration, this has yet to be achieved, and the share has fallen below 12 percent in 2011/12. It is important that this commitment is honored with the deserved political will if progress is to be made in addressing the key challenges in the sector, particularly in human resources (recruitments to fill the existing gap identified in the HSSP-III and retention of workers) and infrastructure.
2. Execution of the development budget continues to be plagued by several impediments, including: low absorption capacity; non-release or delayed release of funds; and complexities in the procurement processes. Efforts should be increased to address these impediments to ensure smooth implementation of the budget.
3. Although the delivery of health services is largely concentrated at the local government level, the largest share of health sector financing is still managed at the central level. Despite this observation, it is worth noting that a significant portion of the funds managed at the central level eventually goes down to the local level, particularly in the form of drugs and medical supplies. Nonetheless, the process of decentralization should be expedited, with particular focus on capacity strengthening for local government authorities in the areas of financial management and procurement.[4]
4. The poor performance of the Internal Audit Unit of MoHSW due to non-release of the allocated funds threatens the functioning of the department and the entire PFM system of the MoHSW. Thus, it is imperative to release funds as budgeted so as to enable the unit to perform its functions effectively.
5. Efforts to promote enrollment of households in the CHF are evident at different levels. Lessons from best-performing districts and programs such as Tanzanian German Program to Support Health and the Swiss Development Cooperation-funded CHF Strengthening program in Dodoma should be harnessed and applied nationwide. The major actors here include NHIF and LGAs.
6. Accreditation of Part I Pharmacies and ADDOs to serve the NHIF/CHF clients is an excellent move. These pharmacies and ADDOs are key conduits for making medicine accessible to rural, marginalized areas and more efforts should be made to work with ADDOs. The NHIF and Tanzania Food and Drugs Authority are key actors here.
7. The government should intensify efforts to strengthen the linkages between CHF and NHIF in working towards universal coverage.

[4]See World Bank (2011), *Basic Health Services Project* on capacity-building mechanisms to improve the capacity of local governments to manage their health services, including training and systems strengthening interventions, with a focus on improved PFM.

1. INTRODUCTION

In the National Strategy for Growth and Reduction of Poverty (Kiswahili acronym MKUKUTA), the government aims to improve people's health by building stronger capacities to prevent and cure diseases. MKUKUTA points to the need to increase the population's access to health care and scale up efforts to reduce child and maternal mortality and eliminate malnutrition. Following the adoption of the new Health Policy in 2007 and the design of a Health Sector Strategic Plan III (HSSP-III) (2009–2015), access to health services has increased, though modestly. New health facilities (dispensaries, health centers, and hospitals) have been constructed, and availability of equipment and medicines has improved. However, although there have been modest gains in the health sector over the past decade – notably the decline in maternal and infant mortality and a decline in the prevalence of HIV/AIDS and tuberculosis (TB) – there are persistent challenges, particularly with regard to adequacy and quality of health services, and shortages of skilled personnel. Addressing these challenges requires commitment to allocate adequate resources to the sector and ensure efficient utilization.

After two years of implementation of the HSSP-III, the Health Sector Public Expenditure Review (PER) for fiscal year (FY) 2011 provides a hands-on tool to immediately track the progress made in key health financing indicators, identify challenges, and make relevant recommendations for successful implementation of the strategy. The health systems approach adopted by HSSP-III prioritizes certain key areas aiming to improve the performance of the health sector, including: infrastructure expansion and improvement; strengthening referral services; increasing the number and quality of human resources; improving management capacity at the council level; and increasing and broadening mechanisms of health financing. These interventions provide the framework for planning, budgeting, and allocation of resources in the health sector, as efforts continue to reverse the poor health status indicators, contribute toward poverty reduction and attainment of growth objectives of the country, and realize the Millennium Development Goals (MDGs).

The Health Sector PER FY11 sets out to assess the budgetary allocations and expenditures to inform stakeholders about progress made in key health financing milestones over the 2006/07–2011/12 period. Specifically, the PER FY11 provides:

- A review of PER FY10 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions for FY11
- Analysis of the trend of recurrent and development budget and expenditures for the past five fiscal years
- Analysis of the trends in the sources of funding for the health sector for the past five fiscal years
- Analysis of budget and expenditure trends for the different sectoral and subsectoral levels including the central-local government split
- Assessment of budget performance (allocation versus actual spending) by classification (development and recurrent), funding sources (government funding and foreign funding), and different levels (central and local)
- Analysis of the core or priority areas/items of expenditure as highlighted in the HSSP-III and the MKUKUTA
- A detailed analysis of income and expenditure at the district level

This review is informed by data collected from both the central-level institutions and Local Government Authorities (LGAs). The central-level institutions include: the Ministry of Finance

(MoF); the MoHSW; the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG), and the National Health Insurance Fund (NHIF). Data from the LGAs were collected from, among other sources, the Comprehensive Council Health Plans (CCHPs) and Technical and Financial Implementation Reports (TFIRs). From the sampled seven districts, data were collected from the District Medical Officer (DMO) offices and sampled hospitals, health centers, and dispensaries.

The PER FY11 is organized in six chapters. After the introduction in Chapter 1, the second chapter presents a review of PER FY10 recommendations and follow-up actions. Chapter 3 summarizes trends in overall public health spending (trends in the total public health budget and expenditures) and various subsector trends, with some detailed analysis of particular recurrent expenditure items and the development budget. Budget execution at different levels, expenditure by MoHSW departments, and expenditure by key intervention areas is also presented in this chapter. Analysis of the contribution of complementary financing in health care financing is presented in Chapter 4. Chapter 5 gives an overview of budgets and expenditures in 125 districts and a detailed assessment of the financial flows in seven tracked councils. Chapter 6 points out key messages from the analysis and provides recommendations for the way forward.

2. REVIEW OF PER FY09 RECOMMENDATIONS AND ACTIONS TAKEN

The main recommendations of the PER FY10, together with actions planned and/or taken during FY11, are presented in Table 2.1.

TABLE 2.1: IMPLEMENTATION STATUS OF THE PER FY10 RECOMMENDATIONS

	Recommendation from the 2010 PER Report	Actions Taken
1.	Increase the government allocation to health in order to decrease donor dependency. Increased allocations are also needed to curb the decreasing trend as observed from 2009/10.	MoHSW is currently preparing the Health Sector Mid-to-Long Term Financing Strategy, which will lay out alternative sustainable financing sources. The strategy will be ready by the end of 2012. Nevertheless, it is important to note the challenge in ensuring a balanced allocation of meager resources across competing priorities – the health sector being one – and to underscore the fact that the health status of the population is determined by more than initiatives in the health sector alone and therefore financing these other sectors, including water and sanitation, education, and agriculture, should be considered in a comprehensive manner.
2.	Improve the execution of the development budget, which is still characterized by poor implementation capacity in the health sector and delays in the disbursement of some of the donor resources.	Delays in disbursement of funds have persisted, although there is some improvement on releases from the government (See Chapter 3, Health Budget and Expenditure Analysis).
3.	Assess the factors hindering the Health Service Fund (HSF) from being fully utilized, in order to increase the HSF absorption capacity.	The MoHSW is about to embark on a review mission, among others, to assess factors hindering absorption of HSF funds. Strategies to improve the performance of HSF funds will be identified during this mission. The review will be done in two districts selected from each region. The review is one of the 2012/13 milestones.
4.	Streamline the NHIF reimbursement process to tap surplus funds for supporting health care delivery. In light of this, there is a need to review the NHIF reimbursement procedures and levels, prices, and the benefit package, in order to enhance fully the utilization of the opportunities provided by NHIF in financing care.	This recommendation will be tabled and considered after getting the recommendations from the Actuarial Valuation Study, which was commissioned by NHIF in June 2010 but the findings have not been disseminated. Also, a costing study which is envisaged will enable the MoHSW to review prices, especially for the public facilities, and align them more closely with the real cost of services. In trying to ease the payment process, NHIF has started to open zonal offices. This has reduced the time required from claim to receipt of the check. Starting next year NHIF will open regional offices in all regions throughout the country. This will simplify the payment process even further, as regions are nearer to the clients.

	Recommendation from the 2010 PER Report	Actions Taken
6.	TIKA (the urban equivalent of the Community Health Fund [CHF]) has been rolled out in only three councils (Tanga City Council, Dodoma Municipal Council [MC], and Moshi MC). It has however been noted that these cities did not follow the proposed TIKA modality. What has been introduced in these MCs follows the CHF principles. It is imperative to roll out TIKA in Dar es Salaam as the model city due to its complexities, and further apply lessons learned to other cities.	A study has been commissioned to collect public perceptions toward TIKA establishment at Temeke MC. The study will provide recommendations on strategies to improve the performance of TIKA. Based on these recommendations, TIKA will be launched in Dar es Salaam in July 2012.
7.	Consider developing a resource-tracking database to improve reporting systems and data availability for monitoring financial resource inflow and expenditures. This will institutionalize the PER and other resource tracking initiatives such as National Health Accounts (NHA) and National AIDS Spending Assessments (NASA).	There are efforts from government and various partners to support the institutionalization of a health expenditure-tracking database. This is in line with implementation of the recommendations of the Commission for Information and Accountability (COIA) for Women's and Children Health. PlanRep II* has been introduced and training given to all councils throughout the country. The plan is to introduce a database which will be linked with all PlanRep in the councils. The World Health Organization (WHO) and Canadian International Development Agency (CIDA) intend to support this activity.
8.	Simplify the procedures for LGAs to access the budgeted funds from own sources earmarked for health. Also, barriers should be minimized to make CHF funds more accessible to the health facilities.	As mentioned above, the MoHSW is about to embark on a review mission among others to assess factors hindering absorption of HSF funds. Recommendations from this study will also be used to develop strategies to improve the performance of budgeted funds from own sources and CHF.
9.	Ensure timely releases of funds from the Treasury to the LGAs for all expenditure categories including the other charges, to improve health budget execution in the LGAs.	Efforts have been made toward ensuring timely release of the funds. However, under the cash budget system, not much can be done if collected revenue is short of the envisaged allocations.
10.	Ensure timely flow of information about transfer of funds and purpose of those transfers from the Treasury to the District Executive Director, and to the DMO, to reduce the misallocation of health funds at LGA level. This is especially important in light of the new consolidation of bank accounts at the LGAs.	PMO-RALG organized trainings which involved Regional Health Management Teams, Council Health Management Teams, Council Treasurers, and District Planning Officers, to discuss the new CCHP guidelines, PlanRep III, and how to improve the flow of financial information.
11.	In addressing inequality in spending, efforts should be made to use the agreed-upon resource allocation formula.	The MoHSW, in collaboration with health sector partners, has started to review the resource allocation formula. The revised formula is expected to be ready by the end of 2012. Since the process would be consultative and inclusive it is expected that all stakeholders will adhere to the formula. This is particularly so since the new formula will be comprehensive; it will include (as much as possible)all concerns from the stakeholders.
12.	Commission a study to assess 10 years for Sector Wide Approach (SWAp) arrangements to show impact (if any) in the financing of the health sector, with regard to the level and	Discussion with health sector partners on mid-term review of HSSP-III is ongoing. Review of SWAp approach and its impacts will be one of the terms of reference in the review. Further, MoF is undertaking a study on sectors' coordination for General Budget

	Recommendation from the 2010 PER Report	Actions Taken
	composition of funding, the financing agents, and alignment of partner systems with the government.	Support and Basket Fund.
13.	In the next PER, effort should be made to unpack development expenditures in order to estimate how much is spent on real capital investment and the amount of recurrent expenditures within the development expenditures.	See Chapter 2 of the Macro PER for the reclassification of the health budget in terms of the split between wages, non-wage recurrent, and true capital spending.

* Plan-Rep is the Planning and Reporting software used by all LGAs to prepare annual plans and budgets. It has a reporting component that allows councils to report on the financial implementation of their budgets in accordance with the objectives, targets, and activities in the budget plan.

3. HEALTH BUDGET AND EXPENDITURE ANALYSIS

3.1 INTRODUCTION

This chapter presents an assessment of public health budget and expenditure trends between 2006/07 and 2010/11. The chapter also evaluates the sector budgetary absorptive capacity and resource allocation to key priority areas to support the HSSP-III and MKUKUTA. The focus of this chapter is on public health sector outlays that are financed by the government of Tanzania and by development partners (through health basket and non-basket mechanisms), households (through official user fees paid at public facilities), and insurance contributions. The data used to carry out the analysis is appended at the end of this report (Annex A). Annex B provides the list of key terminologies used in this PER.

3.2 TOTAL PUBLIC HEALTH SPENDING

Total public health actual spending increased significantly from TZS520 billion in 2006/07 to TZS924 billion in 2010/11, and is projected to increase further toTZS1.164 trillion in 2011/12.That is, between 2006/07 and 2011/12 there has been a 124 percent increase in the public health budget in nominal terms, and a 78 percent increase in nominal actual public health spending. However, in real terms, the total health budget increased by only about 71 percent, from TZS342 billion in 2006/07 to TZS585 billion in 2011/12; while actual public health spending increased by only 46 percent in real terms over the period to 2010/11.

The share of public health budget in total government budget, excluding the Consolidated Fund Services (CFS),was 12.3 percent in 2010/11 but has declined to 10.0 percent in 2011/12.With the CFS included, the share of health budget actually fell from 10.5 percent in 2010/11 to a mere 8.6 percent in 2011/12. Similarly, the share of actual health spending in total government spending (excluding CFS) declined from 13.1 percent in 2009/10 to 11.9 percent in 2010/11, while with CFS included the decline in the share of health spending was rather modest from 9.9 percent in 2009/10 to 9.5 percent in 2010/11. Figure 3.1 shows the trends of public health budget and actual spending in nominal and real terms between 2006/07 and 2011/12. Figure 3.2 shows the share of public health budget and expenditure in the total government budget, including and excluding CFS. It is quite clear that the share of government budget that goes to the health sector has not kept pace with general government spending between 2005/06 and 2009/10, and only increased in 2010/11 before falling back to pre-2005/06 levels.

FIGURE 3.1: PUBLIC HEALTH BUDGET AND EXPENDITURE TRENDS (BN TZS)

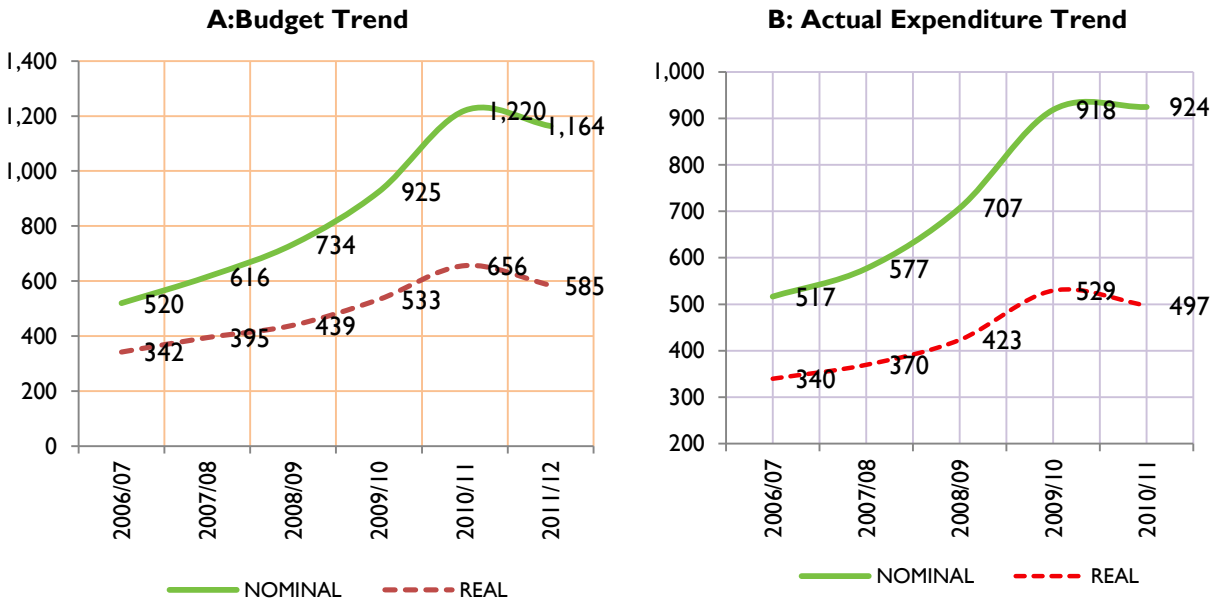
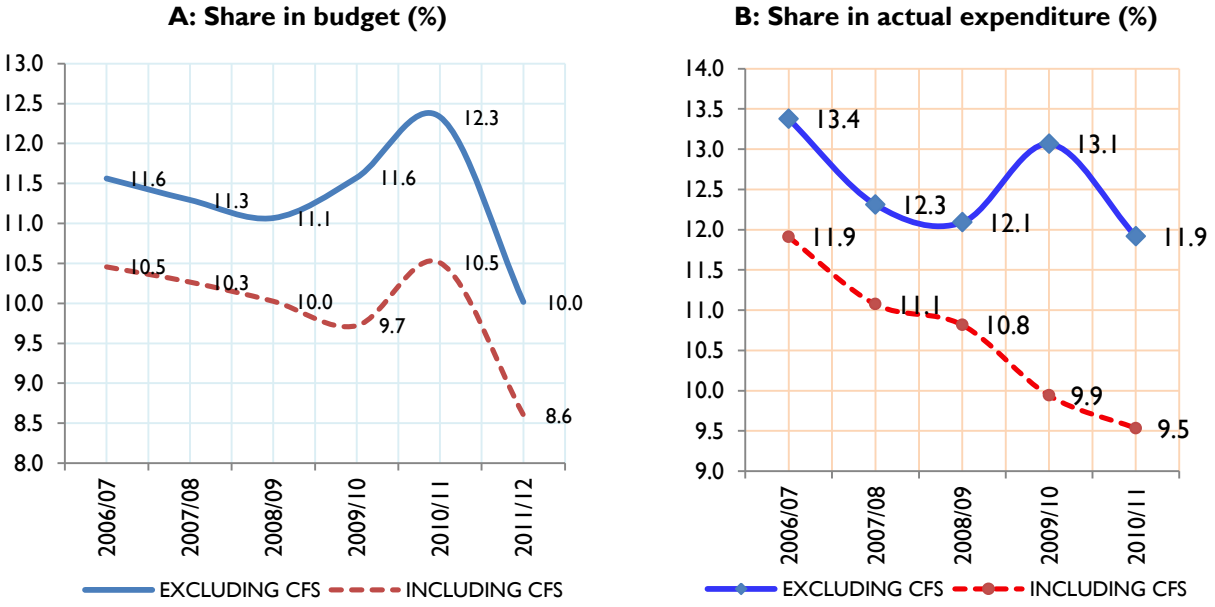


FIGURE 3.2: HEALTH SHARES IN GOVERNMENT BUDGET AND EXPENDITURE



In line with the increase in public health budget and expenditures over the past five years, in nominal terms, public health allocations per capita also increased, from TZS13,385 (USD11) in 2006/07 to TZS28,673 (USD19.80) in 2010/11, before falling to TZS26,563 (USD17.30) in 2011/12. Actual per capita health spending increased from TZS13,698 (USD11) in 2006/07 to TZS21,635 (USD14.90) in 2010/11. In real terms, however, the increase was only modest, from TZS9,069 (USD7.30) to a peak of TZS15,425 (USD10.60) in 2010/11, and then down to TZS13,348 (USD8.70) per capita for public health allocations; and from TZS9,012(USD7.20) to a peak of TZS12,818 (USD8.80) in 2009/10, and down to TZS11,639(USD8) per capita for actual public health expenditures. Table 3.1 summarizes the indicators of aggregate health financing in Tanzania from 2006/07 to 2011/12.

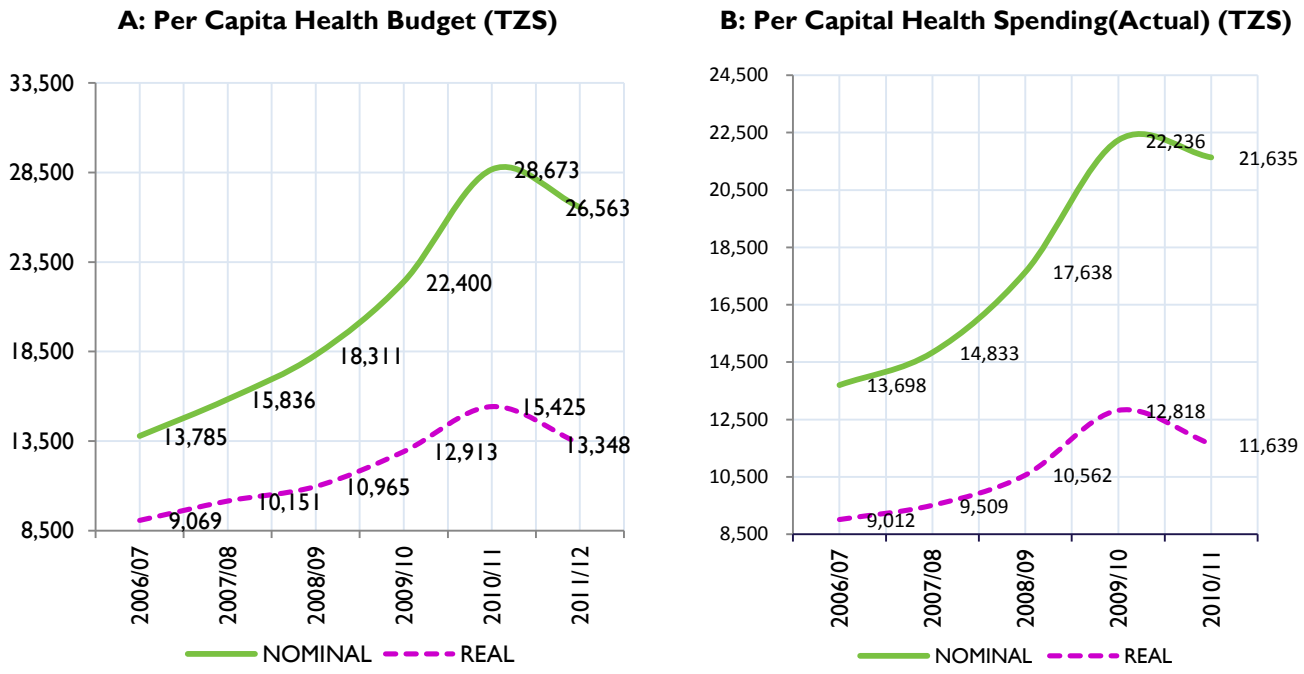
TABLE 3.1: INDICATORS OF PUBLIC HEALTH FINANCING

DESCRIP-TION	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
(BILLION TZS)											
Total govt. expenditure: excl. CFS	4,496	3,862	5,452	4,685	6,631	5,847	7,994	7,029	9,891	7,724	11,616
Total govt. expenditure: incl. CFS	4,972	4,338	5,998	5,209	7,320	6,536	9,517	9,239	11,609	9,655	13,525
Total health spending (nominal)	520	517	616	577	734	707	925	918	1,220	924	1,164
Real health spending	342	340	395	370	439	423	533	529	656	495	585
SECTOR WEIGHTS											
Share of health spending: excl. CFS	12%	13%	11%	12%	11%	12%	12%	13%	12%	12%	10%
Share of health spending: incl. CFS	10%	12%	10%	11%	10%	11%	10%	10%	11%	10%	9%
Health spending as % of GDP	2.7%	2.7%	2.7%	2.5%	2.8%	2.7%	3.1%	3.0%	3.5%	2.7%	2.9%
OTHER AGGREGATE INDICATORS											
Per capita health spending (TZS)	13,785	13,698	15,836	14,833	18,311	17,638	22,400	22,236	28,673	21,635	26,563
Per capita health spending (USD)	11.0	11.0	12.5	11.8	13.3	13.5	15.4	15.3	19.8	14.9	17.3
Real per capita (TZS)	9,069	9,012	10,151	9,509	10,965	10,562	12,913	12,818	15,425	11,639	13,348
Real per capita (USD)	7.3	7.2	8.0	7.5	8.0	8.1	8.9	8.8	10.6	8.0	8.7
GDP (current price) Billion TZS	19,445	19,445	22,865	22,865	26,497	26,497	30,253	30,253	34,629	34,629	39,519
MEMORANDUM ITEMS											
Population (million)	37.7	37.7	38.9	38.9	40.0	40.0	41.3	41.3	42.5	42.5	43.8
Exchange rate	1249.2	1249.9	1262.3	1262.3	1374.3	1309.6	1450.0	1450.0	1450.0	1450.0	1539.0

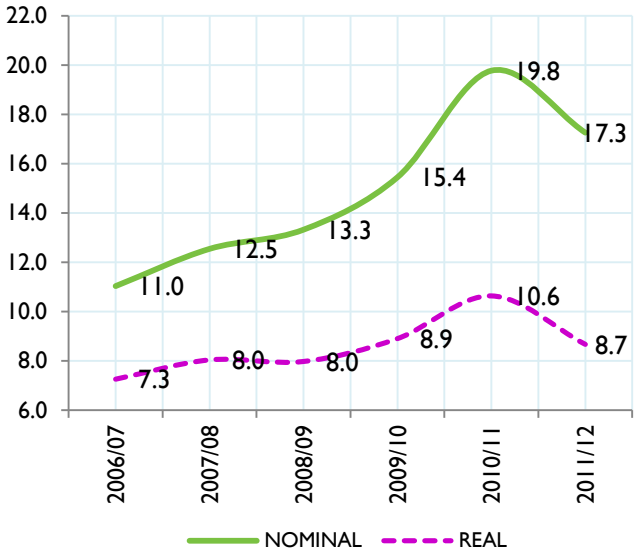
DESCRIP-TION	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Deflator	1.52	1.52	1.56	1.56	1.67	1.67	1.73	1.73	1.86	1.86	1.99

Figure 3.3 presents trends in per capita public health budget and actual spending in nominal and real terms. It is worth noting that per capita health budget and expenditures have increased consistently in nominal terms during the review period, except for the 5 percent decline in 2011/12 from the previous budget. However, in real terms, per capita health allocations have remained below TZS14,000, while per capita health expenditures have also remained below TZS12,000 throughout the review period. Because of domestic inflation and depreciation of the shilling, the estimated per capita health budget and expenditures in real terms have consistently remained below USD10 throughout the review period.

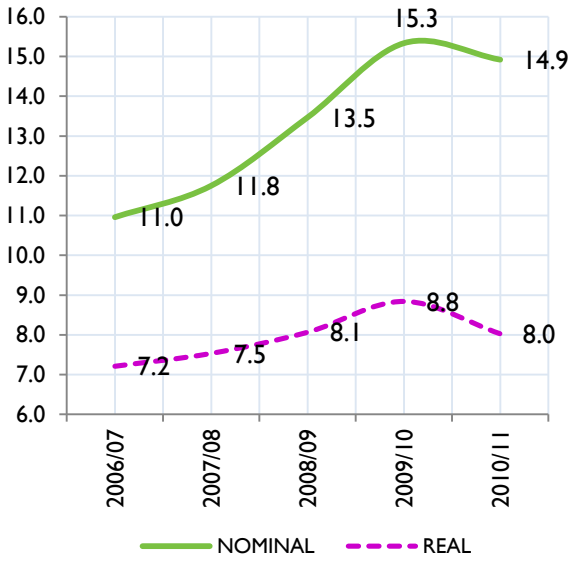
FIGURE 3.3: TRENDS OF PER CAPITA PUBLIC HEALTH BUDGET AND EXPENDITURE



C: Per Capita Health Budget (USD)



D: Per Capita Health Spending (Actual) (USD)

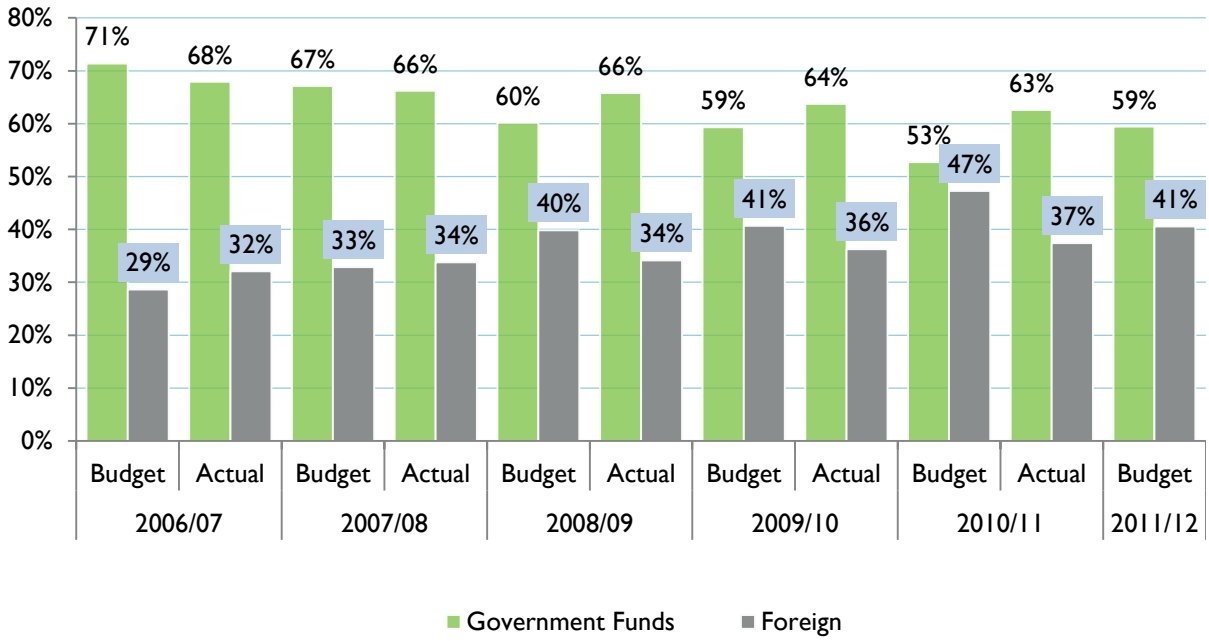


3.3 SOURCES OF FUNDS FOR THE PUBLIC HEALTH EXPENDITURE

Government funding remains the dominant source of public health financing, but the share of foreign funding in the health budget has increased significantly from 29 percent(TZS164 billion) in 2006/07 to 41 percent(TZS340 billion) in 2011/12, matched by a corresponding decline in government funding from 71 percent to 59 percent over the same period.5Government funds in the health budget increased from TZS371 billion in 2006/07 to TZS692 billion in 2011/12, while actual spending of government funds in health increased from TZS349 billion in 2006/07 to TZS569 billion in 2010/11. In absolute terms, the budget of foreign funding in health more than tripled, from TZS149 billion in 2006/07 to TZS472 billion in 2011/12. The biggest increase in foreign funding happened in the non-basket component, increasing more than six-fold from TZS49 billion in 2006/07 to TZS313 billion in the 2011/12 health budget. The main driver of this increase is the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Figure 3.4 portrays the shares of government funding and foreign resources in health financing.

[5] As noted earlier, these percentages are different from those reported in the NHA because private contributions are not included.

FIGURE 3.4: GOVERNMENT AND FOREIGN CONTRIBUTION TO HEALTH EXPENDITURES



Basket funds in the health budget increased from about TZS100 billion in 2006/07 to TZS157 billion in 2011/12, and recorded a peak of TZS161 billion in 2010/11. The dominance of non-basket foreign funding clearly indicates that development partners, notably the Global Fund and PEPFAR, are increasingly channelling their support to the health sector through projects. This trend poses challenges, especially regarding aid coordination and harmonization in health interventions, and the government should be seen to be in the driver's seat in directing funding to mutually agreed priorities. Off-budget health financing, which is composed largely of the HSF (in the form of official user fees), increased from TZS3 billion in 2006/07 to TZS14 billion in 2010/11.Table 3.2 presents a summary of government and donor funds in health budget and expenditures from 2006/07 to 2011/12.

TABLE 1.2: SOURCES OF HEALTH FINANCING (MN TZS)

	2006/07	**2007/08**	**2008/09**		**2009/10**		**2010/11**		**2011/12**
	Actual	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**
Government funds	348,890	378,114	459,495	461,504	548,658	578,682	643,011	569,494	691,628
Foreign funding	164,716	192,960	304,098	239,569	376,441	328,845	576,797	340,425	471,946
Basket	103,204	80,957	99,730	85,401	121,640	128,796	160,596	126,446	158,613
Non-basket	61,512	112,003	204,368	154,168	254,801	200,049	416,201	213,979	313,333
Off-budget	2,964	5,696	-	5,858	-	10,784	-	14,212	-
Grand total	**516,570**	**576,770**	**763,593**	**706,931**	**925,099**	**918,311**	**1,219,808**	**924,131**	**1,163,574**

3.4 TRENDS IN RECURRENT AND DEVELOPMENT EXPENDITURES

During the review period (2006/07–2011/12), the development budget increased from TZS122 billion to a peak of TZS641 billion in 2010/11 (a 425 percent increase), before sliding back to TZS532 billion in the 2011/12 budget. Actual development expenditure also increased about threefold from TZS122 billion in 2006/07 to TZS369in 2010/11. The development budget in 2010/11 (TZS641 billion) was higher than recurrent budget (TZS579 billion) because large amounts of resources from the Global Fund were classified as development budget allocations. However, the development budget does not only contain "development spending" in the sense of investment spending, but had a significant component of recurrent spending that could not be separated within the scope of this PER.6 Although the development budget was higher than the recurrent budget, actual recurrent spending (TZS541 billion) was higher than actual development spending (TZS369). The recurrent budget has grown consistently throughout the review period, increasing by 59 percent from TZS398 billion in 2006/07 to TZS632 billion in 2011/12. Table 3.3 presents a summary of the development and recurrent budget and actual expenditures from 2006/07 to 2011/12.

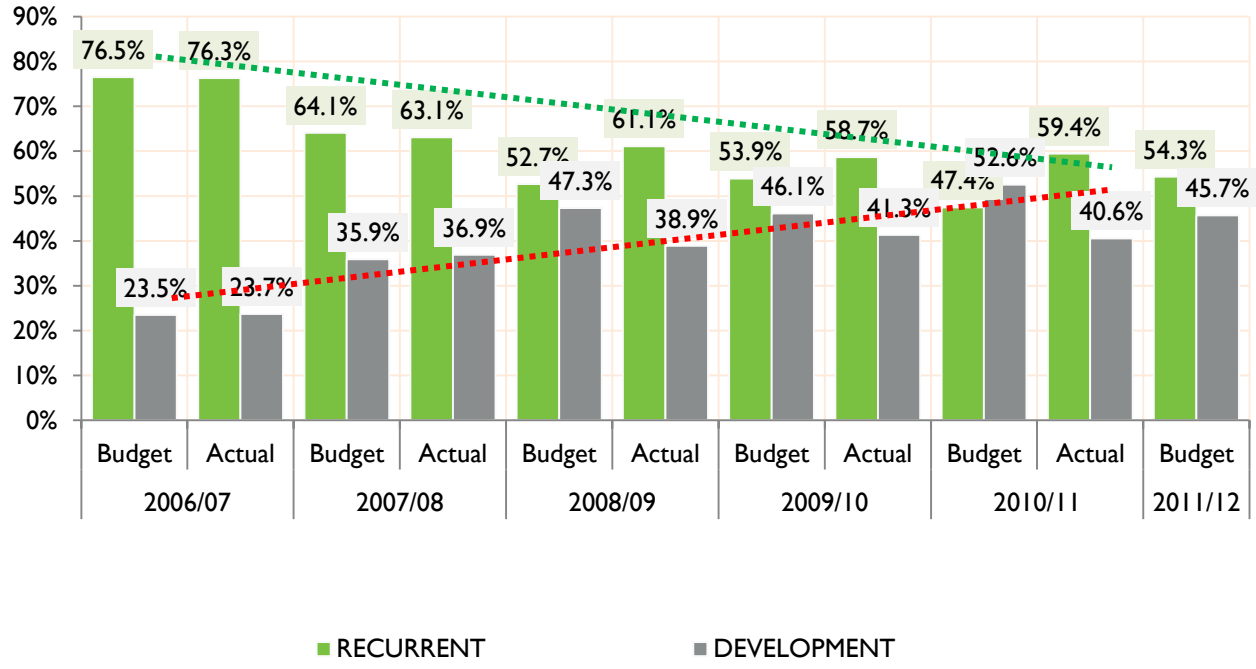
TABLE 3.3: SUMMARY OF RECURRENT AND DEVELOPMENT BUDGET AND EXPENDITURES (BN TZS)

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Budget	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**
Recurrent	398	392	395	360	402	429	499	533	579	541	632
Development	122	122	221	211	361	273	426	375	641	369	532
Total	520	514	616	571	764	701	925	908	1,220	910	1,164
Percentage of Total											
Recurrent	76.5%	76.3%	64.1%	63.1%	52.7%	61.1%	53.9%	58.7%	47.4%	59.4%	54.3%
Development	23.5%	23.7%	35.9%	36.9%	47.3%	38.9%	46.1%	41.3%	52.6%	40.6%	45.7%

Following faster growth in the development budget and expenditures relative to recurrent budget and expenditures, the share of the development budget has increased significantly from 23.5 percent in 2006/07 to 45.7 percent in 2011/12. Also, the share of development actual expenditure increased from 23.7 percent in 2006/07 to 40.6 percent in 2010/11. Figure 3.5 presents the trend of the relative shares of development and recurrent budget and expenditures during the period under review.

[6]A detailed analysis of the recurrent expenditure within development expenditure is available in the Tanzania Public Expenditure Review 2011, Chapter 2(Public Expenditure Review in the Health Sector), Dar es Salaam, May, 2012, Draft.

FIGURE 3.5: TREND OF SHARES OF RECURRENT AND DEVELOPMENT BUDGET AND EXPENDITURES



3.5 PERFORMANCE OF THE HEALTH SECTOR BUDGET

Table 3.4 presents budget performance indicators over the period 2006/07–2010/11, summarized according to budget classification (recurrent and development budget), and sources of funds (government and foreign funds).

TABLE 3.4: BUDGET EXECUTION PERFORMANCE INDICATORS

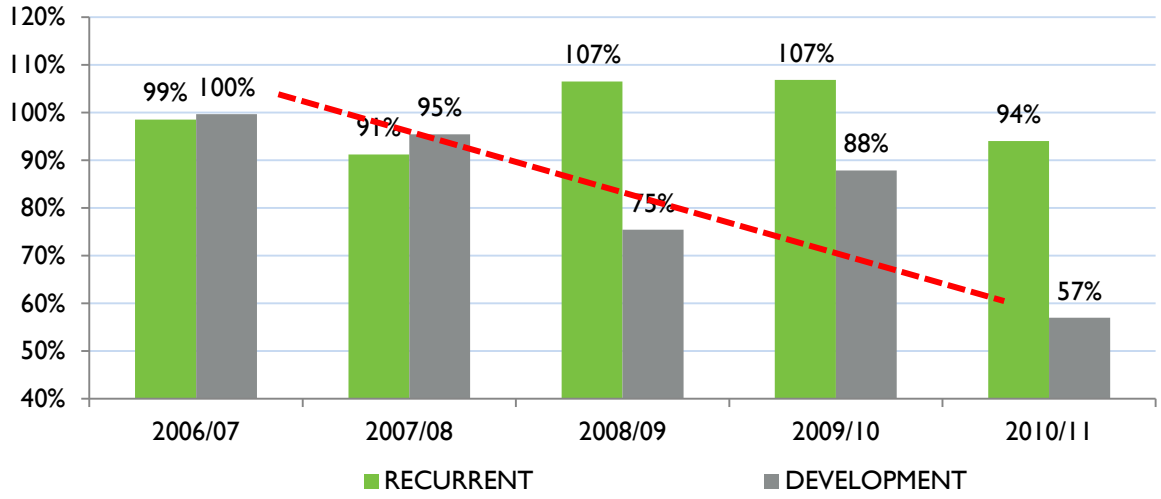
	2006/07	2007/08	2008/09	2009/10	2010/11
Execution of total budget	99%	93%	92%	98%	75%
Execution of recurrent budget	99%	91%	107%	107%	94%
Execution of development budget	100%	95%	75%	88%	58%
Execution of government funds	94%	91%	100%	105%	89%
Execution of foreign funds	111%	95%	79%	87%	59%
Execution of basket funds	103%	100%	86%	106%	79%
Execution of non-basket funds	126%	92%	75%	79%	51%

3.5.1 PERFORMANCE OF RECURRENT AND DEVELOPMENT BUDGET

In general, performance of the health sector budget has been satisfactory throughout the review period, with an average annual execution rate of about 91 percent. However, the execution of the budget in 2010/11 was only 75 percent, the lowest recorded in the past five years. The execution of the recurrent budget has consistently exceeded 90 percent throughout the review period, and in 2007/08 and 2009/10 the performance was 107 percent, which is a reflection of the utilization of

funds after budget reallocations,7 based on the updated information. After 100 percent performance in 2006/07 and 95 percent in 2007/08, the execution of the development budget fell to 75 percent in 2008/09, and even lower, to 57 percent, in 2010/11. The execution performance of the development budget has been generally lower than for the recurrent budget, partly attributable to the lengthy and difficult procurement procedures which cause delays in the implementation of the development budget. Figure 3.6 shows the trend of recurrent and development budget performance.

FIGURE 3.6: RECURRENT AND DEVELOPMENT BUDGET PERFORMANCE



3.5.2 PERFORMANCE OF GOVERNMENT AND FOREIGN FUNDS

The budget execution of government funds has generally been higher than that of foreign funds throughout the review period. However, in 2010/11, the performance of government funds was only 89 percent, down from 100 percent performance in the previous two fiscal years; and the performance of foreign funds was even worse, with only about 59 percent of the budgeted funds executed. Within foreign funds, the execution of the budgeted basket funds has generally been better than that of the budgeted non-basket funds. The performance of non-basket funds has fallen significantly to about 51 percent in 2010/11. The low execution of foreign funds is partly a result of non-release of the budgeted funds. Figure 3.7 shows a comparison of execution of budgeted government and foreign funds.

It is important to note that execution of government funds is higher than that of foreign funds mainly because most of the planned government funds are released, while a significant chunk of budgeted foreign funds is not released. Furthermore, most of the government funds are for recurrent expenditures, and very little is for development expenditures where most of the procurement work is done. Cumbersome procurement procedures hinder the absorption of the development funds (and as a corollary, donor funds) as they are mainly meant for development activities.

[7] It is important to note that reallocations are part of the "official budget" – but they come after the originally approved estimates (by the parliament, in June–July/August). This is why any addition after that, and subsequent spending of the same, would cause "performance" to exceed 100 percent; that is, expenditures exceeded what was originally budgeted. Mathematically, if reallocations are added to the approved estimates (or removed), then budget performance will not exceed 100 percent.

FIGURE 3.7: PERFORMANCE OF GOVERNMENT AND FOREIGN FUNDS

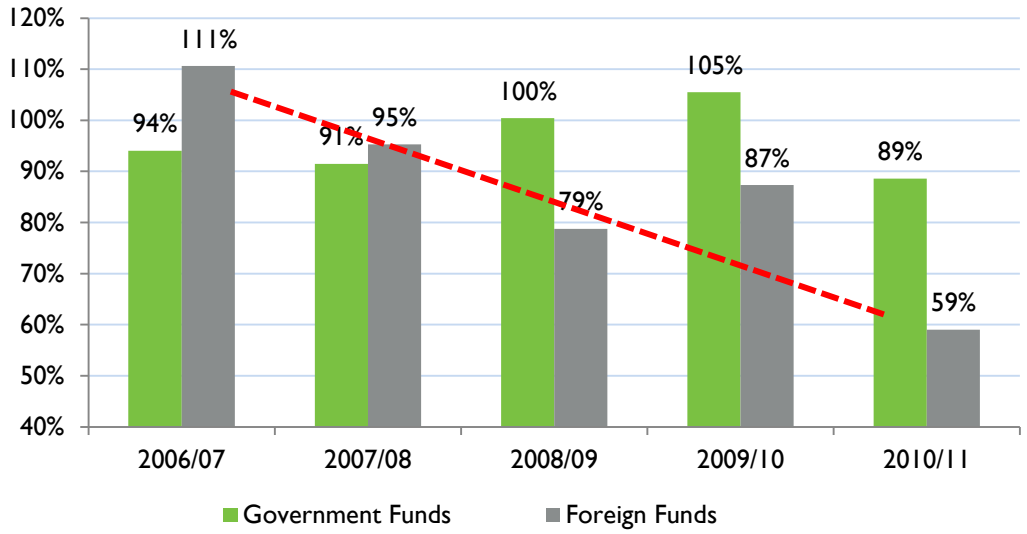
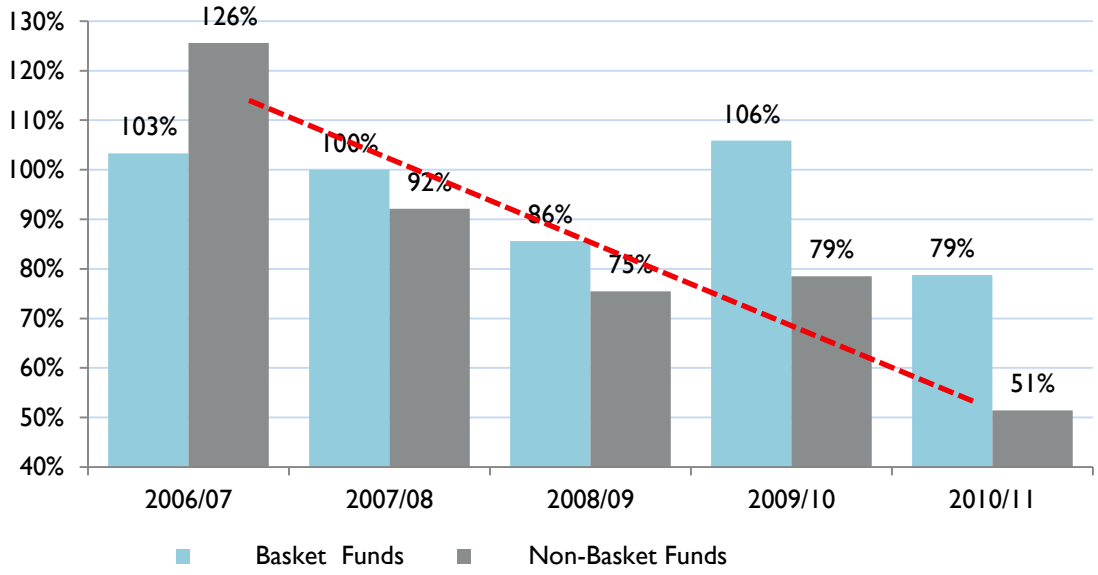


Figure 3.7shows a declining trend in the performance of foreign funds almost throughout the review period. This trend has resulted from declining performance in both the execution of foreign basket and non-basket funds as portrayed in Figure 3.8, reflecting non-release of budgeted funds by the donors and the cumbersome procurement procedures.

FIGURE 3.8: PERFORMANCE OF BASKET AND NON-BASKET FOREIGN FUNDS



3.5.3 BUDGET EXECUTION PERFORMANCE AMONG LEVELS OF GOVERNMENT

Based on collected information, there are variations in budget execution among layers of government spending, with performance at regional and LGA levels being generally higher than other layers. Table 3.5 provides a summary of budget performance among levels of the government.

TABLE 3.5: BUDGET PERFORMANCE AMONG LAYERS OF GOVERNMENT

	2006/07	2007/08	2008/09	2009/10	2010/11
Central	97%	90%	92%	100%	69%
Regions	107%	94%	98%	104%	50%
LGAs	114%	97%	97%	94%	82%

3.5.4 BUDGET PERFORMANCE OF MOHSW DEPARTMENTS

For consistency, the performance of activities by different departments is categorized in four levels as follows:

Level 1: Departments with a funds utilization rate above 80 percent are considered to have fully implemented the activities as stipulated in the Medium-Term Expenditure Framework (MTEF) (excellent performance).

Level 2: Departments with a funds utilization rate between 61 and 80 percent are considered to have partially implemented the activities as stipulated in the MTEF (very good performance).

Level 3: Departments with a funds utilization rate between 41 and 60 percent are considered to have partially implemented the activities as stipulated in the MTEF (average performance).

Level 4: Departments with a funds utilization rate between 0 and 40 percent are considered poor performers.

Based on these categorizations of performance, only three departments fall under Level 1 (excellent performance), which are: Curative Services (97.2 percent), Chief Medical Officer (96.9 percent), and Human Resource Development (85.3 percent) (Table 3.6). The performance of the Curative Services Department is excellent given that it includes funds for medicines (about 50 percent of the "Other Charges") which are sent directly to the Medical Stores Department (MSD).

The second level (very good performance) also has three departments: Preventive Services, Administration and Personnel, and Policy and Planning. Social Welfare and Finance and Accounts departments fall under the average performance category, while the Internal Audit Department has poor performance with an execution rate of only about 34 percent. The poor performance of the Audit Department is due to non-release of the allocated funds. Non-release of funds to the Audit Unit threatens the functioning of the Unit and the entire Public Financial Management (PFM) system of the MoHSW. The overall recurrent budget execution stands at 92.7 percent, which would fall under excellent category, while development budget execution in only average at 55.1 percent.

TABLE 3.6: MOHSW BUDGET PERFORMANCE BY DEPARTMENT, 2010/11

MoHSW Department/Units	Budget (Mn TZS)	Actual Expenditure (Mn TZS)	Execution Performance
Level 1 (Departments with performance above 80%)			
2001 Curative Health Services	151,313	147,064	97.2%
2003 Chief Medical Officer	6,678	6,470	96.9%
5001 Human Resource Development	13,929	11,882	85.3%
Level 2 (Departments with performance between 61% and 80%)			
3001 Preventive Services	26,952	20,564	76.3%
1001 Administration and Personnel	3,202	2,267	70.8%
1003 Policy and Planning	272	175	64.2%
Level 3 (Departments with performance between 41% and 60%)			
4002 Social Welfare	1,611	867	53.8%
1002 Finance and Accounts	186	85	45.9%
Level 4 (Departments/Units with performance 40% and below)			
1004 Internal Audit Unit	92	32	34.3%
Aggregate departmental performance			
Total recurrent	204,235	189,405	92.7%
Development	447,863	246,928	55.1%

Note: The recurrent budget and expenditure presented in the table excludes the MoHSW Personal Emoluments (PE) but includes the PE for parastatals as this is allocated in the Other Charges (OC) budget.

3.5.5 EXPENDITURES BY KEY INTERVENTION AREAS

In the implementation of the 2010/11 budget, the MoHSW utilized about 76.8 percent of the budgeted recurrent funds, and only about 53 percent of the budgeted development funds for key intervention areas (Table 3.7). Apart from TZS6 billion in development funds allocated for reproductive health, which were fully utilized (100 percent), the budget execution in other key intervention areas (for recurrent expenditures) did not exceed 83 percent (in fact, only HIV/AIDS and malaria reached 80 percent). Despite a low allocation for non-communicable diseases (NCDs) (about TZS146 million), only TZS17 million were spent, equivalent to an 11.9 percent execution rate.8 Budget execution in reproductive and child health interventions was 62 percent, with child health interventions alone slightly behind, utilizing only 60 percent of the allocated funds.

[8] The budget for NCDs has been small because initially, the country was facing a higher burden of communicable diseases. It is just recently that the double burden (of communicable and non-communicable diseases) has been realized. Thus, the government is striving to allocate more resources for NCDs, especially on the preventive and promotive aspects.

TABLE 3.7: MOHSW EXPENDITURE BY KEY INTERVENTION AREA, 2010/11

	2010/2011			2011/2012
	Budget	**Actual Expenditure**	**Performance**	**Budget (Mn TZS)**
Recurrent				
Malaria	187	154	82.4%	249
TB	277	193	69.7%	221
NCDs	146	17	11.9%	1,125
HIV/AIDS	6,526	5,279	80.9%	2,368
Reproductive health	539	347	64.4%	437
Child health	550	331	60.1%	1,394
Total	8,225	6,321	76.8%	5,793
Development				
Malaria	186,383	65,696	35.2%	48,802
TB	6,400	5,100	79.7%	155,730
HIV/AIDS	93,720	78,130	83.4%	90,357
Reproductive health	6,000	6,000	100.0%	8,000
Total	292,504	154,927	53.0%	302,889

Going forward, the overall allocation for intervention areas in the 2011/12 budget has increased by about 3 percent, courtesy of a30-fold increase in the allocation for the development budget in TB interventions. These funds are from various sources including the Global Fund and the central government. If these resources for TB interventions are treated separately, the total allocations for the other key intervention areas declined by about 48 percent in the 2011/12 budget. Despite the seven-fold increase in recurrent allocation for NCDs and an approximately three-fold increase in allocations for child health interventions, the total recurrent allocations for key intervention areas declined by 30 percent. Furthermore, recurrent and development allocations for HIV/AIDS interventions declined by 64 percent and 4 percent, respectively. Development spending for malaria declined by 74 percent, while recurrent allocations for malaria increased by 33 percent. Poor performance of the NCDs budget poses a concern given the threat these diseases pose to current societies.

3.6 HEALTH SECTOR BUDGET AND EXPENDITURE BY LEVELS OF GOVERNMENT

The relative shares of resources among levels of government have not changed much over the review period, with the share of resources controlled by the MoHSW remaining dominant throughout. However, the MoHSW share has declined slightly from 59.1 percent of the budget in 2006/07 to 52 percent in 2011/12, and from 58.2 percent of actual spending in 2006/07to 51.4 percent in 2010/11. Similarly, the share of centrally controlled resources, which includes MoHSW, PMO-RALG, and the NHIF, declined from 67.9 percent in 2006/07 to 57.7 percent in 2011/12. The share of resources going to the LGAs has increased from 27.7 percent of the budget in 2006/07 to 36.3 percent of the budget in 2011/12. Tables 3.8 and 3.9 present a summary of total funding and shares of resources for the health sector at different levels of the government.

TABLE 3.8: HEALTH SPENDING BY LEVEL OF GOVERNMENT (BN TZS)

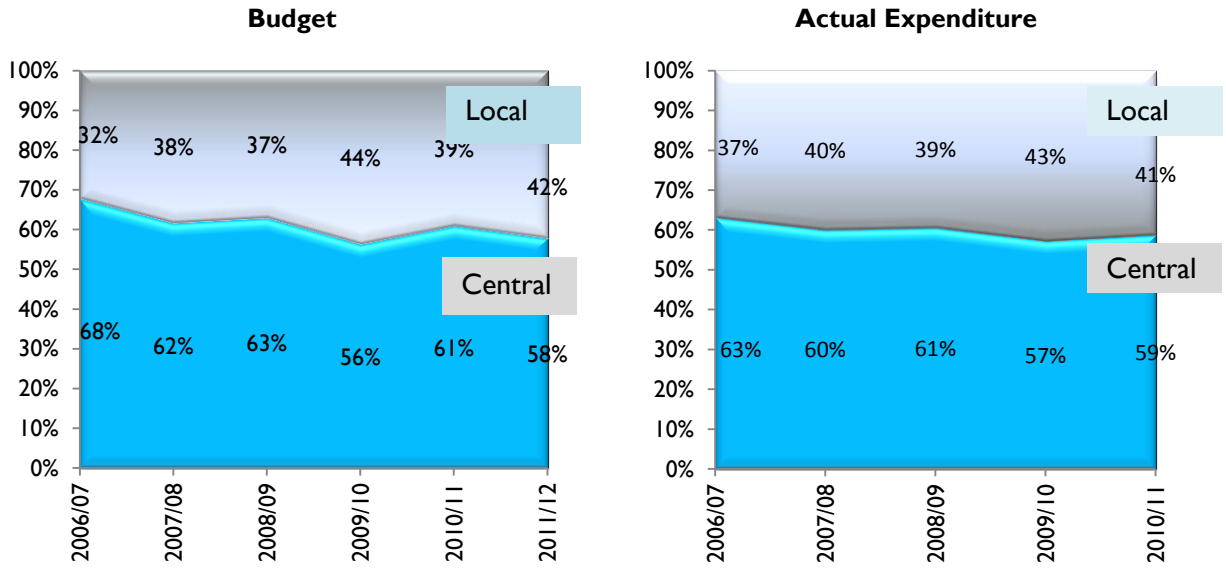
	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Central	353	325	379	343	481	426	521	521	743	536	672
Regions	23	25	42	40	52	51	57	60	72	40	69
LGAs	144	164	194	188	231	225	347	327	405	334	422
Total	520	514	616	571	764	701	925	908	1,220	910	1,164

TABLE 3.9: SHARE OF HEALTH RESOURCES TO THE DIFFERENT LEVELS OF GOVERNMENT

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Central	67.9%	63.3%	61.6%	60.1%	62.9%	60.7%	56.3%	57.4%	60.9%	58.9%	57.7%
Regions	4.4%	4.8%	6.9%	6.9%	6.8%	7.2%	6.2%	6.6%	5.9%	4.4%	5.9%
LGAs	27.7%	31.9%	31.5%	32.9%	30.3%	32.0%	37.5%	36.1%	33.2%	36.7%	36.3%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

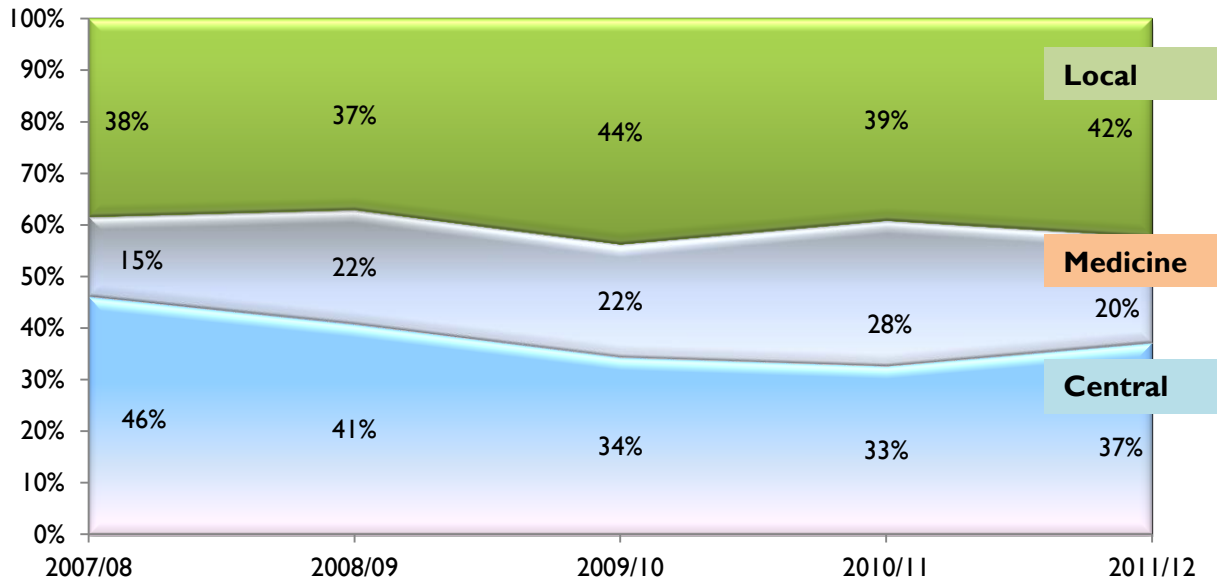
Table 3.9 gives an assessment of the shares of health sector budget and expenditures among two broad levels – the central and local levels. The central level is aggregated to include the resources controlled by the MoHSW, as well as resources under the NHIF and the PMO-RALG. The local level includes resources under LGAs and regions. Health sector budget and expenditures have continued to be concentrated at the central level, although there is slow progress in shifting the share of resources to the local levels. The share of centrally controlled resources has declined from 68 percent of the budget in 2006/07 to 58 percent of the budget in 2011/12. Figure 3.9 shows the relative shares of health budget and expenditure at the central and local levels.

FIGURE 3.9: TREND OF DISTRIBUTION OF RESOURCES BETWEEN CENTRAL AND LOCAL LEVELS



The persistent dominance of central control of resources is partly a result of the procurement of medical supplies (most of which eventually go down to the local level) and the payment of wages and salaries, which are managed at the central level. Based on the available budget data, during the review period, the share of medicines in the health budget increased from 15 percent in 2006/07 to a maximum of 28 percent in 2010/11, before declining to 20 percent in 2011/12. By taking into consideration the medicines budget, separation of health financing shares by government level portrays a slightly different picture, with the central share declining to 37 percent in 2011/12. Figure 3.10 shows the trend of health financing shares with the medicine component isolated.

FIGURE 3.10: HEALTH FINANCING BY GOVERNMENT LEVEL, WITH MEDICINES ISOLATED



4. COMPLEMENTARY HEALTH FINANCING

4.1 HEALTH SERVICES FUND

The HSF continues to be an important source of funding for health facilities especially for operations and maintenance. The HSF receipts accounted for 3 percent of health expenditures by the LGAs in 2010/11.The same level of financing was observed in 2009/10.

Receipts from the HSF almost doubled between 2007/08 (TZS5.089 billion) and 2010/11 (TZS10.117 billion).This could be a reflection of the increase in population, but also the fact that the majority of the population is not insured (see the discussion in Section 4.3, The Community Health Fund)9 and hence end up paying out of pocket for health services. On the other hand, this might be reflecting an increase in the utilization of services and/or better strategies for fee collection by the health facilities. The HSF still has significant unspent funds, which by 2010/11 were equivalent to 20 percent of the receipts – a decline from 26 percent observed in 2009/10. Both in 2009/10 and 2010/11, spent funds exceeded the amounted collected which resulted in a decline in unspent balances (Table 4.1). Since user fees are known to limit access to care especially for the poor, it is important to ensure that all funds collected are utilized to improve service delivery, and as a corollary, stimulate the demand for health services. It is also important to continue sensitizing communities on the advantages and importance of prepayment schemes, especially in rural areas where incomes are not predictable.

TABLE 2: HEALTH SERVICES FUND (MN TZS)

	2007/08	2008/09	2009/10	2010/11
Balance brought forward	3,016	1,614	3,905	2,037
Receipts	5,696	5,858	7,870	10,078
Payments	5,089	5,280	9,767	10,117
Unspent balance	3,615	2,192	2,008	1,998
Unspent balance as a % of receipts	63%	37%	26%	20%

4.2 THE NATIONAL HEALTH INSURANCE FUND

The NHIF mobilizes funds from employees and employers to finance health care services for its members. The contribution rate is provided in the act establishing the fund as 6 percent of the employee's gross monthly salary (met equally by both employer and employee – 3 percent each). NHIF membership size for the year 2010/11 is as follows: principal members, 468,611; dependents, 2,030,309; total beneficiaries, 2,498,920.

[9] There could be other factors for the increase but identifying those is beyond the scope of this PER. A research project has to be commissioned to explore other factors, including whether there has been an increase in user-fee levels or whether many more people seem to be coming to the public facilities versus the private facilities, which may indicate improved attractiveness of the public facilities.

A comparison of figures from 2009/10 and 2010/11 indicate a continued increase in the premium contribution to NHIF and income from other sources such as investment (about 50 percent for both sources). This increase emphasizes the importance of NHIF in financing health services. However, total funds paid to health facilities remains low at 27 percent (or 65 percent of total expenditure) due to a number of challenges, some of which are discussed below.

Compared to FY09 figures, the NHIF unspent balance has declined slightly from 63 percent to 59 percent of the total annual income (Table 4.2), which is a concern considering the financing shortages facing the health sector. Table 4.3shows the NHIF expenditures by component. Benefit payments accounted for 65.2 percent of the total expenditures in 2010/11, which is a slight increase from 2009/10, followed by administrative expenses (27.8 percent).

TABLE 3: NHIF INCOME AND REIMBURSEMENTS (MN TZS)

	2006/07	2007/08	2008/09	2009/10	2010/11
Contributions	45,516	55,472	73,282	90,084	134,891
Total income (incl. income from investments and others)	56,884	72,168	76,512	108,845	164,146
Percentage of funds paid out to health services against total income of NHIF	14.4%	14.1%	18.4%	23.0%	27.0%
Actual spending including administration	23,950	26,719	34,325	39,782	68,048
Unspent balance as % of total income	58%	63%	55%	63%	59%

Source: NHIF (2012) and authors' calculations.

TABLE 4: NHIF EXPENDITURE BY COMPONENT (MN TZS)

Expenditure Components	2009/10		2010/11	
	Expenditure	**% of total**	**Expenditure**	**% of total**
Administrative expenses	12,180.45	30.6%	18,946	27.8
Benefits payment (reimbursement)	25,154.06	63.2%	44,352	65.2
Members services	2,426.51	6.1%	4,723	6.9
Finance charges	21.02	0.1%	28	0.04
Total expenditure for the NHIF	39,782.04	100.0%	68,048	100.0%

Source: NHIF (2012) and authors' calculations.

Tables 4.4 and 4.5 present information on reimbursements by ownership category and by the level of health facility, respectively. One notable aspect is the reimbursements made to faith-based health facilities and pharmacies, which received 54 percent of the total. Faith-based health facilities are important actors in health service delivery, especially in marginalized areas. Payments to Part I Pharmacies alone accounted for 9.6 percent of the total disbursements. These are important entities in addressing the problem of access to medicines. Disbursement to ADDOs is small, which is partly a reflection of the size of these entities countrywide. However, the ADDOs are key conduits for making medicine accessible to rural marginalized areas and more efforts should be made to collaborate with these entities. This is also an area where the CHF funds could be used effectively.

TABLE 5: REIMBURSEMENT BY TYPE OF HEALTH FACILITY OWNERSHIP, 2010/11 (MN TZS)

Ownership	Amount	% of Total Payment
Government facilities	14,471,051	32.6%
Faith-based/NGO facilities	19,707,673	44.4%
Private facilities (excluding pharmacies and ADDOs)	5,860,353	13.2%
Pharmacies	4,241,981	9.6%
ADDOs	70,496	0.2%
Total	44,351,555	100.0%

TABLE 6: REIMBURSEMENT BY LEVEL OF HEALTH FACILITY, 2010/11 (MN TZS)

Level of Facility		2010/11		2011/12
		Budget	**Actual**	**Estimates**
Hospitals	Referral	14,628,329	23,292,492	27,569,863
	Regional	3,278,730	5,220,678	6,850,554
	District	3,472,588	5,612,227	6,714,488
Health centers		1,721,931	2,741,807	3,312,869
Dispensaries		1,992,023	3,171,872	3,574,468
Pharmacies		2,597,834	4,241,981	4,600,607
ADDOs		162,564	70,496	137,033
Total		**27,853,999**	**44,351,554**	**52,759,882**

That government facilities are receiving 32.6 percent of total reimbursement is cause for concern given the fact that they provide more services than faith-based facilities. The reimbursement is according to fees for service. It is understandable that the government facilities receive less given their lower charges, but this would effectively mean that the government is subsidizing the NHIF.

Over half of the budget and spending is going to referral hospitals (Table 4.5). There are many factors involved in this, including the following:

- Most of the services provided at the referral level are very expensive compared to lower levels
- Prices per service are higher at the referral level and most referral hospitals have reviewed their fee schedules
- Most of the NHIF "Green Card[10] "members are found at the urban centers compared to rural areas

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

The NHIF faces several challenges in executing its functions, including:

i. Fraudulent practices among the accredited health facilities. The fund receives a number of fraudulent claims from some accredited health service providers, featuring over-invoicing, irrational medical practices(for instance, overuse of investigations), non-adherence to the National Essential Medicine List and Standard Treatment Guidelines, extension of hospital admission days or reporting of false admissions, and missing patient signatures or forged signatures.

ii. Retrieval of NHIF membership ID cards of retired members and others whose membership has expired. This is a problem because most staff leave their employers with their NHIF ID cards, which makes it difficult to trace them.

iii. Frequent stock-outs of medicines in most accredited health facilities.

iv. Uncontrolled and frequent fluctuation of prices for services, medicines, and medical consumables in the general market.

v. Insufficient health services and health personnel, particularly in rural areas where most NHIF "Brown Card[11]" members reside. This means that NHIF members in those areas do not receive services consistent with their expectations of the benefits of their membership.

vi. Negative attitude by some health providers towards NHIF members on the use of cards versus cash due to immediate need of cash by heath facilities.

4.3 THE COMMUNITY HEALTH FUND

The CHF scheme was initiated in 1997/98 after the Igunga District Council (DC) pilot in 1996. By 2011, CHF had enrolled a total of 561,370 households, which is only 7.4 percent of the total population (Table 4.6). CHF envisaged increasing membership from 400,000 households as of December 2009/10 to 600,000 by June 2011, a level which was almost reached. However, the ambition to increase the enrollment to 1,000,000 by 2012 will most likely not be achieved. Table 4.7 presents the actual figures as of December 2011, which shows a decline of enrolled households from 561,370 in June to 531,734 and which is equivalent to an estimated coverage of 7.4 percent of the total population. TIKA (the urban equivalent of the CHF) has not picked up substantially, and only 150,138 households were enrolled in 2010/11.The number is projected to increase only to 171,156 in 2011/12.

Underperformance of CHF is a result of several factors, including lack of access to medicines. As a result, some LGAs have lowered their premiums (Table 4.7). Efforts to promote enrollment of households in CHF are evident at different levels. For instance, advocacy meetings have been organized to impart CHF knowledge, data, and information to participants as shown in Table 4.7. There are other efforts to promote CHF enrollment by international and national organizations such the German Development Corporation (GIZ) and the German development bank, KFW, through Tanzanian German Program to Support Health, Swiss Development Cooperation in Dodoma, and Ifakara Health Institute in Morogoro Region.

[11] See note 10.

TABLE 7: MEMBERSHIP IN CHF/TIKA

	2010/11 (Actual)	2011/12 (Estimates)
CHF		
Households	561,370	721,474
Beneficiaries	3,368,220	4,328,844
Payment of matching funds	2,016,739,000	4,000,000,000
Others	0	0
TIKA		
Households	25,023	28,526
Beneficiaries	150,138	171,156
Payment of matching funds	30,938,000	100,000,000

TABLE 8: IMPLEMENTATION OF CHF ACTION PLAN

Area	Components	Status as of June 30, 2011	Status as of Dec. 30, 2011	Remarks
CHF coverage	Total households registered	561,370	531,734	The CHF coverage with an average family size of 6 represents 7.4% of the total population (based on the 2011 population projections)
	Councils that reported	108	108	
	Total population covered	3,368,220	3,190,404	
Household contributions profile	Amount which households contribute per year(each)	TZS5,000–20,000	TZS5,000–20,000	13 councils have revised their premiums upward: Bukombe, Moshi Municipal, Korogwe, Mtwara Municipal, Tandahimba, Nachingwea, Ruangwa, Songea Municipal, Namtumbo, Morogoro District, Bukoba District, Kilolo, and Igunga. 3 councils lowered their premiums; Sumbawanga, Bagamoyo, and Ngorongoro.
CHF benefits package and referral arrangements	Standard basic benefit package covers reproductive and child health care, communicable diseases, NCDs and trauma, and clinical support services	Varies in its applicability among councils	Varies in its applicability among councils	Though the package was provided in the CHF operational guidelines in 1999, most users are not aware of this – each council offers what seems to be convenient to them. The matter has been brought to the attention of the Directorate of Medical and Technical Services at NHIF, especially regarding the TIKA benefit package.
Matching funds	Payments made to councils whose applications qualify to be matched with government grants	TZS2.5 Bn	TZS3.5Bn	As of December 2011

Area	Components	Status as of June 30, 2011	Status as of Dec. 30, 2011	Remarks
	Matching funds under process	0	TZS840.3Mn	Most applications that were received were found to have anomalies; hence, correspondence with respective zones/councils was made.
Advocacy on CHF by headquarters	Participants imparted with CHF knowledge, data, and information.	550	960	410 participants from Lindi, Health Financing Committee, Tanga, and Arusha (CRDB Microfinance) were sensitized or informed on CHF between June and December 2011.
Councils status of operation	Councils with by-laws and instruments	108	108	There have been no changes during the period under review. However, promoting TIKA is expected to increase the rollover.
	Dormant councils (did not apply for matching fund in the last two years)	24	21	The list of dormant councils has been shrinking, as it started with 48 in 2009/10.

Considering the statistics presented in Table 4.8 below, about 6 million people out of Tanzania's population of about 43 million (based on the 2011 population projections) has access to health services through the two parallel schemes(the NHIF and the CHF). This is equivalent to about 14 percent of the total population. This means the majority of Tanzanians who are not exempted from paying for health services must pay at the point of service delivery, as discussed in section 4.1, Health Services Fund. It is estimated that only about 3 percent of Tanzanians are insured through private health insurance, and 1 percent through the National Social Security Fund.

TABLE 9: INSURANCE COVERAGE TO TOTAL POPULATION, 2010/11

	Principal Members	Dependents	Total Beneficiaries	Coverage to Total Population*
NHIF membership	468,611	2,030,309	2,498,920	5.8%
CHF membership	561,370	2,806,850	3,368,220	7.8%
Total NHIF and CHF beneficiaries	1,029,981	4,837,159	5,867,140	13.6%

*Using 2011 population projections

5. LOCAL GOVERNMENT HEALTH SECTOR SPENDING

5.1 INTRODUCTION

This chapter presents an analysis of local government health spending based on the data compiled from the CCHPs; TFIRs in 125 out of the 133 LGAs; and data from the seven tracked districts. While the data from the 125 LGAs were meant to shed light on the sources of health financing and allocations to different sub-votes and programs, the data from the tracked districts go further by providing some information on service delivery in terms of availability of essential drugs. A total of 14 dispensaries, 19 health centers, 4 districts hospitals, and 4 regional hospitals participated in the tracking study. The primary purpose of collecting the service delivery information is to gauge the value for money – that is, whether the disbursed funds as analyzed in the PER have an impact on service delivery.

5.2 SOURCES OF FUNDS TO FINANCE HEALTH SERVICES IN LGA

The sources of funding to finance the health sector are in five major categories: the budgetary allocations from the government (block grants); donor basket and non-basket funds; funds from council own sources; fees and subscriptions from various schemes; and other sources that are unclassified. Table 5.1shows the sources of funds, allocations, and expenditures for 2010/11. Block grants from the government constitutes the largest share (57.4 percent of actual expenditures), followed by donor basket funds (18 percent of the actual expenditures). The share of block grants increased from 52.2 percent in 2009/10 to 57.4 percent in 2010/11. Meanwhile, the share of basket funds has declined from 21.3 percent in 2009/10 to 18 percent in 2010/11.

The average expenditure from in-kind sources amounted to 8 percent of the total expenditure. Further, other funding sources (not specified) contributed about 6 percent of the total expenditure, and this contribution is expected to reach 9 percent based on the 2011/12 budget estimates. These unpredictable and substantial off-budget funds pose challenges to LGAs' planning processes. The average actual expenditure from councils' own resources accounted for only 1 percent in 2010/11, which is a decline from 2 percent in 2009/10; it is estimated to return to2 percent for 2011/12. This low allocation from LGAs' own revenue threatens the sustainability of health interventions should there be a shock to the funds from the central level (government and development partners).

Some districts indicated the Primary Health Services Development Program (in Swahili, acronym MMAM) as a source of funds and it accounted for 5 percent of the total actual expenditures of the surveyed LGAs. This is a huge increase compared to the share reported in the 2009/10 PER (0.6 percent). This could be a reflection of the fact that more districts are reporting MMAM as a source of funds rather than an increase of the disbursements. It has been reported that there are large amounts of unrealized funds from development partners. Also there are challenges in the way this fund is allocated – using a recurrent formula rather than assessing the needs for infrastructure development against objectively determined requirements. This leads to some councils not having sufficient funds to do what they need to do. These funds come from a combination of government and development partner sources and are earmarked for MMAM activities.

There is concern over LGA budgeting for some sources. LGAs seem to be overambitious in budgeting and the budgeting for some sources do not reflect the previous spending. This is notable

for NHIF, cost sharing, and MMAM funds (Table 5.1). For instance, the estimate for 2011/12 for MMAM is more than double the actual expenditure in 2010/11. This is not realistic.

TABLE 5.1: SOURCES OF FUNDS AND TOTAL AMOUNT FOR 125 LGAS (TZS)

Sources	2010/2011			2011/2012
	Approved Budget	Actual Expenditure	Actual Expenditure (% of Total)	Estimates
Block grants	216,454,617,771	170,980,370,156	57.4%	275,144,699,103
Basket fund	57,378,810,288	53,762,902,631	18.0%	65,992,031,177
Global Fund	4,788,370,409	844,741,984	0.3%	4,792,297,004
UNICEF	1,951,577,906	910,947,561	0.3%	10,721,692
CHF	3,519,419,856	2,627,257,173	0.9%	4,411,925,252
NHIF	1,657,255,399	1,036,486,116	0.3%	2,453,000,212
Cost sharing	9,497,199,609	7,156,968,446	2.4%	12,465,167,399
Own source	6,439,655,159	2,703,534,631	0.9%	9,202,929,745
DRF	346,419,322	439,892,812	0.1%	459,369,100
In-kind	199,884,711,219	24,020,575,605	8.1%	40,310,387,269
JRF	495,966,083	428,269,210	0.1%	388,804,735
LGDG	2,297,364,394	1,128,398,612	0.4%	5,913,877,254
MMAM	32,898,294,754	14,397,617,202	4.8%	37,039,790,240
Others	43,494,961,697	17,692,256,874	5.9%	44,571,021,795
TOTAL	581,104,623,869	298,130,219,016	100.0%	503,156,021,977

Note: DRF=Drug Revolving Fund; JRF=Joint Rehabilitation Fund; LGDG=Local Government Development Grant; MMAM=*Mpango wa Maendeleo ya Afya ya Msingi*

It is important to note that there are variations in sources of funds per council which are masked by the nationally presented averages. Table 5.2 illustrates the sources of funding in the seven LGAs tracked for the year 2010/11. Noticeably, there are significant variations in the composition of funds from the identified sources across LGAs. Budget allocations from the central government in form of block grants range from 83 percent in Babati Town Council (TC) to 39 percent in Kondoa DC. Basket funding ranges from a low of 13 percent of the total public health sector funds in 2010/11 in Arusha City Council (CC) to a high of 23 percent in Mbozi DC. This variation is a cause for concern given that the government budget and health basket funds are meant to be applied by same formula; that is, the ratio should be stable even if other sources vary by district. While the ratio for Kondoa DC was 2:1, the one for Muleba was 8:1, which is a huge variation.

TABLE 5.2: PERCENT SHARE OF SOURCES OF FUNDS FOR HEALTH EXPENDITURES

	Name of District	Block Grant	Basket Fund	Complementary Financing	Council Own Fund	In-Kind Receipts	Other Sources
1.	Rufiji DC	59.5%	18.4%	6.8%	0.3%	11.0%	4.1%
2.	Mbozi DC	63.6%	23.5%	4.6%	0.5%	0.0%	7.8%
3.	Kondoa DC	39.2%	20.4%	2.1%	1.3%	0.0%	37.0%
4.	Muleba DC	46.1%	15.6%	38.3%	0.0%	0.0%	0.0%
5.	Arusha CC	62.2%	12.7%	2.3%	13.5%	0.0%	9.3%
6.	Babati TC	83.2%	9.7%	-	0.0%	0.0%	7.2%
7.	Mtwara MC	49.3%	20.5%	0.4%	0.1%	6.8%	23.1%

There is significant health funding in the LGAs from "other sources." Kondoa DC has the highest share of expenditure from other sources (37 percent), followed by Mtwara MC (23 percent). Mostly, the funds from other sources are off-budget and are not reported at the central level. These are sources which are specific to the councils, e.g., funds from private bilateral arrangements for direct project support. Most LGAs didn't report the in-kind support, but it has been found to be 7 percent and 11 percent, respectively, for Mtwara MC and Rufiji DC. Complementary financing is very high in Muleba DC (38 percent) as a result of significant financing from the NHIF and HSF. Muleba DC is also well networked with faith-based organizations – their fees are a bit higher, but the council is good about claiming for reimbursement as shown in several NHIF reimbursements reports. Expenditures from council own funds are insignificant in all councils except Arusha CC (13.5 percent).

It is important to note that expenditure data collected at the central level on overall health spending at the LGA level is different from the data collected at the LGA level. According to the information collected from MoF, LGAs spent a total of TZS333,863 million on health services in 2010/11, compared to TZS298,130 million reported at LGA level by the 125 LGAs. The difference is significant, and it could be echoing poor record-keeping at the LGA level, but also the fact that only 125 councils have been included in the analysis.

Of the total TZS298,139 million expended by the LGAs, TZS170,980 million (57 percent) went to recurrent expenditures, and 86 percent was utilized for personnel emoluments (Table 5.3). The central government contributed 63 percent of funds spent at the LGAs in 2010/11. Development expenditures were largely financed by development partners mainly through basket funding, accounting for about 42 percent, which is a decline from 59 percent observed in 2009/10.

TABLE 5.3: LOCAL GOVERNMENT HEALTH SPENDING (TZS)

Sources of Funds	2010/11			2011/12
	Approved Estimates	**Actual Expenditure**	**% of Total (Actual)**	**Approved Estimates**
Government Fund (PE)	178,143,254,266	146,401,509,485	85.62%	242,360,873,095
Government Fund (OC)	38,311,363,505	24,578,860,672	14.38%	32,783,826,008
RECURRENT	216,454,617,771	170,980,370,156	57.35%	275,144,699,103
DEVELOPMENT TOTAL	364,650,006,098	127,149,848,860	42.65%	228,011,322,874
Grand Total	581,104,623,868	298,130,219,016	100%	503,156,021,976

5.3 BUDGET PERFORMANCE IN LGAS

Table 5.4 presents the figures on budget performance by the 125 LGAs studied. According to the classifications stipulated in Section 3.5.4, Budget Performance of MoHSW Departments, overall, councils have very good performance (77 percent). It is worth noting that in the analysis, the Global Fund, in-kind support, and funds from other sources have been omitted since they are unpredictable and, in most cases, not released. The basket fund and Drug Revolving Fund (DRF) have excellent performance (94 percent and 86 percent, respectively). For the DRF funds, the expenditure exceeds the budget which may reflect under budgeting and possible reallocation of funds. Contrary to 2009/10 when CHF had the lowest performance (50 percent), Table 5.4 shows that 74 percent of the budgeted funds were actually spent. However, the councils collected only half of what was estimated.

The seven districts that were tracked in this study showed an impressive budget performance, apart from Babati DC and Mbozi DC (Table 5.5). As shown in Table 5.2, only Rufiji DC and Mtwara MC reported expenditures from in-kind support, while Kondoa DC and Mtwara MC reported large expenditures from other sources. These two sources of funds have the lowest budget performance (19 percent and 14 percent, respectively). These funds have contributed to the low performance observed in the respective districts.

TABLE 5.4: BUDGET PERFORMANCE IN 125 LGAS (TZS)

Sources	2010/2011			2011/2012
	Approved Budget	**Actual Expenditure**	**% Expenditure**	**Estimates**
Block grants	216,454,617,771	170,980,370,156	78.99%	275,144,699,103
Basket fund	57,378,810,288	53,762,902,631	93.70%	65,992,031,177
UNICEF	1,951,577,906	910,947,561	46.68%	10,721,692
CHF	3,519,419,856	2,627,257,173	74.65%	4,411,925,252
NHIF	1,657,255,399	1,036,486,116	62.54%	2,453,000,212
Cost sharing	9,497,199,609	7,156,968,446	75.36%	12,465,167,399
Own source	6,439,655,159	2,703,534,631	41.98%	9,202,929,745
DRF	346,419,322	439,892,812	126.98%	459,369,100
JRF	495,966,083	428,269,210	86.35%	388,804,735
LGDG	2,297,364,394	1,128,398,612	49.12%	5,913,877,254
MMAM	32,898,294,754	14,397,617,202	43.76%	37,039,790,240
TOTAL	332,936,580,541	255,572,644,550	76.76%	413,482,315,909

TABLE 5.5: BUDGET PERFORMANCE OF THE SAMPLED SEVEN LGAS (TZS)

	Name of District	Budget	Actual Expenditure	% Expenditure
1.	Rufiji DC	4,529,672,583	3,468,018,903	76.56%
2.	Mbozi DC	4,751,658,415	3,248,974,697	68.38%
3.	Kondoa DC	10,109,795,116	7,596,788,718	75.14%
4.	Muleba DC	763,634,663	699,583,952	91.61%
5.	Arusha CC	4,054,710,000	3,889,893,425	95.94%
6.	Babati TC	1,854,255,827	1,242,272,601	67.00%
7.	Mtwara MC	2,301,039,418	2,131,964,623	92.65%

5.4 HEALTH SPENDING AT THE LGA LEVEL BY SUB-VOTES

Information on intergovernmental transfers for the sector (i.e. the recurrent block grants and any development grants), is disaggregated by four sub-votes in the LGA budget as per government official estimates. The sub-votes are:

- 5010 Health Services (largely curative and includes any Council District Hospital and District Designated Hospitals, and allocations for Council Health Management Teams and Council Health Services Board)
- 5011 Preventive Services (these include preventive outreach services and health education)
- 5012 Health Centers
- 5013 Dispensaries

Table 5.6 shows the allocation of funds by these sub-votes. It is important to note that since 2009/10, another category has been introduced in the CCHPs – namely, "Community Initiatives." It is noted from Table 5.6 that the actual amount spent in 2010/11 falls short of the approved amount

by only 17 percent. Further, health spending at the LGA level has increased by 24 percent from 2009/10.

TABLE 5.6: HEALTH SPENDING AT THE LGA LEVEL BY SUB-VOTE (MN TZS)

	2007/08		2008/09		2009/10		2010/11		2011/12
	Approved Estimates	**Actual Expenditure**	**Approved Estimates**	**Actual Expenditure**	**Approved Estimates**	**Actual Expenditure**	**Approved Estimates**	**Actual Expenditure**	**Approved Estimates**
5010 (Health Services)	41,033	41,033	48,071	48,071	49,646	42,423	68,057	50,423	62,384
5011 (Preventive Services)	16,710	16,710	17,293	17,293	72,023	60,496	54,962	72,166	95,519
5012 (Health Centers)	35,128	35,128	35,598	35,598	61,846	48,592	83,206	60,890	83,700
5013 (Dispensaries)	44,592	44,592	43,940	43,940	78,920	63,200	116,638	87,889	102,369
Community Initiatives					35,872	17,788	28,831	17,589	24,539
TOTAL	137,463	137,463	144,902	144,902	298,308	232,499	351,694	288,957	369,511

Table 5.7 shows the shares of expenditures by sub-votes. The shares were almost constant across the sub-votes from 2006/07 to 2008/09, with Health Services (sub-vote 5010) and Dispensaries (sub-vote 5013) receiving the biggest share, followed by Health Centers (sub-vote 5012). However, from 2009/10, there is a notable change, with Preventive Services receiving a larger share than Health Services.

TABLE5.7: AVERAGE SHARES OF TOTAL EXPENDITURE PER SUB-VOTE FOR 125 LGAS

	2007/08	2008/09	2009/10	2010/11	2010/11 (Estimates)
5010 (Health Services)	30%	33%	18%	17%	17%
5011 (Preventive Services)	12%	12%	26%	25%	26%
5012 (Health Centers)	26%	25%	21%	21%	23%
5013 (Dispensaries)	32%	30%	27%	30%	28%
Community Initiatives	NA	NA	8%	6%	7%

Again, these averages (average for 125 LGAs) mask the district variations as observed in the six tracked districts (Table 5.8).There is no consistency in funds allocated by sub-votes across the six councils that provided data. For instance, while Mbozi DC allocated only 10 percent of funds to sub-vote 5010 (Health Services), Arusha CC allocated the highest amount (52 percent) of all the councils. No clear pattern of expenditure by sub-vote can be noted from Table 5.8.

TABLE 5.8: RECURRENT BLOCK GRANT ALLOCATIONS PER SUB-VOTE, 2010/11

	District/Sub-Vote	Health Services	Preventive Services	Health Centers	Dispensaries	Community Initiatives	VAH
1.	Rufiji DC	11%	35%	22%	30%	1%	0%
2.	Mbozi DC	10%	45%	30%	13%	2%	0%
3.	Kondoa DC	35%	17%	19%	28%	2%	0%
4.	Arusha CC	52%	4%	39%	-	3%	2%
5.	Babati TC	23%	15%	22%	35%	5%	0%
6.	Mtwara MC	19%	6%	22%	32%	21%	0%

VAH=Voluntary Agencies Hospital

5.5 HEALTH SPENDING BY PROGRAMS

Pharmaceuticals command 50 percent of the total expenditures on programs, followed by expenditures on reproductive and child health (Table 5.9). These levels of spending are a reflection of the national priorities as stipulated in the HSSP-III.

TABLE 5.9: HEALTH SPENDING BY PROGRAM (TZS)

	2010/11			2011/12
	Estimates	**Actual**	**% Expenditure**	**Estimates**
HIV	11,886,902,874	6,944,387,965	14%	13,480,857,036
Malaria	1,754,450,178	1,268,099,850	3%	4,700,397,592
Pharmaceuticals	33,160,999,255	24,172,634,994	50%	44,400,364,460
TB	3,553,871,372	1,371,884,430	3%	3,061,168,454
Reproductive and child health	20,172,569,882	14,609,470,296	30%	30,733,854,467
TOTAL	70,528,793,562	48,366,477,536	100%	96,376,642,008

Analysis of availability of tracer drugs in the sampled councils shows that most of the tracer drugs were available during the survey period: at dispensaries (79 percent); health centers (80 percent), district hospitals (95 percent), and regional hospitals (100 percent). Annex C shows the list of tracer drugs on which information was sought.

5.6 HUMAN RESOURCES FOR HEALTH

Data collected from the central level show great improvement in deployment of human resource for health. This improvement is a reflection of the budget allocation for training and deployment of human resource for health. The overall gap in 2010/11 is 41 percent. The gap for AMOs has almost closed, followed by laboratory technicians (Table 5.10). A huge gap is still observed with dentists and pharmacy technicians.

TABLE 5.10: HUMAN RESOURCE GAP

Cadre	Required	Available	% of Required Staff Available	% Human Resource Gap
Doctors	1031	578	56.1	44.0
AMOs	2093	1527	73.0	27.0
Dentists	184	65	35.3	64.7
Dental assistants	1022	422	41.3	58.7
Pharmacists	220	129	58.6	41.4
Pharmacy techs	464	200	43.1	56.9
Clinicians	9963	5781	58.0	42.0
Nurses	15753	9268	58.8	41.2
MCH aide	866	855	98.7	1.3
Laboratory staff	733	461	62.9	37.1
Radiology staff	237	132	55.7	44.3
Health officers	2278	1242	54.5	45.5
Others	700	316	45.1	54.9
TOTAL	35544	20976	59.0	41.0

Source: MoHSW Human Resource Department, and report presented to the Parliamentary Committee with regard to progress made in implementing MMAM.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 HIGHLIGHTS OF PER FY11 FINDINGS

General trend of health financing

The share of the public health budget in the total government budget, excluding CFS, has declined from 12.3 percent in 2010/11 to 10.0 percent in 2011/12; with the CFS included, the share of health budget fell from 10.5 percent in 2010/11 to a mere 8.6 percent in 2011/12. Similarly, the share of actual health spending in total government spending (excluding CFS) declined from 13.1 percent in 2009/10 to 11.9 percent in 2010/11, while with CFS included the decline in the share of health spending was modest, from 9.9 percent in 2009/10 to 9.5 percent in 2010/11. This level of expenditure (which includes donor funding) is below the Abuja target, despite the reiterated commitment by the government to increase the share of health allocation in the budget to 15 percent of total government budget. In 2010/11, public health expenditures were only about 2.7 percent of GDP, while public health budgetary allocations were down to 2.8 percent of GDP in the 2011/12 budget compared to 3.5 percent of GDP in the 2010/11 budget.

Per capita expenditures

In nominal terms, public health allocations per capita increased from TZS13,385 (USD11) in 2006/07 to TZS28,673 (USD19.80) in 2010/11, before falling to TZS26,563 (USD17.30) in 2011/12. Actual per capita health spending increased from TZS13,698 (USD11) in 2006/07 to TZS21,635 (USD14.90) in 2010/11. In real terms however, the increase was only modest, from TZS9,069 (USD7.30) to a peak of TZS15,425 (USD10.60) in 2010/11, and then down to TZS13,348 (USD8.70) per capita for public health allocations; and from TZS9,012 (USD7.20) to a peak of TZS12,236 (USD8.80) in 2009/10, and then back down to TZS11,639 (USD8) per capita for actual public health expenditures. Thus, the per capita health spending is still low, and falls significantly short of the WHO recommended target of USD54 to address health challenges. It is also well below the HSSP-III projections of USD15.75 per capita spending by 2009/10.

Government contribution

Government contribution to health expenditures declined from 71 percent in 2006/07 to a low of 53 percent in 2010/11, and is estimated at 59 percent in the 2011/12 budget. However, because of much higher execution of local funds in the implementation of the budget, the share of government funds in the actual health spending has remained above 60 percent throughout the review period. The share of external health financing increased from 29 percent in the 2006/07 budget to a maximum of 47 percent in the 2010/11 budget, and is estimated at 41 percent in the 2011/12 budget. Also, it is worth noting that foreign funding still accounts for a dominant share of the development budget in health interventions. This trend points to a potential threat to the sustainability of health sector financing in case of an unanticipated decline in donor funding in the sector.

Budget performance

Although the execution of the health sector budget was generally good throughout the review period, with annual average execution of 91 percent, the performance of the 2010/11 budget was very low (only 75 percent of the budgeted funds utilized). The performance of the recurrent budget has been generally higher than the development budget, which recorded a very low execution of 58 percent in 2010/11. Performance of government funds was generally higher than foreign funds for

the past three fiscal years. With regard to foreign funds, the execution of basket funds was better than the non-basket funds, which recorded a very low execution of 51 percent in 2010/11. Budget performance continues to be hindered by factors including the low absorption capacity of the spending units, delays in the release of funds, non-release of funds, and lengthy and cumbersome procurement processes, which affect particularly the implementation of development projects.

Complementary financing

Between 2007/08 and 2010/11, receipts from the HSF have almost doubled. Although this could be reflecting an increase in population, it is also reflecting the fact that majority of the population is not insured; only 14 percent of Tanzanians are insured through NHIF and CHF combined. Further, the HSF continues to accumulate unspent balances, and in 2010/11 the balance was equivalent to 20 percent of receipts, which is a decline from 26 percent observed in 2009/10. In both 2009/10 and 2010/11, more was spent than was collected which resulted in decreases of the unspent balance. NHIF also has a large unspent balance, although this balance has declined from 63 percent in 2009/10 to 59 percent in 2010/11 of the total annual income. These funds (HSF and NHIF) should be used to improve health services promptly while maintaining prudent, actuarially determined reserves. Holding very large reserves defeats the whole purpose of collecting these funds.

Local government spending

"Other" sources of funding (which are substantially off-budget) increased from 7 percent in 2009/10 to 14 percent in 2010/11. Further, actual expenditure from councils' own resources remained constant at 2 percent. This is a threat to the sustainability of health interventions should there be a shock to the funds from the central level (government and development partners).

Access to tracer drugs

Access to tracer drugs from the sampled health facilities was found to be high. This reflects efforts made by councils to procure medicines from MSD, but also reflects the accreditation of Part I Pharmacies and ADDOs to serve NHIF/CHF clients. These pharmacies and ADDOs are key conduits for making medicine accessible to rural, marginalized areas, and more efforts should be made to work with ADDOs. This is also an area where the CHF funds could be used effectively.

Human resource for health

There has been great improvement in the deployment of human resource for health, which is a reflection of budget allocations to training and deployment of human resource for health. The overall gap in 2010/11 is 41 percent, compared to about 65 percent in 2006/07.

6.2 RECOMMENDATIONS

1. Despite the reiterated commitment to increase the share of health sector financing in the government budget to at least the 15 percent recommended in the Abuja Declaration, this has yet to be achieved, and the share shrank to below 12 percent in2011/12. It is high time that this commitment is honored with the deserved political will if progress is to be made in addressing the key challenges in the sector, particularly in human resources (retention and recruitments to fill the existing gap) and infrastructure.
2. Execution of the development budget continues to be plagued by several impediments, including the low absorption capacity, delayed release of funds, non-release of funds, and complexities in the procurement processes. Efforts should be scaled up to address these impediments to ensure smooth implementation of the budget.
3. Although the delivery of health services is largely concentrated at the local government level, the largest share of health sector financing is still managed at the central level. Despite this observation, it is worth noting that a significant portion of the funds managed at the central

level eventually goes down to the local level, particularly in the form of medical supplies. Nonetheless, the process of decentralization should be expedited, with particular focus on capacity strengthening for LGAs in the areas of finance management and procurement.

4. The poor performance of the MoHSW Internal Audit Unit due to non-release of the allocated funds threatens the functioning of the unit and the entire MoHSW PFM system. Thus, it is imperative to release funds as budgeted so as to enable the unit to perform its functions effectively.
5. Efforts to promote enrollment of households in CHF are evident at different levels. Lessons from best-performing districts and programs such as Tanzanian German Program to Support Health and Swiss Development Cooperation's CHF Strengthening program in Dodoma should be harnessed and applied nationwide. The major actors here include NHIF and LGAs.
6. Accreditation of Part I Pharmacies and ADDOs to serve the NHIF/CHF clients is an excellent move. These pharmacies and ADDOs are key conduits for making medicine accessible to rural, marginalized areas, and more efforts should be made to work with ADDOs. The NHIF and Tanzania Food and Drugs Authority are key actors here.
7. The government should intensify efforts on the linkages between CHF to NHIF to work toward universal coverage.

ANNEXES

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

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates
Recurrent											
National Health Insurance Fund	24,050	23,950	27,971	26,719	30,177	34,325	41,283	39,782	63,700	68,048	85,538
Ministry of Health											
Government funds	195,981	178,822	192,875	168,379	196,378	207,521	218,393	221,575	229,979	220,629	219,367
Donor basket funds	20,389	31,482	-	-	-	-	-	-	-	-	-
Regional Administration (Regions)											
Government funds	19,115	19,052	28,761	26,024	30,927	32,218	37,447	36,214	42,933	36,036	49,650
Local Government Authorities											
Government funds	114,779	115,392	145,286	139,168	144,902	154,494	201,488	235,171	242,000	216,088	277,281
Donor basket funds	23,331	23,094	-	-	-	-	-	-	-	-	-
Total recurrent	397,645	391,792	394,893	360,290	402,384	428,558	498,611	532,742	578,612	540,801	631,836
Development											
Ministry of Health											
Government funds	7,123	7,010	5,481	4,940	13,029	11,778	13,029	9,339	9,874	6,973	9,874
Donor basket funds	34,766	25,534	36,595	36,595	49,302	36,247	50,331	64,606	58,315	53,781	72,736

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates
Foreign (non-basket)	48,969	56,018	113,357	103,826	166,707	134,225	197,240	184,686*	380,254	186,174	282,185
PMO-RALG											
Government funds	70	70	57	57	23,057	56	56	56	-	-	-
Donor basket funds	21,424		450	450	650	1,626	687	687	687	686	687
Foreign (non-basket)	-	2,435	2,435	2,435	1,320	-	-	-	-	-	1,566
Regional Administrations											
Government funds	3,852	2,435	7,848	7,848	10,012	10,097	13,862	13,545	16,225	-	11,119
Donor basket fund					2,100	1,905	4,200	4,257	5,051	3,729	4,200
Foreign (non-basket)	-	3,059	5,742	5,742	8,726	6,423	1,827	5,609	7,654	-	4,154
Local Government Authorities											
Government funds	6,021	2,159	4,979	4,979	11,013	11,015	23,100	23,000	38,300	21,720	38,799
Donor basket funds		23,094	43,912	43,912	47,678	45,623	66,422	59,246	96,543	68,250	80,990
Foreign (non-basket)	-				27,615	13,520	55,734	9,754	28,293	27,805	25,428
Total development	122,225	121,814	220,856	210,784	361,209	272,515	426,488	374,785	641,196	369,118	531,737
Total on-budget	519,870	513,606	615,749	571,074	763,593	701,073	925,099	907,527	1,219,808	909,919	1,163,574
Funding Sources for On-Budget Expenditures											
Government	370,991	348,890	413,258	378,114	459,495	461,504	548,658	578,682	643,011	569,494	691,628
Donor basket funds	99,910	103,204	80,957	80,957	99,730	85,401	121,640	128,796	160,596	126,446	158,613
Donor non-basket funds	48,969	61,512	121,534	112,003	204,368	154,168	254,801	200,049	416,201	213,979	313,333

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12
	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates	Actual Expenditure	Approved Estimates
TOTAL	519,870	513,606	615,749	571,074	763,593	701,073	925,099	907,527	1,219,808	909,919	1,163,574
Off-Budget Expenditure											
Cost sharing											
Health Services Fund – hospital/cost sharing	-	2,964	-	5,696	-	5,858	-	9,767	-	10,116	-
Community Health Fund – primary health care	-	-	-	-	-	-	-	1,017	-	4,096	-
Total off-budget	-	2,964	-	5,696	-	5,858	-	10,784	-	14,212	-
Grand total	519,871	516,570	615,748	576,769	733,878	706,931	925,099	918,311	1,219,808	924,131	1,163,574

*There was a typing error with this figure in the 2009/10 Health Sector Public Expenditure Review. The correct figure is 184,686, not 84,686

ANNEX B: GLOSSARY OF TERMS

Consolidated Fund Services (CFS): The component of government spending that covers public debt service.

Exchange Rate: The price of one currency in terms of another (in this report, exchange rate refers to the price of 1 U.S. dollar [USD] in terms of Tanzanian shillings [TZS]).

Community Health Fund (CHF): CHF is a voluntary pre-payment scheme whereby members pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount at the health facility through user fees if they become sick. It was instituted as possible mechanism that could help in granting access to basic health care services to populations in the rural areas and the informal sector in the country.

Drug Revolving Fund (DRF): This fund was established as a source of revenue for replenishing drugs in the public facilities. The idea was for patients to pay 50 percent of the cost of the drug at the public health facilities. The money collected would be used by hospitals to supplement the government budget allocation for drugs.

Health Services Fund (HSF): HSF are funds that are collected at the point of service delivery at the public health facilities as cost sharing in health for people who are not insured through CHF, NHIF, TIKA, or any other health insurance agency.

Joint Rehabilitation Fund (JRF): The JRF came into operation in 2004 as the means of earmarking and channelling funds for the rehabilitation of primary health care facilities in poor condition. The main contributors were the government, Danida, and the Health Basket Fund. A small amount of funding was also provided to Regional Health Management Teams for supervision and to the Prime Minister's Office-Regional Administration and Local Government for technical support to councils, audit, and coordination and monitoring.

JRF was replaced by the Health Sector Development Grant (HSDG) in 2008/09. This operated as a "window" within the broader Local Government Development Grant system, using the same allocation formula as the health Other Charges and the Health Basket Fund. Subsequent years' allocations were expected to be based also on performance. Funds under HSDG are to support the implementation of the Primary Health Services Development Program (MMAM in Swahili) with the aim of improving access to quality health services. It is a 10-year program (2007–2017) which is geared toward improving access to primary health services.

Local Government Development Grant (LDGD): The LGDG system was initiated under the Local Government Reform Program to provide additional funds for capital development at the Local Government Authority (LGA) level. There are two types of grant – the LGDG for those councils meeting a minimum set of criteria reflecting both existence of necessary structures as well as performance; and Capacity Building Grants for those councils which did not meet the criteria.

Matching Fund: This is the fund paid to the LGAs based on how much they have collected in terms of CHF and TIKA (the urban equivalent of CHF). The fund matches what the LGAs have collected. The matching fund is paid by NHIF but not out of members' contributions or income from its investments; the money is from a WB loan facility. For instance, if an LGA has collected TZS100 million, then the National Health Insurance Fund matches it by paying TZS100 million to the respective council.

National Health Insurance Fund (NHIF): The NHIF mobilizes funds from employees and employers to finance health care services for its members. The contribution rate is provided in the act establishing the fund, which sets the premium at 6 percent of the employee's gross monthly salary (met equally by both employer and employee – 3 percent each).

Nominal Expenditure: The value of expenditure reported at current prices.

Real Expenditure: The value of expenditure adjusted for the effect of price changes (inflation/deflation).

Deflator: A factor used to adjust the nominal values to real values by removing the effect of price changes.

Off-Budget: Expenditure items that are not captured in the budget records.

Tiba kwa Kadi (TIKA): TIKA is the urban equivalent of the CHF. This has been introduced in urban areas in order to address urban-specific dynamics in living arrangements and accessing health care.

ANNEX C: LIST OF TRACER MEDICINES/ITEMS FOR COMPREHENSIVE COUNCIL HEALTH PLANS

(VACCINES, MEDICINES, CONTRACEPTIVES, AND MEDICAL AND LABORATORY SUPPLIES)

Select 1 or 0: 1=Available; 0=Not available

If Not available, then select A, B, or C:
A= Not available less than 1 week;
B= Not available for 1–3 weeks;
C= Not available the whole month.

Line No.	Description	Available?	If "No"	Stock-Out Rate
1	DPT + HepB/HiB vaccine for immunization	1=Yes 0=No	A: <1 week B: 1–3 weeks C: whole month	
2	Artemether/Lumefantrine (ALu) oral			
3	Amoxycillin or Cotrimoxazole oral			
4	Albendazole or Mebendazole oral			
5	Oral rehydration salts			
6	Ergometrine or Oxytocin injectable or Misoprostol oral			
7	Medroxyprogesterone injectable contraceptive			
8	Dextrose 5% or Sodium Chloride + Dextrose IV solution			
9	Syringe and needle, disposable			
10	Malaria rapid diagnostic test (MRDT) or Supplies for malaria microscopy			
11	Optional Line 1:			
12	Optional Line 2:			

TRACER LINES FOR HEALTH MANAGEMENT INFORMATION SYSTEM (MTUHA)

Background

The Ministry of Health and Social Welfare has revised and updated the indicator on the availability of drugs, medical supplies, laboratory reagents, and vaccines that will be part of the pilot new health management information system (MTUHA). The indicator reports a number of "tracer" lines/items that is set to a maximum of 10, to keep the burden of reporting manageable. There can be an additional two lines left as blanks on the data collection form to be defined according to local interest (at the districts/regions each year)– for example, safe delivery kits/packs for mothers.

Definition of Availability

For each tracer line, "availability" is defined as continuous supply of the specified item or therapeutic equivalent. If the required service or treatment was provided to clients and patients of all age groups throughout the month, then the tracer line is defined as **available**.

EXAMPLE 1: If labor was managed with oxytocin injection while ergometrine injection was out of stock, then the Tracer Line 6 is reported as **available**, because the case was managed with a therapeutic equivalent. If all of the therapeutic alternatives (oxytoxin, ergometrine, or misoprostol) were out of stock, then Line 6 is reported as **not available** because the recommended treatment could not be provided.

EXAMPLE 2: If cases of malaria in one of the age groups could not be treated, then the Tracer Line 2 for the antimalarial medicine "ALu" is reported as **not available**. If an adult with malaria was dispensed ALu in two strips of 6 X 2 (instead of one strip of 6 X 4) then ALu is reported as **available**, because the treatment dose was provided.

Purpose

The purpose of this tracer indicator is to report on the Comprehensive Council Health Plan indicator on availability: **"Proportion of health facilities by level with constant supply of drugs/medical supplies and laboratory agents at hospital, health center, and dispensary level."**

Reporting

Each health facility reports availability (Yes/No) of tracer items during the reporting period (1calendar month). If "No," then facility reports the duration of stock-out (<1 week. 1–3 weeks, or whole month). The district report tabulates the number and proportion of health facilities reporting continuous supply for each tracer line. Secondary analysis tabulates the number of facilities having stock-out of all therapeutic alternatives in the tracer line, and the number falling in each category (A, B, or C).