United Republic of Tanzania
Ministry of Health

Final report

Health sector PER update FY 05

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Ministry of Health
Tanzania

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Acronyms

AGO	Accountant General's Office
AIDS	acquired immuno-deficiency syndrome
ARVs	anti-retroviral (drugs)
BER	Budget Execution Report
bn	billion
CCHP	Comprehensive Council Health Plan
CFS	Consolidated Fund Services
CHF	Community Health Fund
CMO	Chief Medical Officer
CPI	consumer price index
DC	district council
DfID	Department for International Development (UK)
DPP	Directorate of Policy and Planning
FY	financial year
GAVI	Global Alliance for Vaccines and Immunisations
GBS	general budget support
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
GPF	General Purpose Fund (for LGAs)
HIV	human immuno-deficiency virus
HSF	Health Service Fund
HSPS	Health Sector Programme Support (Denmark)
HSSP	Health Sector Strategic Plan (July 2003 – June 2006)
IFMS	Integrated Financial Management System
KCMC	Kilimanjaro Christian Medical Centre
LGA	Local Government Authority (ies)
m	million
MC	municipal council
MDA	ministries, departments and agencies
MKUKUTA	[Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania]
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	non-governmental organisation
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
OC	other charges
PE	personal emoluments
PER	Public Expenditure Review
PFIR	Physical and Financial Implementation Report
PHC	primary health care
PORALG	President's Office – Regional Administration and Local Government
PRS	poverty reduction strategy
PRSP	poverty reduction strategy paper
SBAS	Strategic Budget Allocation System
TACAIDS	Tanzania Commission for AIDS
TC	town council
TFNC	Tanzania Food and Nutrition Council
TOR	terms of reference
TPDF	Tanzania People's Defence Force
TRHS	Three Regions Health Study (African Development Bank)
TSh	Tanzania shillings
US$	United States dollars
WHO	World Health Organisation

Acknowledgements

The health sector PER update for FY05 was undertaken by a Task Team comprised of officials from the Ministry of Health Department of Policy and Planning, supported by colleagues from other Departments. An external consultant health economist, Ms Sally Lake, was contracted by the Swiss Agency for Development and Cooperation to support the process.

Thanks are due to the various officials of the MOH who contributed data for this exercise, and also to colleagues in the Ministry of Finance and the President's Office – Regional Administration and Local Government. Mr Muhume, Chief Pharmacist MOH, and Mr Tesha of Medical Stores Department provided useful information on drugs and medical supplies, while Mr Sendoro, the Community Health Fund coordinator, and Dr McLaughlin of the World Bank provided information on the CHF. Mr Noel contributed figures from the National Health Insurance Fund. Mr Lapper of the Local Government Reform Programme provided useful clarification on queries relating to block grant funding of councils. Mr Rosche of JSI Deliver updated information on antiretroviral procurement.

Welcome comments and feedback were received from members of the Technical Sub-Committee of the Ministry of Health, and also by participants following presentation at the annual Health Sector Review meeting in April 2005.

Finally, some information drawn on in this report was compiled by the consultant during a separate assignment, the Three Regions Health Study, funded by the African Development Bank, and implemented by Medical Service Corporation International with the MOH.

Executive Summary

Purpose, output and limitations

In contrast to recent years, the health sector Public Expenditure Review update for FY05 is presented largely as an internal sectoral document for reviewing trends in budget and expenditure rather than as a detailed input to the budget process due to its delayed timing and a change in the focus of the overall government poverty reduction strategy with the development of the MKUKUTA (the Kiswahili acronym for the National Strategy for Growth and Poverty Reduction, the second Poverty Reduction Strategy Paper)[1]. This highlights "priority cluster outcomes" rather than priority sectors, and entailed a change in the way that sector inputs to the budget guidelines were prepared and presented, together with a recognition that undertaking full sectoral PER updates would present a significant administrative burden on line ministries in addition to these changes. This document is therefore somewhat less detailed than its predecessors.

The document was produced by a team led from the Ministry of Health Department of Policy and Planning, supported by an external consultant. Major constraints, as in previous years, remain the timely availability of the necessary data, both within the sector and from Ministry of Finance, together with the questionable quality of data provided by local government authorities in the absence of detailed expenditure data collated on their behalf through the Integrated Financial Management System (IFMS). Data on off-budget sources of funding, namely cost-sharing revenues and expenditures and details of off-budget external resources, remain particularly weak.

Initial findings use Ministry of Finance summary data, while subsequent analysis of sub-sectoral spending relies on data compiled specifically for the PER update. Inconsistencies remain but are not believed to affect the major findings.

Sectoral budget and expenditure trends

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

Key figures – on-budget Ministry of Finance data:

- Nominal budget outturn for FY04 rose year on year from TSh186.7bn in FY03 to TSh 218.2bn in FY04, an increase of 16.9%. This represented a real increase of 12.5%
- For FY05, the nominal budget rose to TSh 290.4bn, an increase of 33% on FY04 outturn. This is represents a real increase of almost 28%
- Final budget outturn for FY04 shows a sector share of 9.7% of overall government spending (excluding CFS) compared with FY04 PER estimates of 9.2%.
- This is projected to rise to 10.1% for FY05, but still falls short of the FY03 figure of 10.4%
- The share of government spending remains low relatively to the Abuja target of 15%
- Per capita spending remains low in relation to costs of delivering on health sector goals and targets at US$7.42 for FY05, but has seen a substantial increase on FY04 outturn from US$5.71

[1] Mkakakti wa Kukuza Uchumi na Kuondoa Umaskini Tanzania.

Although the sector remains severely under-funded in relation to the Abuja target of 15% of GOT budget, and in relation to recent estimates of what it would cost to provide a limited package of services to the Tanzanian population, the overall picture of both expenditure in FY04 and the budget for FY05 is more positive than it was in the previous year. Overall MOF data show that the final share of FY04 expenditure (excluding Consolidated Fund Services, CFS) was 9.7% compared to an estimate of 9.2% at the time of the FY04 PER update. It should be stressed, however, that this still represents a fall from the FY03 figure of 10.4%.

In FY05, the picture is redressed somewhat with a budgeted share of 10.1% of total GOT spending (excluding CFS). In nominal terms, this represents an increase (on FY04 outturn) of 33%, while in real terms the increase is almost 28%. In nominal per capita US dollar terms, the allocation to the sector has risen from US$5.71 to US$7.42. This increase is due both to a significant rise in external funding, notably the significant inflow from the World Bank, but also to an increase in domestic recurrent funding (including General Budget support, GBS) of Other Charges.

Key figures – PER data

- The budgeted overall public health sector resource envelope rose in nominal terms from TSh 291.1bn in FY04 to TSh 453.2 bn in FY05, an increase of 56%
- Compared with FY04 estimates of outturn, this represents an increase of 46%
- This converts to a per capita US dollar figure of US11.57, a significant increase on the US$8.12 of FY04
- In real terms, the increase in the value of the resource envelope represents an increase of 40%

PER data show that the nominal total health sector resource envelope including off-budget sources also grew significantly, by 56% in terms of year-on-year budget, and by 46% compared with FY04 outturn. A 60% increase in MOH recurrent spending and a 29% increase in the recurrent LGA allocation (compared with FY04 outturn) were the major drivers of this rise, both partly due to the increase in the basket funding to the sector. In real terms, the increase was still substantial, at 40% overall and 36% in per capita Tanzania shillings (FY05 budget compared with FY04 outturn). When off-budget sources are taken into consideration, the per capita US dollar allocation to the sector rises to US$11.57 for FY05[2].

Analysis of sub-sectoral spending is largely confined to on-budget sources, using PER data, due to lack of data on how off-budget funds are spent.

For FY05, the split between the recurrent and development budgets has remained broadly stable, with recurrent spending accounting for 77% of the total on-budget. In actual expenditure terms, there was a continued slight fall in the share of recurrent spending due to improved budget performance of the development budget.

Linked to the substantial absolute increase in basket and other external funding to the sector, the share of domestic funding (including GBS) in the sector budget has fallen from 23% in FY04 to almost 38% in FY05. This is largely temporary as much of the World Bank funding will move to GBS for FY06 onwards. The external share of actual outturn for FY04 was almost 28%, higher than budgeted due to the within-year reallocation to the development budget and reasonable disbursement thereof.

In comparison with recent years, there has been a noticeable recentralisation of the budget in FY05, with the local government share falling from 33% of the final FY04 budget to 27% of

[2] Data concerns regarding off-budget funding are noted in the main report and should be taken into consideration.

the FY05 budget. This is largely due to the significant absolute rises in both central level GOT and basket funding, which mask a corresponding increase in the allocation for drugs and medical supplies for other levels. Another source of this shift is the increase in the budgeted GOT transfer to the NHIF, again ultimately intended to result in spending at LGA and regional (hospital) level. Although the same definitions have been used for consistency and comparison with previous years, the large share of central spending which is channelled to other levels means that this analysis is of limited use, and a more comprehensive attempt to determine the allocation of such funds to beneficiary levels is overdue.

Such an attempt is made in terms of GOT recurrent funding by activity type (administration, hospital and preventive/primary), although minor concerns remain regarding the completeness of this information. The available data indicate a slight reduction in the share of actual expenditure going to Administration between FY03 and FY04, from 44% to 42%, a similar reduction to the Preventive and Primary category (from 16% to 14%), with a corresponding increase in the allocation to hospitals. This may in part be due to the reassignment of funds during the FY for the purchase of anti-retroviral drugs which are delivered at hospital level.

The projected share of off-budget spending for FY05 is 6% higher than it was in FY04 at 31%. Actual off-budget expenditure in FY04 accounted for an estimated 29% of the total. Concerns regarding data quality and completeness and the assumptions used in estimation of both external and cost-sharing reduce the usefulness of this analysis. Notwithstanding, reported data indicate an increase of 51% in the nominal value of Health Service Fund (HSF) revenues, and a rise in the per capita value of such receipts from TSh59 in FY03 to Tsh87 in FY04. Community Health Fund data remain very weak, and various assumptions and extrapolations were required to reach a very tentative national revenue estimate of TSh4.75bn. Off-budget external financing estimates for FY05 were taken from the data submitted to the MOF External Finance Department, and indicate a significant increase from TSh69bn in FY04 to almost TSh 133bn in FY05.

Budget performance

Budget performance of the on-budget sectoral total (PER data) improved in FY04, with expenditure matching net approved budget, partly due to a higher than budgeted release of funding to NHIF, and partly due to improved release of funding through the MOH headquarters development budget during the course of the year.

IFMS data on MOH headquarters budget performance (release as % budget) indicate an improvement in this component of sector spending, with 97% of budgeted funds released by MOF in FY04, compared with 90% in FY03 (GOT and basket) and only 86% of the GOT share of this. In terms of absorption capacity (expenditure as % of release), MOH performance also improved, from 97.9% (GOT and basket) to 99.5% in FY04. Data on the first half year performance for FY05 indicate that over 50% over budgeted funds had been released by the end of December 2004 (50.6% of GOT funds and 62% of basket funds). Absorption of these funds was at 75% overall by end December 2004.

At Regional level, expenditure as a percentage of approved estimates was 98.7% for FY04, with both Curative and Preventive sub-votes performing well. Personal Emoluments (PEs) performed slightly better than Other Charges (OCs).

For the large hospitals, IFMS data indicate a 98% release of funding for FY04, with 100% expenditure of released funds.

MOH HQ spending on drugs and supplies, a key input in the sector, has risen from an actual level of TSh 29.2bn in FY04 to a budgeted figure of TSh 50.2bn for FY05 (which excludes a

further TSh3.5bn for anti-retroviral drugs). The health basket is expected to contribute roughly 24% of this figure. Drugs and medical supplies are expected to account for 42% of MOH OCs in FY05, up from 36.5% in FY04 (actual), while the per capita US dollar figure rises from US$0.76 in FY04 to a projected US$1.37, of which only a small proportion is currently due to anti-retroviral drugs (ARVs). More work is required in this area to ascertain total figures from all sources of funding as the PER analysis concentrates on GOT and basket funding.

Local government spending

Budgeted allocations to councils rose for FY05 to TSh63.6bn, a 37% increase on releases during FY04. In real terms, this represents year-on-year growth of 31% in the LGA allocation. This was largely driven by an increase in the OC allocation, in contrast to the previous year where PEs accounted for the whole of the 14% increase over FY03. The nominal value of the LGA health budget (PE and OC) converts to an approximate US dollar value of $1.62 per capita.

Although data for individual councils was incomplete, summary data indicate that budgeted Health sub-votes account for 17.6% of LGA allocations on average for FY05. This represents a 1% increase on FY04 which is encouraging, but also indicates that the sector has failed to attain its baseline share of 18%. Given a 14.2% reduction from original to net approved estimates for LGA OCs during FY04, it is also likely that the final share of actual expenditure could be quite different, but unfortunately data were not available to compare actual as opposed to budgeted proportions.

Budget performance appeared to be satisfactory at LGA level, with PER data indicating releases of 101% of the final budget. This was driven by releases for PEs exceeding budget by 5.1% (slightly higher for urban than for district councils) which masked an 8% shortfall in the OC release (broadly similar by council type).

Financial years for central and local government were harmonised from the start of FY05. In addition, the geographical allocation formula employed for the health basket was also applied to the block grant (although it remains unclear whether this was for both OC and PE components). These moves are both expected to facilitate future analysis of sectoral funding, and the LGA component thereof, and are welcomed.

Although the quarterly health sector physical and financial implementation reports produced by each council are a potentially valuable source of information on the intra-district allocation of funding and on actual expenditures, for many councils they remain weak in terms of data quality and comprehensiveness. Opportunities for central level comparative analysis of LGA finances are therefore not exploited. Further efforts to improve the quality and consistency of such reports (and analysis thereof) would be worthwhile, particularly in the continued absence of IFMS data at the LGA level.

Sectoral performance

As a priority sector, Health showed a slight gain in its share of overall GOT spending (as noted above) compared with FY04, but has not yet regained the level attained in the earlier years of PRSP 1.

The available data suggest that spending on priority items within the sector has fallen for the second year running as a share of sector spending (GOT on-budget). The figures for FY04 are likely to have been affected by the substantial over-spend on NHIF under Vote 23, while incomplete data on spending on drugs and medical supplies for district health services may

also have contributed to this picture. This should be explored in more detail in the next update.

In terms of sectoral performance indicators, the substantial increases in the overall resource envelope are reflected in positive movement of the central and local government values of indicator 1 which monitor the per capita GOT allocation to health at each level. There has been a slight fall in the budget for the regional level for FY05. Indicator 2 measures the total per capita resource envelope for the sector, and has also seen a 52% increase in the year on year budget in FY05.

However, in terms of the breakdown between levels of the health system, as far as the PER data were able to show, there has been a continued poor showing in terms of the allocation between central and local government shares, despite a stated commitment in the Health Sector Strategic Plan to decentralisation and to improving the performance of district health services in particular.

Recommendations

Early agreement is required both on the terms of reference for any subsequent health sector PER update to feed into internal sectoral review and discussions, but also on the nature of any cross-sectoral PER exercise which might seek to reflect the cluster approach of the MKUKUTA. Timing will need to be arranged in order to prevent duplication of these two potentially parallel processes.

The PER Working Group should be approached to help facilitate the timely and simple transfer of the necessary information for the PER update from MOF, Treasury and PORALG, among others. Ideally the PER Task Team should endeavour to compile this on a quarterly basis in order to reduce the task at year-end. This should be extended also to internal data from the Chief Pharmacist on the allocations for drugs and medical supplies which is already compiled quarterly for departmental purposes, and for the National Health Insurance Fund, along with any other major data providers.

A more detailed assessment of the total value and volume of drugs and essential medical supplies within the sector should be undertaken, to include the development budget, off-budget external funding, and regional and local government spending. This should also include more analysis of the allocation by level of the health system, by key intervention areas, and by geographical area, in order to ensure that this key input is being used to maximum effectiveness.

Work to determine the allocation by final beneficiary level of the health system of the various expenditures made on their behalf by the central level should be undertaken in order to provide both a more comprehensive analysis than has been undertaken in the recent PER updates. This should cover all on-budget sources (ie including basket and other development spending) rather than simply GOT recurrent as has been the practice in recent years.

Additional areas where better information is required include off-budget external funding, both in terms of harmonising information from the MOF External Finance database with that in the official budget estimates, and in terms of obtaining a better picture of actual expenditures, as this is currently subject to a number of questionable assumptions in the PER. Further analysis might be usefully undertaken to ensure that such funding is in accordance with sector/national priorities.

The quality of data on cost-sharing has been raised as a concern for several years, particularly regarding the Community Health Fund. Given the current debate on this issue,

both in Tanzania and on the international policy agenda, and the widely diverging opinions held, a much stronger evidence-base would be most welcome.

Greater efforts should be made to improve the quality, consistency, and central analysis of reports prepared by the LGAs in order to obtain useful information on allocation and sector performance at that level.

1 Introduction

1.1 Background and context

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

For the financial year FY2004/05 (FY05[3]) the process has been changed somewhat due to the additional administrative burden on government departments of contributing to the second Poverty Reduction Strategy Paper (PRSP), the National Strategy for Growth and Poverty Reduction[4], which has moved away from the concept of priority sectors to focus on a number of priority outcomes. This represents a concerted effort to link financial and other inputs to priority poverty-reducing outcomes which are the result of the activities in a number of different sectors.

Input to the budget guidelines for FY06 was undertaken prior to and separately from the PER exercise, and due to the introduction of new software, involved substantially greater time in its preparation. In recognition of the additional workload represented by the development of MKUKUTA and the Budget Guidelines submission using the newly developed Strategic Budget Allocation System (SBAS) software, this PER is less detailed than in previous years, focusing on key expenditure trends.

A Task Team and Consultant carried out the study prior to the preparation of the Medium Term Expenditure Framework (MTEF) for 2005/06 to 2007/08 for the Ministry of Health (MOH). Members of the Task Team were:

- Mr Richard Mkumbo, Economist, Directorate of Policy and Planning (DPP), MOH (Coordinator)
- Ms Mariam Ally, Economist, DPP, MOH
- Ms Neema Jamu, Economist, MOH
- Mr Kenny Lawson, Economist, DPP, MOH
- Mrs Masunga, Deputy Chief Accountant, MOH
- Mr Richard Shankango, Accounts Section, MOH
- Ms Sally Lake, Consultant

Two definitions of the sector are used throughout this document, as summarised in Table 1 below.

[3] Throughout this document, the notation FYXX is used to refer to the financial year ending on 30 June 19XX or 20XX, eg FY02 refers to the period 1 July 2001 to 30 June 2002.

[4] The document is henceforward referred to as MKUKUTA, the Kiswahili acronym for "Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania."

Table 1 Health sector definitions used in the FY05 PER update

Health sector definition	
On-budget	Recurrent and development, local and foreign budget and expenditure figures as reflected in official GOT estimates for: • Vote 52 – Ministry of Health headquarters • Vote 56 – PORALG (Project 5421 in development budget) • Vote 23 – NHIF subvention through Accountant General's Office • Regions – Sub-votes 3001 Curative and 3002 Preventive • LGAs – Sub-votes 5010 Health services, 5011 Preventive, 5012 Health centres and 5013 Clinics/dispensaries
Total	As for on-budget, plus: • Reported expenditures (or where no expenditure possible, revenues) from cost-sharing within public health institutions (Health Service Fund, Community Health Fund and associated user fees, Drug Revolving Fund) • External funding captured in MOF database but not within official budget estimates

It should be noted that this excludes two areas: health-related spending in other Ministries, Departments and Agencies; and some of the spending which now appears under TACAIDS yet which can be seen as health-related expenditure. On the former, time constraints prevented collection and analysis of this data, while the latter is assumed covered under the cross-sectoral Public Expenditure Review update for HIV/AIDS. As last year, these definitions have been used in order to reflect the official government definitions of health as a priority sector, and it is envisaged that this will change in the future with the new approach under MKUKUTA.

1.2 Terms of Reference

No sector-specific Terms of Reference (TORs) were produced for the health sector PER update for FY05. Work undertaken was based on previous years outputs, together with the generic TORs provided by the PER Macro Group, and comments from individual development partners.

1.3 Process

As was the case the previous year, the process of updating the Health sector PER for FY05 was undertaken entirely in Dar es Salaam, through desk review, and data collection from relevant ministry departments and other agencies.

As has typically been the case, the process of obtaining much of the data was long and drawn out, with substantial gaps remaining at the end of December 2004. This was the case both in relation to information from within the MOH itself, and also to data from outside the MOH, eg on actual disbursements to local government authorities.

Recommendations to strengthen the process for the FY05 update were generally not acted upon. In light of the uncertainty regarding the process in future years, given the "cluster approach" within MKUKUTA, recommendations are reiterated in Section 5 as a means of maintaining updated information on health sector budgets and expenditures for internal sectoral purposes, and to feed into any future multi-sectoral PER.

1.4 Structure and contents of the report

1.4.1 Changes from PER update for FY04

Unlike previous years, this report has been prepared in isolation from the Budget Guideline submission, and is therefore not expected to feed greatly into budget preparation. It is indeed questionable whether this has actually been achieved in previous years. The sections on Future Costs and Revenues are therefore excluded, having been largely addressed in the Budget Guideline submission, and given the uncertainty regarding the nature and purpose of sectoral PER updates for FY05. The desire to more closely link the PER and budget/MTEF preparation processes in the future of course remains high on the agenda for the Ministry of Finance and other line ministries.

The aim of the health sector PER update for FY05 is to summarise key findings of a retrospective analysis of the sectoral budget and expenditure, and to propose areas for follow-up during the coming financial year. Where appropriate, implications of these findings for the coming budget preparation cycle will be highlighted.

1.4.2 Report structure

Section 2 begins with a review of the recommendations and follow-up on main findings of the PER update for FY04. It then continues with a review of the major trends in health budget and expenditure, using two main sources of data. Section 2.2 is based on Ministry of Finance aggregate sectoral data, and presents both absolute levels of spending, and examines the share of overall GOT budget assigned to Health. Sections 2.3 onwards use data collated specifically for the PER update from the disaggregated sources, ie individual council releases, MOH appropriation accounts etc. Section 2.3 itself examines sub-sectoral trends, based on the PER data, while Section 2.4 reviews budget performance over the past year. Section 2.5 updates analysis on the area of drugs and medical supplies specifically, and also adds a brief section on anti-retroviral drugs which are increasing in importance within the sectoral budget and expenditure.

Section 3 looks at the issue of local government budgets and expenditure in some more detail, covering the overall level and share of spending at the service delivery level, together with a summary of budget performance. The section also presents some data from councils' own sources, highlighting variations in reported income and expenditure, and the need to strengthen such reports in order to maximise opportunities for improving financial information and performance.

Section 4 summarises sectoral performance, both as a priority sector and of the priority items within the sector, as well as presenting updated values of the financial indicators for the sectoral Performance Profile.

Section 5 summarises key findings from the preceding sections, and makes some recommendations for future action and emphasis.

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

2 Recent trends in health sector expenditure

2.1 Review of previous PER studies

In order for the PER to serve its intended purpose, its conclusions and recommendations need to be agreed and acted upon in order to strengthen the future level and allocation of sectoral resources. This is the fifth consecutive PER exercise, and it is useful therefore to begin by reviewing the key findings and recommendations of the previous update in order to set the context for the analysis presented below. Main findings and recommendations of the FY04 health sector update, together with actions taken by the sector to address them where necessary, are therefore summarised in Table 2 below.

Table 2 Key findings and actions from health sector PER update for FY04

Finding/recommendation	Action taken
Decline in the health sector share of overall GOT budget	• Lobbying by Development Partners at the Health Sector Review, and at the Development Partners Group Heads of Agency meeting, and by the MOH to Ministry of Finance contributed to a supplementary budget which resulted in a net increase to the sector ceiling both in nominal terms and in the sectoral share[5].
Failure to activate the agreed high-level Joint Health Finance Committee during FY03/04	• This committee was activated in October 2004, and has met 3 times to date. Members include the Commissioner for Budget and the desk officer for Health from the Ministry of Finance, a representative from PORALG, the Director of Policy and Planning and other MOH officials, together with development partner representation. Deliberations have covered the development of TORs for the group, MKUKUTA in terms of the resource allocation framework, and the sector input to the Budget Guidelines for FY06.
More disaggregated work to be undertaken to determine complete breakdown between level of health system (central, local)	• Not done
Analysis of spending in at least two programmatic areas, at central and LGA levels, to be included in FY05 PER	• Not done due to non-inclusion in discussion of TORs and lack of time during PER update exercise, together with delay in decision as to whether there should be a Health sector update as per PER Macro Group discussions.
MOH to take forward issue of falling Health share in LGA spending	• This is a broader issue than Health alone, and has not been addressed. The additional work which the sector has undertaken in terms of strengthening district capacity merits further lobbying regarding this indicator.
Tracking study of local government spending (GOT, basket and other) to update the 2001 pro-poor tracking study	• Not done for the health sector, although one is planned for spending on HIV/AIDS. Due in part to same reasons as above, ie desire for lighter exercise, and delay in decision re Health sector PER update.
No analysis undertaken of information on Health Service Fund – different sources of fee revenue and types of expenditures	• Not done. Reiterated in this PER update. The planned Health Financing Workshop to be held in May 2005 is expected to raise issues relating to cost-sharing with a view to reflecting on current mechanisms in place in the country, and the strengthening of health financing strategy in the future.

[5] Nominal estimates included in the PER update for FY04 were TSh 197.2bn compared with Actual expenditure of TSh 218.2bn, an increase of almost over 10%. The original share of the FY04 budget was 7.6% (including CFS) and 9.0% (excluding CFS), while the final shares were 8.5% (including CFS) and 9.7% (excluding CFS).

Lack on information on the CHF to be addressed	• No real improvement. Reiterated in this PER update. As above, it is expected that this will receive attention in the forthcoming Health Financing Workshop.
More detailed tracking study on the whole area of spending on drugs and supplies, at all levels, on and off budget	• Not done, in part for reasons as above. Reiterated in this PER update due to importance for the sector in terms of service quality, accountability, and user satisfaction.
Need to firm up data on off-budget external funding	• Not done. Reiterated in this PER update.
Improvement in timing of PER necessary to enable it to perform its function of feeding into budget preparation	• Not possible this year due to confusion regarding whether an update would be done at all. Some concern remains regarding MOH internalisation of the PER, despite agreement on its place as an input to the April Joint Health Review, with continued MOH failure to initiate data collection and other preparatory activities from July each year resulting in an unnecessarily rushed exercise. This should be discussed further for FY06 when the whole nature of the PER update will presumably change due to the cluster focus of the MKUKUTA.
Data constraints due to lack of follow-up during FY by MOH staff, and to unnecessary bureaucratic requirements of MOF/Treasury staff in releasing routine data should be addressed	• Not done. Same delays were experienced this year. In addition, although there was greater readiness to supply electronic data, this contained inconsistencies and data gaps, and was not always an improvement on the hard copies. Routine in-year monitoring of releases and expenditures is recommended, together with acceptance by MOF of the public nature of such data. The PER Macro group should perhaps specify the need for the relevant data sections of the MOF to routinely provide the necessary information to line ministries for in-year and timely end of year monitoring of budget performance.

2.2 Total public health budget and expenditure

This section, unlike the data in Sections 2.3 onwards, uses official published GOT data to review sectoral performance in relation to the overall budget. As in previous years, different central level official sources reveal inconsistencies, and it has not been possible to unpack all the data to cross-check each component. The decision was therefore made to use the published figures from the October 2004 Budget Review produced by the Ministry of Finance[6] as these provided sufficient detail for the main analysis.

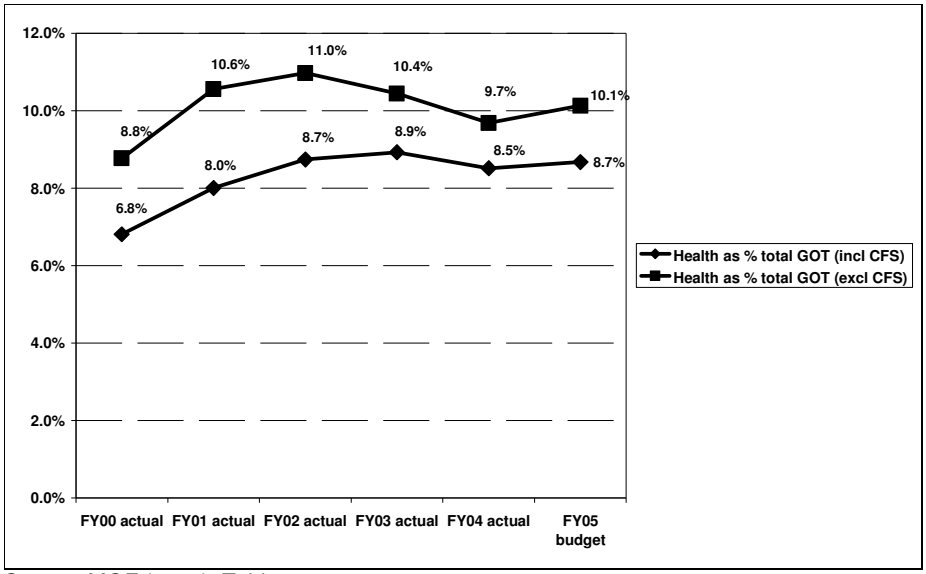
2.2.1 Health in relation to the total GOT budget

Health was identified as a priority sector within the first Poverty Reduction Strategy (PRS), and as such was expected to benefit from increases in both the absolute level of government funding, and in its share of the budget. Figure 1 below plots total on-budget spending on health as a percentage of total government spending over the past five years, together with the budgeted amount for the current financial year (FY). Figures are shown both inclusive and exclusive of spending on the Consolidated Fund Services (CFS)[7].

[6] MOF (2004). *Budget review: recent developments in budget execution and formulation*. Dar es Salaam: October 2004

[7] CFS largely comprises debt and interest payments (both domestic and foreign) which have first claim on national resources. The GOT budget excluding CFS is therefore used to define the 'discretionary budget' within which government has more scope to articulate its spending priorities.

Figure 1 Sectoral spending as a proportion of the total GOT budget, FY00 – FY05



Source: MOF (2004), Table 2, p4

Figure 1 shows that there has been a slight increase in the Health sector share of the budget for FY05 compared with the outturn of the previous financial year (which was itself much improved during the course of the FY due to a supplementary budget and reallocations within the foreign development budget). The projected sectoral share of the total GOT budget excluding CFS for FY05 is 10.1%, representing a 0.4% increase on the outturn for FY04. This is encouraging, although it should be noted that it still falls short of the share achieved in the early years of the PRS, which according to this data had reached a high of 11% in FY02. It also falls short of the 15% Abuja commitment (although some relevant expenditure may be covered under the priority sector of HIV/AIDS rather than Health)[8].

When CFS is included, the share shows a slightly smaller increase, of only 0.2%, due to the large rise in the value of CFS within the FY05 budget[9].

2.2.2 Total on-budget health spending

In nominal terms

As noted in Section 2.2.1 above, following the publication of the PRS the allocations to the sector initially increased in terms of share of total government spending before falling from FY02 to FY04, and lately rising again. While the nominal value of Health sector spending has increased consistently, the rate of growth has fluctuated in recent years, as shown in Figure 2 below.

[8] Time did not permit an update of the analysis in the FY04 PER report which attempted to separate out spending on HIV/AIDS from the broader health sector total. This could be done subsequently if felt useful.

[9] 56%, up from TSh 309.3bn in FY04 to TSh481.2 bn in FY05.

Figure 2 Nominal on-budget health spending and rate of growth, FY01 – FY05

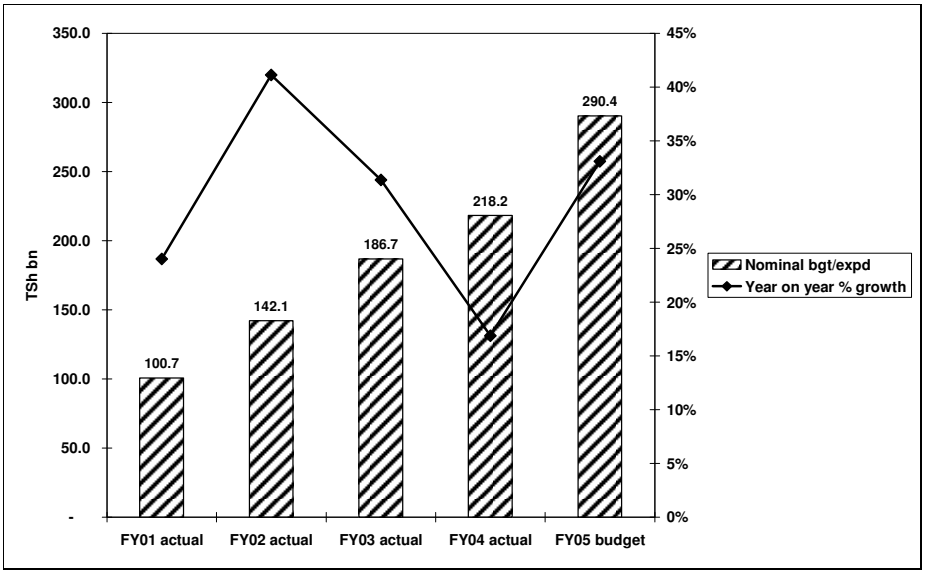
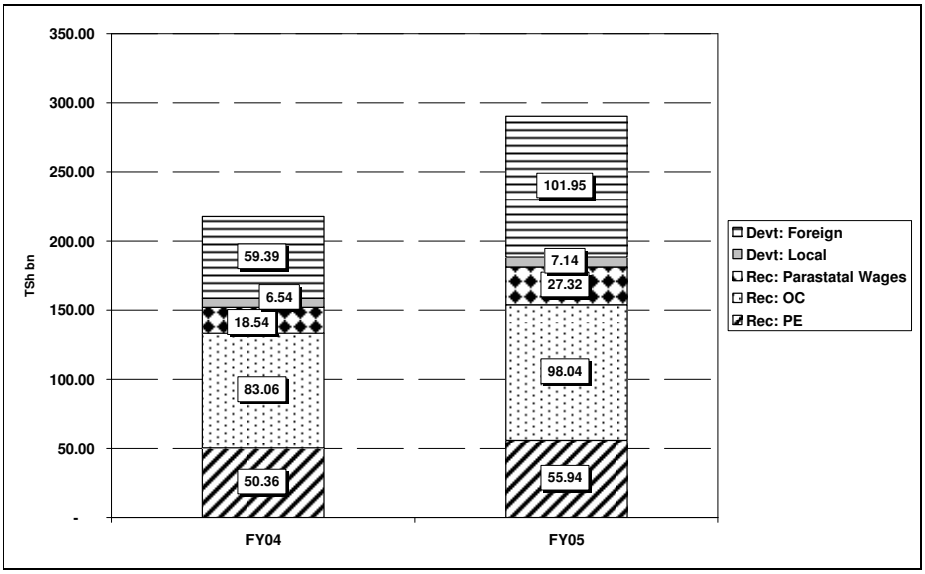


Figure 2 shows a steady increase in the nominal value of the health sector budget, rising 33% in FY05 from the FY04 outturn. As mentioned before, this outturn was substantially better than indicated in the initial FY04 budget figures, which had shown only 5% growth and were at a level of TSh197.2bn (see Figure 4 in PER update for FY04). The reallocation to the Health sector was in part due to lobbying from the MOH and development partners following the publication of the PER, and shows the potential use of such a review for ensuring that stated government priorities are borne out in budget formulation and execution.

This increase appears to a large extent to have been driven by an increase in external spending in the sector. Although not entirely consistent, more disaggregated data also provided by the MOF indicates the following breakdown for FY04 and FY05, as shown in Figure 3.

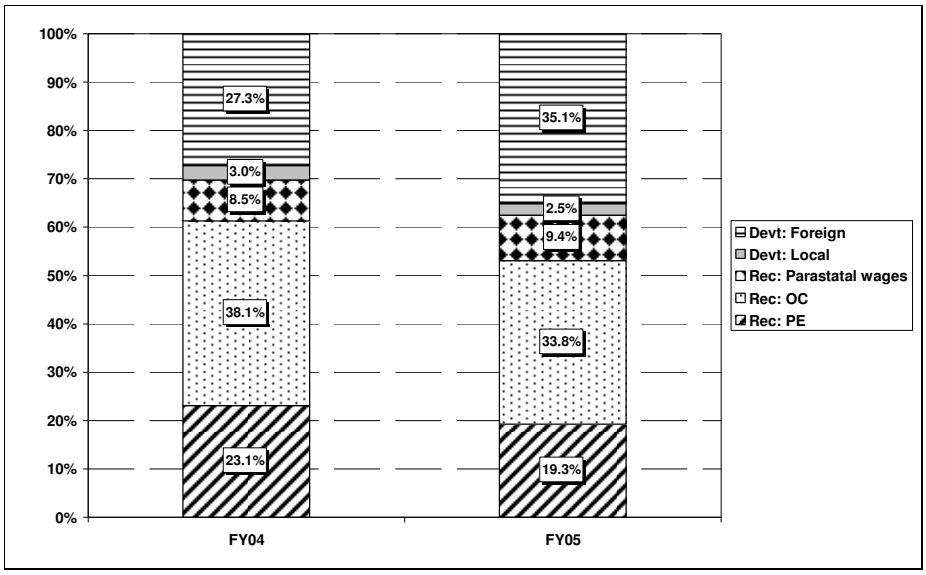
Figure 3 Increase in nominal spending FY04 to FY05, by component (TSh bn)



Note: FY04 assumed to be actual expenditure, given that the figure is close to that in the MOF Budget Review. FY05 is budget. It should be noted that health basket funds are included here within the Foreign Development component.

Figure 3 shows that of the overall nominal increase from TSh217.9bn to TSh 290.4bn (ie TSh 72.49 bn), TSh 42.56bn, or 59% of this was due to an increase in the foreign development component of the FY05 budget. When shown in percentage terms, as in Figure 4 below, this increase is shown more clearly, with the share of this component increasing from 27.3% to 35.1%.

Figure 4 Changing component shares within the Health allocation, FY04 and FY05



This is largely due to a substantial increase in the value of the health sector basket for FY05, due to the inclusion of funding under the World Bank Health Sector Development Project Phase II APL (an investment instrument that disburses to the sector directly). From FY06, this will in part shift to the Poverty Reduction Support Credit (ie general budget support), resulting in a fall in the Bank's contribution to the basket of some US$20m. It is expected, as per the agreement with the World Bank, that the MOF allocations to the health sector will increase by at least this amount to compensate for the shift to GBS, and would therefore be reflected in the recurrent OC and PE budgets.

Figures 3 and 4 also show the small absolute value and the fall in the share of the local development budget, illustrating a concern raised in the 2004 PER Joint Evaluation Report about the relatively low apparent priority given to development within the GOT budget[10].

Other measures of health spending

Table 3 below presents a number of other useful measures of health expenditure and budget using the MOF data. Firstly, the equivalent figures in US dollar terms are given, in order to enable some comparison with other countries. Secondly, the per capita figures are presented, in both Tanzanian shilling and US dollar terms. Finally, by deflating by Consumer Price Index (CPI) in recent years, we can obtain a measure of real spending in the health sector, ie taking account of general inflation in the country[11]. The allocation has therefore been re-valued in FY01 prices, and is shown both in absolute and per capita TSh terms.

[10] GOT/Development Partners (2004). *Review of fiscal developments and budget management issues FY03 – FY04*. Joint Evaluation Report presented at the Public Expenditure Review FY04 consultative meeting, Dar es Salaam, 14 May 2004 (p11).

[11] The official Tanzanian Consumer Price Index was re-weighted and re-based on 2001 prices during FY04, and the figures for FY04 and FY05 are taken from the inflation rate based on the new CPI. The deflator used in this report was calculated separately for the two periods FY01 – 03 and FY04 – 05, and although there is therefore a break in series, this is not expected to significantly affect the figures.

Table 3 Additional measures of spending, MOF on-budget data FY01 – FY05

	FY01 actual	FY02 actual	FY03 actual	FY04 actual	FY05 budget
Nominal (TSh bn)	100.7	142.1	186.7	218.2	290.4
in US $ million	120.9	152.1	186.5	202.5	271.2
Per capita TSh	3,109	4,256	5,424	6,150	7,939
Per capita US$	3.73	4.56	5.42	5.71	7.42
In real terms (TSh bn, FY01 prices)	100.7	135.6	170.6	192.0	245.3
Per capita TSh	3,109	4,060	4,957	5,412	6,707
CPI deflator	*100*	*104.8*	*109.4*	*113.6*	*118.4*
US$ exchange rate	*833*	*934*	*1,001*	*1,078*	*1,071*
Population	*32,391,792*	*33,390,850*	*34,420,722*	*35,482,358*	*36,576,738*

Note: break in series of CPI/inflation deflator from FY04

The data in Table 3 show a far more positive picture than that in the FY04 PER update, with positive trends in all indicators. Notably, whereas last year the data showed a reduction in the per capita US$ value, this update shows that the budgeted figures at least represent a substantial jump, from US$5.71 to US$7.42 per capita, ie an increase of 30%. The real value of the FY05 budget is also substantially higher than the budget outturn for FY04, by almost 28%.

2.2.3 Trends in overall public health expenditure

The data in the section below is compiled as part of the PER process, rather than taken from central government sources, and as such, differs in a number of respects which are either commented on in the text, or in Annex A on data sources and assumptions.

Table 4 below shows the combined estimates for on and off-budget public health spending in Tanzania over the past four years, and includes both external finance not captured within the official Treasury sources, and cost-sharing at public health facilities. These two sources are both subject to concern regarding the quality and completeness of data, but are presented in order to provide a more comprehensive picture.

Table 4 Total health expenditure in Tanzania, FY02 – FY05 (TSh billion)

	2001/2002		2002/2003		2003/04		2004/05
	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Recurrent							
AGO	8.97	5.29	6.92	5.53	6.62	10.56	10.12
MOH	61.60	58.99	82.16	72.32	87.47	87.08	138.99
Region	7.06	6.58	7.86	7.82	12.06	11.90	9.68
Local Govt	46.26	46.28	57.66	57.48	66.14	63.77	82.26
Total rec.	**123.89**	**117.15**	**154.60**	**143.14**	**172.28**	**173.31**	**241.04**
Development							
MOH	32.07	21.12	34.07	29.03	42.28	41.44	56.69
PORALG					0.34	0.34	0.68
Regions	2.35	1.28	4.99	2.48	3.19	2.70	9.38
Local Govt	1.70	1.45	1.75	1.70	2.31	2.32	5.02
Total devt	**36.12**	**23.86**	**40.80**	**33.21**	**48.12**	**46.79**	**71.77**
Total on budget	**160.01**	**141.01**	**195.40**	**176.36**	**220.40**	**220.10**	**312.81**
Off budget expenditure							
Cost sharing		1.24		1.67	1.67	7.48	7.48
Other foreign funds	66.14	79.37	49.25	59.11	68.99	82.79	132.86
Total off budget	**66.14**	**80.61**	**49.25**	**60.77**	**70.66**	**90.27**	**140.33**
Grand total	**226.16**	**221.62**	**244.66**	**237.13**	**291.06**	**310.37**	**453.15**

Source: MOH PER data FY05

Notes: AGO spending on NHIF. PORALG spending on PHC rehabilitation administration costs (actual rehabilitation included under Local Govt). Basket funding included as recurrent or development as appropriate.

Table 4 shows a substantial jump in the total health sector resource envelope for FY05 rising by 56% both in terms of year on year budget and 46% when compared with the actual

outturn for FY04. When the on-budget component of this is considered, the increase is still considerable, at 42% compared both with the FY04 budget and in relation to FY04 outturn.

Major drivers of this increase are seen both in the recurrent and development components, with a significant increase in MOH recurrent spending which is the largest single element both within the on-budget and total figures, at 44% and 31% respectively. This rose by 60% compared to the FY04 outturn due in large part to the substantial increase in the health basket funding for the FY, and to an increased GOT allocation in part to cover ARVs and other HIV/AIDS spending within the sector. Significant real increase is also seen in the allocation to LGAs which account for the second largest element within the on-budget component, and which are projected to increase by 29% on the FY04 actual.

Within the development budget, MOH accounts for the largest share, at 18% of the on-budget and 12.5% of the total envelope, and is also expected to increase by 37% on last year's outturn. PORALG shows a percentage increase of almost 100%, but from a very low base, with the continuation of funding for administrative costs of the rehabilitation of PHC facilities. Inclusion of the budget for the actual rehabilitation work at the LGA level has contributed to the 118% increase in the development budget at this level.

The largest element of the off-budget component is external funding at 29% of the total resource envelope. Although, as noted above, there are concerns regarding the quality of this data, the 93% increase in budgeted funds is presumably relatively reliable as it is based on development partner submissions to the MOF through MOH. Comparison with actuals is less worthwhile given known data problems.

Table 5 shows various other measures of the overall sector resource envelope for the past four years, using the same deflators as in Table 3 above.

Table 5 Additional measures of spending, overall MOH PER data FY02 – FY05

	FY02 actual	FY03 actual	FY04 actual	FY05 budget
Nominal (TSh bn)	221.6	237.1	310.4	453.1
in US $ million	237.3	236.9	288.0	423.2
Per capita TSh	6,637	6,889	8,747	12,389
Per capita US$	7.11	6.88	8.12	11.57
In real terms (TSh bn, FY01 p	211.4	216.7	273.1	382.8
Per capita TSh	6,331	6,296	7,698	10,466
CPI deflator	*104.8*	*109.4*	*113.6*	*118.4*
US$ exchange rate	*934*	*1,001*	*1,078*	*1,071*
Population	*33,390,850*	*34,420,722*	*35,482,358*	*36,576,738*

Unsurprisingly, this confirms the substantial rise in the envelope for FY05, with the 46% increase in the nominal value still representing a healthy 40% increase in the real value, ie from TSh 273.1bn to TSh 382.8bn. In nominal per capita US$ terms, the increase is again significant, up by 43% from US$8.12 to US$ 11.57, while in real TSh per capita terms, the increase is 36%.

2.3 Sub-sectoral trends in budget and expenditure

This section examines in more detail some of the sub-sectoral trends in health spending over recent years, again using the data collated for the PER.

2.3.1 Recurrent and development spending

Table 6 shows the on-budget split between recurrent and development spending in recent years. Lack of information on where off-budget funds are spent precludes their inclusion in

the analysis although it is likely that many cost-sharing revenues boost recurrent spending, while much external funding would be considered development spending. However, the table concentrates on the official GOT estimates and accounts.

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

	Budget				Actual		
	FY02	FY03	FY04	FY05	FY02	FY03	FY04
Recurrent	77%	79%	78%	77%	83%	81%	79%
Development	23%	21%	22%	23%	17%	19%	21%

Table 6 shows that the allocation between the recurrent and development components of the budget has remained largely stable over the past four years, with recurrent accounting for between 77% and 79%. Actual recurrent expenditure for FY04 continued the downward trend seen in the previous two FYs, falling from 83% in FY03 to 79% in FY04, and as such was closer to the budgeted figures than in earlier years. This may be due to improved planning and disbursement of development funds, particularly foreign project funding (see also Section 2.4.1 on budget performance).

2.3.2 Domestic and foreign spending

The split between domestic and foreign spending is of interest due to concerns regarding the predictability and sustainability of external assistance over the longer term, and also in terms of dependency and national sovereignty. With the move by an increasing number of development partners to GBS, whether through grant or loan funding, this distinction becomes less clear with an increasing share of the domestic budget actually reliant on such budget support. The distinction in Table 7 below therefore reflects only earmarked foreign sectoral support, ie through the health basket (captured in both the recurrent and development budgets as appropriate) and on-budget development project funding as reflected in official GOT estimates and account. For the off-budget component, cost-sharing revenues/expenditures are considered as domestic funding.

Table 7 Public health spending, by funding type (TSh billion)

	2001/2002		2002/2003		2003/04		2004/05
	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Recurrent							
Domestic funds	100.60	95.58	121.34	110.87	153.11	154.13	187.82
Foreign funds	23.29	21.57	33.26	32.27	19.18	19.18	53.22
Total rec.	**123.89**	**117.15**	**154.60**	**143.14**	**172.28**	**173.31**	**241.04**
Development							
Domestic funds	5.34	5.04	6.12	5.43	6.45	6.45	7.23
Foreign funds	30.79	18.82	34.68	27.78	41.67	40.34	64.54
Total devt	**36.12**	**23.86**	**40.80**	**33.21**	**48.12**	**46.79**	**71.77**
Total on budget	**160.01**	**141.01**	**195.40**	**176.36**	**220.40**	**220.10**	**312.81**
Off budget expenditure							
Domestic funds		1.24		1.67		7.48	7.48
Foreign funds	66.14	79.37	49.25	59.11	68.99	82.79	132.86
Total off budget	**66.14**	**80.61**	**49.25**	**60.77**	**68.99**	**90.27**	**140.33**
Grand total	**226.16**	**221.62**	**244.66**	**237.13**	**289.39**	**310.37**	**453.15**

Source: MOH PER data

Table 7 indicates that as in previous years, domestic funding (including GBS) drives the recurrent budget, while foreign funding is the major source of development spending.

It is worth noting, although subject to many caveats (see Section 2.3.5 for details of estimation method), that the potential contribution of cost-sharing could exceed that of domestic development funding for the first time in FY05, which both reflects the low level of

priority given to domestic funding for development, and the gradual increase in contribution of cost-sharing to the sectoral resource envelope.

Figure 5 shows the split between foreign and domestic funding (including GBS) for the on-budget component of the health sector resource envelope in recent years.

Figure 5 On-budget share of domestic and foreign funding, FY02 – FY05

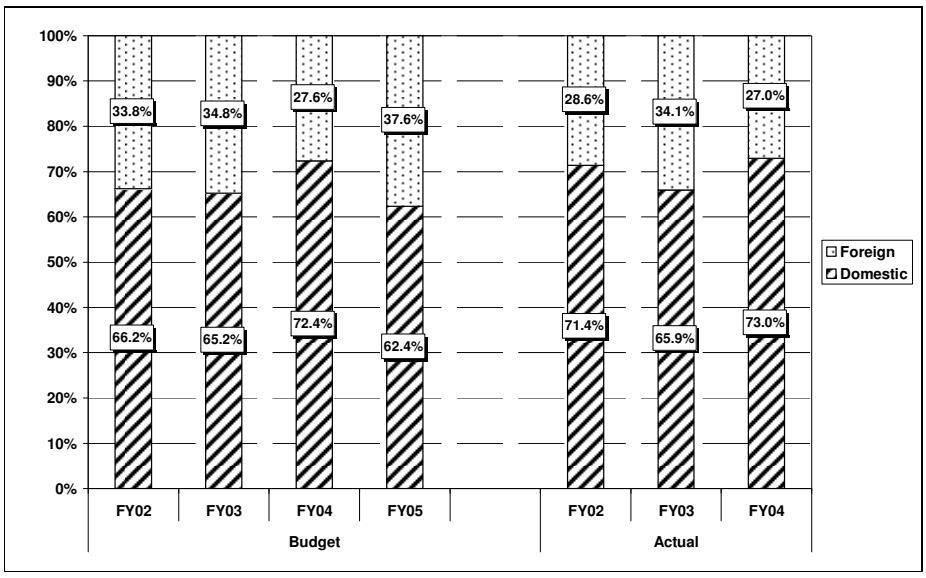


Figure 5 shows a return in FY05 to the trend towards a rising share of foreign funding within the total on-budget resource envelope, following the temporarily reversal in FY04 (due to the move by DfID to GBS), with a 10% year on year budget increase in the foreign share. However, this may also be seen as temporary due to the definitional capture of World Bank funding in FY05. The picture in terms of actual expenditure mirrors that of budget.

Figures 6 and 7 below show in more detail the role of foreign funds in the increasing sectoral budget in recent years (in nominal terms), Figure 6 presenting the absolute level of spending by type/source, and Figure 7 showing the percentage shares.

Figure 6 Role of foreign funds in increased (nominal) sectoral budgets FY02 - FY05 (TSh bn)

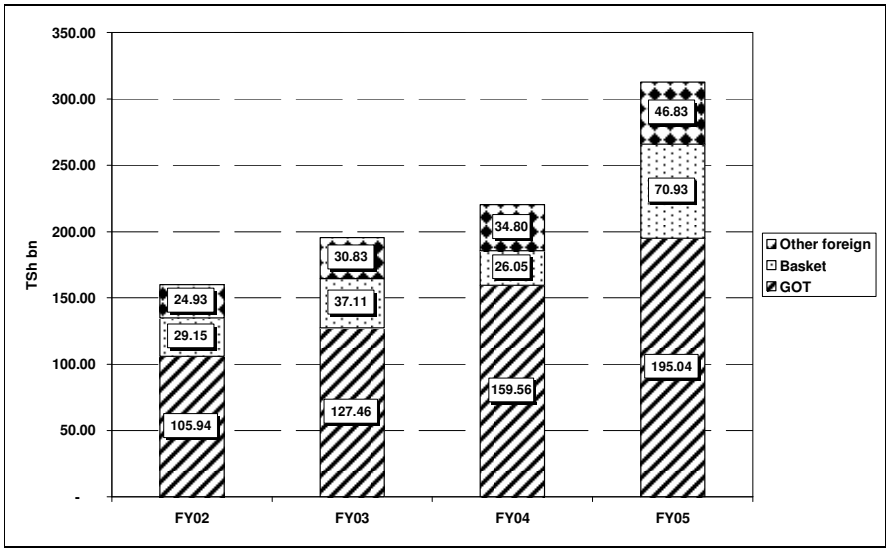


Figure 7 Health budget, percentage breakdown by type of funding, FY02 – FY05

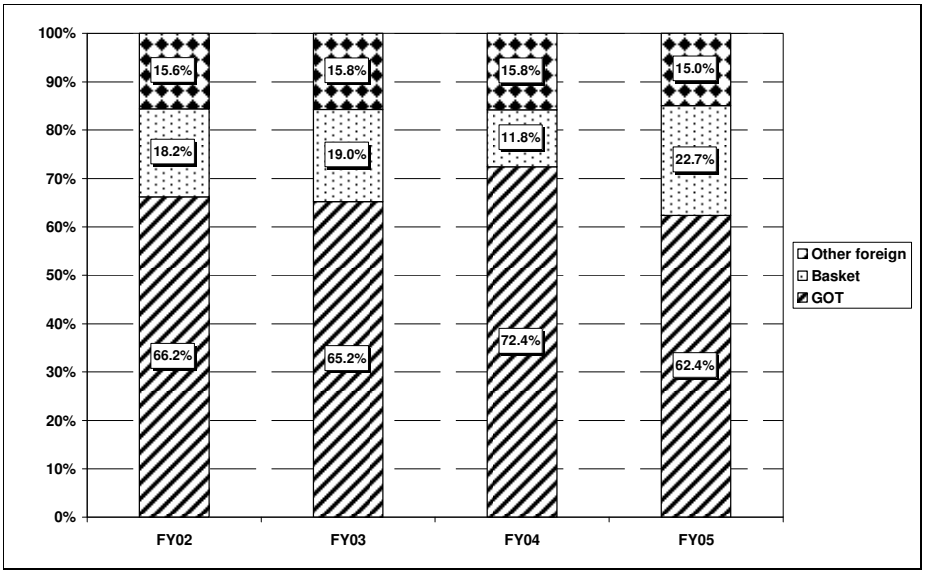


Figure 6 shows that although all three sources of funding have shown a significant nominal increase, particularly between FY04 and FY05, the rise was highest for basket funding which grew by 172% year-on-year compared with 22% for GOT and 35% for other foreign[12].

Figure 7 shows that in terms of the shares of the total on-budget resource envelope, budgeted "other foreign" funding has remained largely stable over the last four years, while the FY05 basket funding returns to the earlier trend of an increasing share at the expense of GOT funding. As mentioned above however, this is expected to be temporary and is largely definitional.

Recurrent support to the sector through the basket

Within foreign funding, basket funding has in general played an increasingly important role in supporting day-to-day operations within the health sector, both through recurrent budget support to MOH headquarters, support to various projects within the development budget, and through the recurrent grants to LGAs. In FY05, this has been supplemented by the allocation, through the PORALG development budget, to fund the rehabilitation of PHC facilities at the LGA level, the larger part of which funding will be channelled to the selected LGAs.

Although the importance of basket support to the central MOH was reduced in FY04 due to the move by DfID to general budget support, some limited recurrent level MOH spending did take place, notably through a reallocation to provide emergency funding of contraceptives. With the addition of World Bank funds to the basket for FY05, the central level support has been restored and, although recorded through the development budget for the purposes of the IFMS, recurrent support is clearly identified through a specific project - "6275 Support to recurrent activities" - for each department.

Figure 8 below shows the significance of the health basket in providing on-budget recurrent support to the sector between FY02 and FY05.

[12] It should be noted that there are some outstanding queries regarding the basket funding for FY05, both in terms of slight discrepancies between information sources, both on the absolute total (in Tanzanian shillings) and also in terms of the breakdown between recurrent and development spending.

Figure 8 Basket funding as a share of recurrent health spending, FY02-FY05

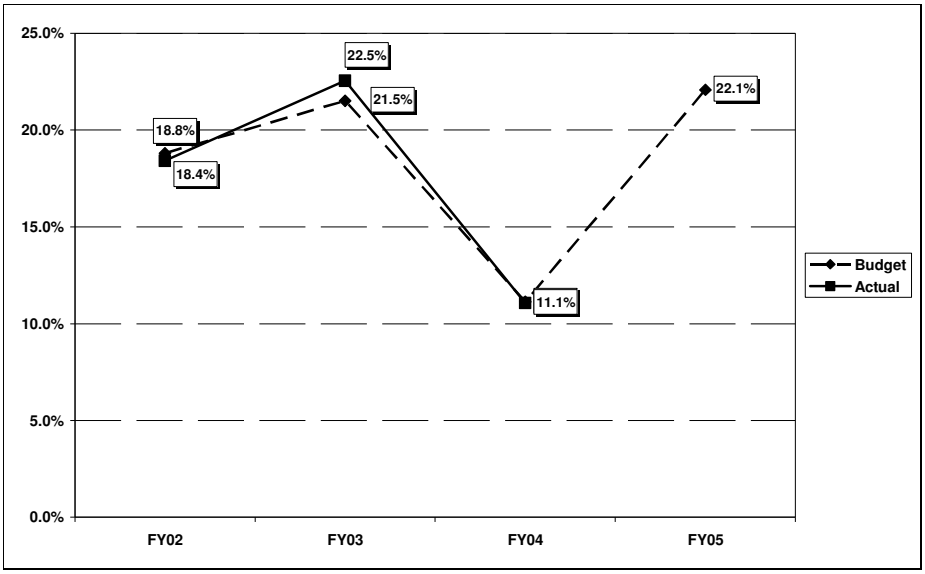


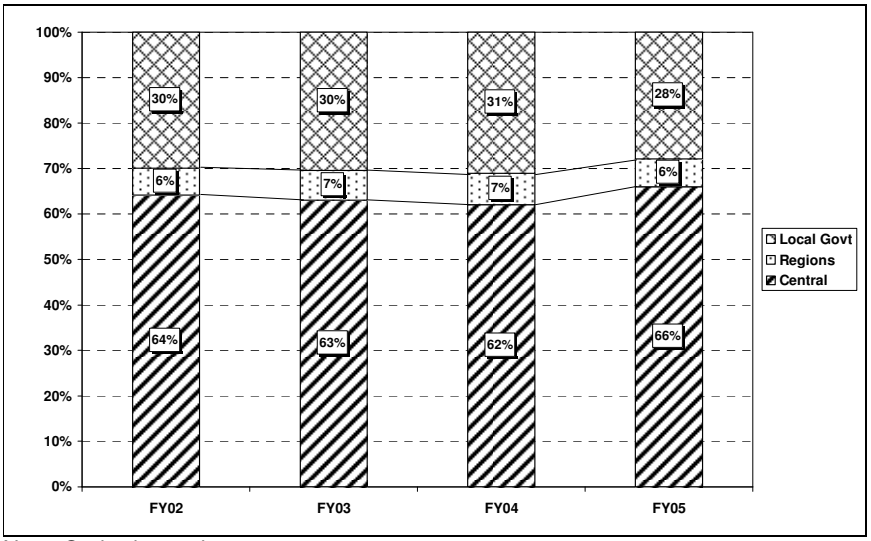
Figure 8 shows that 22.1% of the MOH recurrent budget is expected to be funded through the basket in FY05, representing a slight increase on the FY03 figure of 21.5%.

2.3.3 Spending by level of the health system

In previous years, a crude breakdown of the allocation by level of the health system has been given, based on the entries within official budget estimates (and subsequent expenditure). While recognising that this presents a rather misleading picture due to there being a number of transfers between levels at subsequent stages, or that central allocations include funds for procurement of drugs and medical supplies on behalf of LGAs, the analysis is repeated for continuity and comparison with previous years. In the context of increasing decentralisation, it also provides the basis for discussion of the extent to which LGAs are being entrusted with full responsibility for their spending decisions.

Figure 9 shows this breakdown for budget figures over the past four years, while Figure 10 shows the actual turnout in terms of actual expenditure (release) for the past three years.

Figure 9 Proportion of estimated budget by level, FY02 – FY05



Note: On-budget only

Figure 9 shows a reversal in the planned allocation of funds to the local government level between FY04 and FY05, from 31% of the final FY04 budget to 28% of the original FY05 budget. Although in absolute terms, the local government element of the budget has increased by almost TSh19bn (28%)[13], the central allocation has increased much faster, by 51%, at the expense not only of the share assigned to LGAs but also to the regional level. This, coupled with the fact that the central level allocation is the largest in absolute terms, has driven the increase in the sectoral on-budget total.

Much of the central level jump is due both to the significant increase in the GOT recurrent OC allocation (from TSh 82.1bn to TSh 123.8bn, ie 51%) and the resumption of a sizeable health basket at the MOH. A further contributor is the jump in the allocation to the National Health Insurance Fund, from TSh 6.6bn to TSh 10.1bn, or almost TSh 3.5bn, ie a 53% in the nominal value of the allocation. This follows a significant in-year adjustment during FY04 (see below), the reason for which is not clear[14].

Although NHIF expenditure is ultimately expected to result in transfers to hospitals (government and other) and a part at least thereof would therefore more accurately be captured at the regional (or in terms of the second Health Sector Strategic Plan (HSSP), hospital) and district level, concerns remain as articulated in last year's PER update regarding the cost-effectiveness, efficiency and equity of the service package provided to NHIF beneficiaries. Notably:

- in relation to cost-effectiveness, the agreed service package goes beyond the services defined in Tanzania's Essential Health Package, yet many elements of this package remain unfunded or under-funded for the majority poor at primary (and thus priority) level;
- the lesser efficiency of the hospital level in tackling major causes of death and disease are well documented, again arguing in favour of greater spending at the LGA and primary levels on preventive, promotive and basic health care; and
- the assignment of a substantial share of health sector spending to a relatively small, non-majority poor sub-group of the population (ie public servants, who form a subset of the limited formal sector employed) without clear cross-subsidisation of services for the poor can be viewed as inequitable.

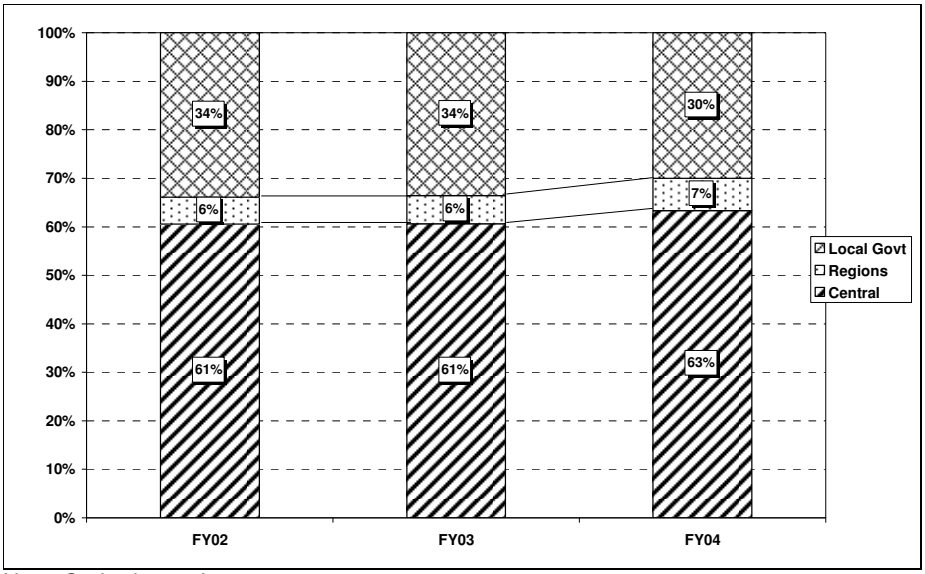
Time has not permitted a detailed breakdown of each component of the budget to determine the ultimate beneficiary as indicated above, but in future years, it would be worth devoting some attention to such an exercise.

Figure 10 shows the breakdown of actual expenditure (or releases where expenditure data are not available) between the intermediate spending levels over the past three years.

[13] See Table 32 in Annex D.

[14] Although during the previous PER update for FY04 the Director General of the NHIF had indicated that the government was not contributing at the stipulated level for the number of public servants entitled to coverage.

Figure 10 Proportion of actual expenditure by level, FY02 – FY04



Note: On-budget only

This shows that although there was no change between FY02 and FY03, there was a shift of actual expenditure in favour of the central level in FY04. As already indicated above, this was largely due to the substantial increase in the release to the NHIF through the Accountant General's Office, which was 60% over-budget at TSh10.56 bn. This represented a 91% increase in year on year spending, and effectively increased the share of the NHIF in total on-budget expenditure from 3.0% to 4.8%.

The overall increase in on-budget expenditure from FY03 to FY04 was 25%[15]. The central MOH allocation increased slightly faster, by almost 30%, with the GOT funding more than compensating for the FY04 fall in central basket spending to 10% of its FY03 level. Another area where annual growth in expenditure was higher than the average was the basket allocation to district councils (28%) due to the application of the resource allocation formula[16]. In addition, foreign spending through the development budget, both basket and non-basket, increased substantially year on year, by 56% and 46% respectively. Although year on year growth in the regional allocation (recurrent + development) was faster than average at 42%, the small absolute value of this element of sectoral spending results in only a 1% change in the share.

2.3.4 Spending by activity type (GOT recurrent only)

The incomplete analysis of spending by activity type undertaken in recent years has become somewhat more complicated from FY05 onwards with the assignment of HIV/AIDS spending, particularly anti-retroviral drugs, to the sub-vote for the Chief Medical Officer. It was not possible to allocate these drugs to particular hospitals, and the Tsh2bn allocation has therefore been removed from the denominator. In addition, not all queries relating to information on the allocation of funds for other drugs and medical supplies could be clarified (see Section 2.5.1 below).

However, as in past years, a crude attempt is made to update the table to include FY04 expenditure in order to provide an indicator for the Performance Profile. It is questionable

[15] See Table 33 in Annex C.

[16] a higher proportion of urban than rural councils were "held harmless", thus reducing their share of the overall council basket

whether this analysis should be maintained in the future in its current form without serious work to further disaggregate the various spending components. The table includes GOT recurrent spending at central MOH, regional and local government levels.

Table 8 Summary of GOT health spending by level/category, FY01 – FY04 (TSh billion)

	FY01			FY02			FY03			FY04		
	PE	OC	Total	PE	OC	Total	PE	OC	Total	PE	OC	Total
MOH Admin							3.79	7.95	11.75	4.63	11.59	16.22
NIMR							1.59	0.35	1.95	1.73	0.91	2.64
TFNC							0.66	0.22	0.88	0.72	0.48	1.20
MOH Admin, NIMR and TFNC	**2.90**	**3.69**	**6.58**	**3.25**	**5.24**	**8.50**	**6.05**	**8.52**	**14.57**	**7.07**	**12.99**	**20.06**
Hospitals												
Muhimbili National Hospital	3.79	1.20	4.99	4.78	1.72	6.51	5.36	1.75	7.11	5.41	6.92	12.33
Muhimbili Orthopaedic Institute	0.54	0.30	0.85	0.56	0.38	0.94	1.53	0.85	2.38	1.62	1.16	2.78
Ocean Road Cancer Institute	0.28	0.23	0.51	0.29	0.43	0.72	0.35	0.40	0.75	0.40	0.75	1.16
Bugando Medical Centre	0.71	0.86	1.57	0.72	0.41	1.13	0.94	1.09	2.04	1.14	1.44	2.59
Kilimanjaro Christian Medical Centre	1.20	0.83	2.03	1.33	0.71	2.04	1.48	0.63	2.11	1.70	1.29	2.99
Referral hospitals, MoH *	1.74	4.06	5.81	2.03	0.32	2.35		-	0.87		1.76	1.76
Regional hospitals	4.43	2.07	6.50	5.14	2.40	7.54	5.69	1.83	7.52	6.89	5.34	12.22
District hospitals	3.53	5.06	8.59	5.22	4.39	9.62	6.54	2.66	9.20	8.00	8.32	16.31
Designated District Hospitals	3.07	1.27	4.33	2.94	2.23	5.16	3.43	1.19	4.62	3.60	2.58	6.18
Voluntary Agencies - Hospital	1.91	0.23	2.14	1.94	0.09	2.03	2.32		2.32	2.37	0.20	2.56
Total hospitals	**21.20**	**16.11**	**37.31**	**22.93**	**13.07**	**38.03**	**27.65**	**10.41**	**38.06**	**31.13**	**29.76**	**60.88**
Preventive/Primary health care												
MoH preventive services	0.27	3.55	3.82	0.27	6.01	6.28	0.30	5.89	6.19	0.34	12.32	12.67
Regional preventive services	0.13	0.08	0.21	0.25	0.05	0.30	0.15	0.15	0.30	0.17	2.67	2.85
Council preventive	14.11	12.86	26.97	18.50	17.45	35.95	23.40	11.08	34.47	25.22	18.80	44.02
Total Preventive/Primary	**14.51**	**16.49**	**31.00**	**19.02**	**23.51**	**42.53**	**23.85**	**17.12**	**40.97**	**25.74**	**33.79**	**59.53**
Total Health recurrent			**74.90**			**89.06**			**93.60**			**140.48**

Notes:

- Breakdown of MOH Admin, NIMR and TFNC not available prior to FY03
- No attempt made to update table for FY03 which was also incomplete
- Excludes NHIF allocation through AGO which would increase the Administrative category; also excludes basket funding and HSPS allocation for drug kits in Quarter 2.
- No PE details obtained for MOH referral hospitals
- Excludes TPDF hospital drug allocations (TSh 93m) and ARVs (TSh2bn) from both numerator and denominator
- Calculated total falls short of total GOT recurrent (as per Master Table, with deductions as above) by TSh 5bn, ie 0.7%.

Figure 11 below shows how the trend in allocation between these three crude categories has changed in recent years.

Figure 11 The trend in allocation by category of spending, FY01 – FY04

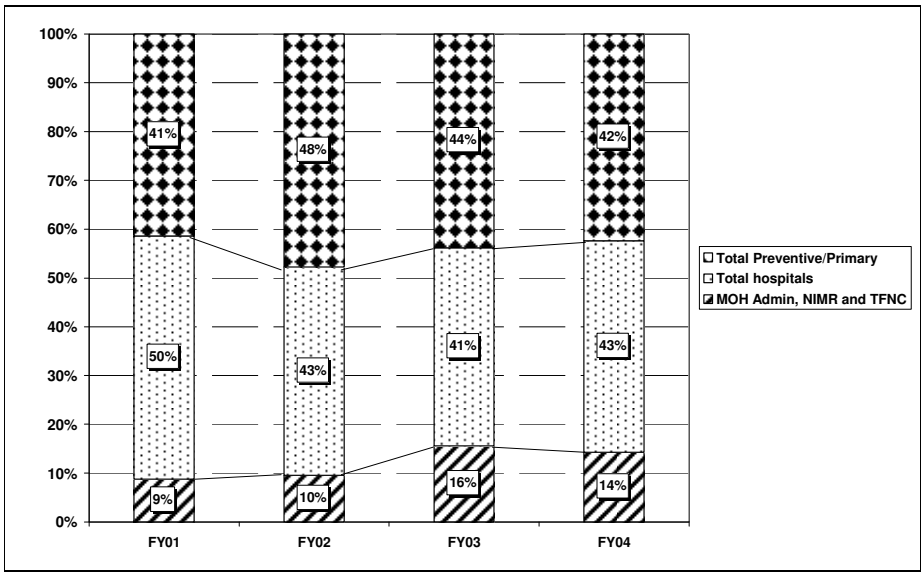


Figure 11 shows that there has been a slight decline in the share of administrative spending within GOT recurrent expenditure, but that this has been due to an increase in the share of the hospital sector rather than towards the priority area of preventive and primary spending. To the extent that funds have been diverted during the course of the FY towards antiretroviral

drugs (not captured in this analysis), this can be assumed to be an under-representation of this picture. However, given the incomplete nature of the data, it would be unwise to comment further on the picture beyond to stress that more detailed analysis of sectoral spending in terms of the ultimate beneficiary level is long overdue. Incorporation of development and basket funding would also strengthen this analysis.

2.3.5 On and off-budget spending

As in previous years, the off-budget spending reported in the PER update comes from two main sources. The first is the domestic off-budget spending from cost-sharing revenues at public health facilities, through the Health Service Fund at hospital level, and the Community Health Fund at council level, including primary facilities. In addition, many hospitals operate a Drug Revolving Fund, but there appears to be no central level data recording revenues and expenditures under this fund. This should be reviewed in any future assessment of sectoral income and expenditure.

The second source of off-budget funding, given the ongoing but (generally) lessening discrepancy between total external funding and that proportion captured within the official budget[17], is an estimate of the difference between these two, based on reporting by development partners through the MOH to the External Finance Department of the MOF. This latter estimate is subject to extreme caution.

Both elements of off-budget spending are subject to various data queries, and this is a particular area of the PER which would benefit from additional efforts to strengthen the completeness and quality of the available data, in order to present a more complete picture.

The total estimated contribution of the combined off-budget sources of funding in FY05 is TSh 140bn, which represents 31% of the overall resource envelope presented in Table 4. This represents a nominal increase of TSh 69.7bn on the original projections made for FY04, ie an increase of almost 99%.

In terms of the relative shares of on- and off-budget funding, Table 9 shows that there has been a move back in budgetary terms from an estimated 75-25% split in FY04 to almost one-third of the potential resource envelope for FY05 being tentatively off-budget. Further comment is reserved given the caveats regarding the data.

Table 9 On- and off-budget shares of health spending, FY02 – FY05

	2001/02		2002/03		2003/04		2004/05
	Budget	Expd	Budget	Expd	Budget	Expd	Budget
On-budget	71%	64%	80%	74%	76%	71%	69%
Off-budget	29%	36%	20%	26%	24%	29%	31%

Comments on the available data for each particular component on the off-budget element of the PER are given below.

Health Service Fund

The Health Service Fund (HSF) is the term for cost-sharing at public hospitals. Information on revenues by type of fee and spending by type of expenditure item is reported on a monthly basis to the MOH HQ. Apparently no analysis of this more detailed information takes place, although an annual summary of balances brought forward, revenues, expenditures, and balances carried forward is presented in the annual Appropriation Accounts of the MOH.

[17] The PRBS review indicates that *"While capturing of direct-to-project funds remains difficult, MDA reporting in 2003/04 was significantly higher than reporting in 2002/03, signalling improvement in capturing"* (GOT (2004). *PRBS Joint Annual Review Report*. Draft 1 of November 2004. p 45)

As in previous years, information on HSF revenues and expenditures is incomplete, with several hospitals not providing data. Time did not permit follow-up to determine why such data gaps persist, but it is recommended that this be undertaken during the course of FY05, together with analysis of the breakdown of revenue and expenditure categories. If the data is not required, there is little to recommend continuing its collection as it presumably represents an administrative burden on the facilities concerned, to little benefit. There are also queries regarding apparent negative balances brought forward.

Available data for the HSF in FY04 indicate a nominal increase of 51% compared with FY03, rising from TSh 2.04bn to TSh 3.08bn, as shown in Table 10 below. This represents a 47% increase in the per capita value of receipts. Expenditures have risen even faster, from TSh1.51bn to TSh 2.73bn, or by 81%, between FY03 and FY04. This is partly due to the increased revenues, but also due to an improvement in the absorption of net receipts from 74% in FY03 to 88% in FY04[18]. Per capita expenditure grew by 75%, but still remains a relatively small amount at only TSh77 per capita in FY04.

Table 10 Reported HSF revenues and expenditures, FY02 – FY04

	FY02	FY03	FY04
Revenue	1,531,946,542	2,036,653,642	3,082,288,980
Expenditure	1,082,642,718	1,509,458,307	2,725,582,152
Expd as % Revenue	71%	74%	88%
Per capita receipts	46	59	87
Per capita expenditure	32	44	77
Population	*33,390,850*	*34,420,722*	*35,482,358*

One major gap in relation to cost-sharing revenues at hospital level relates to the three large hospitals – Muhimbili Medical Centre, Bugando and KCMC – which have parastatal status and are apparently therefore not required to report their revenues to the MOH. This is only one area of the poor accountability of these large hospitals which receive substantial subventions from the MOH in both cash and in drugs and supplies, and which therefore should be reporting to both the parent ministry and to the population served. Further study is recommended in this area, to determine the total revenues, total expenditures, and breakdown of each, of these large hospitals.

Community Health Fund

As in previous years, it proved extremely difficult to get information on the activity of the Community Health Fund, raising questions about accountability – both to the government and to the population – as well as about the efficiency of use of scarce resources within the sector.

Some data were provided by the World Bank, relating to the value of membership fees in 16 of the 41 councils in which the CHF was operating during FY04[19]. Unfortunately, even this small amount of data was not available by financial year. As shown in Table 11 below, the average annual equivalent membership revenue in the 16 councils can be calculated as approximately TSh278m.

[18] Many hospitals have substantial balances brought and carried forward. This calculation looks at only expenditures from new receipts reported during the FY. Further investigation would be worthwhile to determine the reasons for maintaining such balances, given that cost-sharing is intended to directly improve the quality of service in the various hospitals.

[19] According to the MOH submission for the FY06 Budget Guidelines - MOH (2004). *Ministry of Health and the Health Sector Resources Requirements for Budget Guidelines 2005-2006*. Dar es Salaam: November 2004 (p17)

Table 11 CHF data on membership revenues and numbers

Council	Period	No of months	Members	Contribution	Mean annual figures Members	Mean annual figures Contribution	Membership fee	Ann pc cont'n
Iringa DC	July 2002 - Sept 2003	15	7,024	35,120,000	5,619	28,096,000	5,000	113
Ulanga DC	July 2003 - Sept 2004	15	1,947	10,295,000	1,558	8,236,000	5,288	41
Nzega DC	July 2002 - Sept 2004	27	3,238	16,190,000	1,439	7,195,556	5,000	17
Igunga	July 2002 - Sept 2003	15	6,596	32,980,000	5,277	26,384,000	5,000	78
Mbulu	July 2003 - Sept 2004	15	4,926	24,630,000	3,941	19,704,000	5,000	80
Sumbawanga	July 2002 - Sept 2004	27	3,799	18,995,000	1,688	8,442,222	5,000	22
Singida	July 2003 - Sept 2004	15	7,848	39,374,000	6,278	31,499,200	5,017	77
Iramba	July 2003 - Sept 2004	15	2,629	13,148,000	2,103	10,518,400	5,001	28
Hanang	July 2003 - Sept 2004	15	940	9,400,000	752	7,520,000	10,000	35
Urambo?	July 2003 - Sept 2004	15	2,849	14,245,000	2,279	11,396,000	5,000	30
Songea DC	July 2003 - Sept 2004	15		56,000,000	-	44,800,000	see note	295
Kigoma	Jan - Sept 2004	9	2,678	13,390,000	3,571	17,853,333	5,000	35
Mwanga	July 2003 - Sept 2004	15	3,236	16,180,000	2,589	12,944,000	5,000	110
Masasi	July 2002 - Sept 2004	27	8,000	80,000,000	3,556	35,555,556	10,000	79
Mbinga	July 2003 - Sept 2004	15	334	5,010,000	267	4,008,000	15,000	10
Mufindi	July 2003 - Sept 2004	15	1,000	5,000,000	800	4,000,000	5,000	14
Total				**389,957,000**		**278,152,267**		

Notes: Sumbawanga, Singida and Kigoma are rural rather than urban councils. The Songea membership fee varies according to the level of services. Regular membership is TSh7,500 while inclusion of the mission hospital raises the premium to TSh 20,000. It has not been possible either to access the Songea membership numbers, not to clarify the other questionable fee rates.

In order to make a crude estimate of the total revenue generated by the CHF, it is necessary also to include the revenues from the user charges which have been introduced at primary level (ie health centres and dispensaries) in those councils as an incentive for the population to join the scheme. In Hanang DC, the only council for which there appears to be relatively recent (accessible) data[20], membership revenues accounted for only 15% of total income, with user charges contributing the other 85%. Extrapolation of these percentages gives a total estimated CHF income for these 16 councils of TSh 1.85bn, as shown in Box 1. However, as Table 11 shows, the majority of the councils reported above were charging an annual membership fee of TSh 5,000 per household. Hanang DC is therefore unrepresentative in that its annual fee is twice this amount, and this crude calculation should be treated as an upper estimate. This figure is further crudely extrapolated to the 41 councils in which the scheme is operating to give a national estimate of TSh4.75bn. It should be noted that this cannot be compared with previous estimates which have been based on equally limited data, and different assumptions. It should also be noted that while HSF data relates to expenditure, CHF data is based on revenues. Again, based on findings from the Hanang assessment, potentially significant unspent balances mean that this is likely to overstate the expenditure.

Box 1 Extrapolation of available data to estimate total annual CHF revenue

A recent assessment in Hanang district (Musau 2004) found that around 15% of CHF revenues originated from membership dues (excluding the matching grant) while the remaining 85% were generated from user charges (p xiii). Taking the annual estimate of membership revenues in the 16 councils for which data were provided, this results in the following:

Annual estimated membership revenue (by calculation)	TSh 278,152,267
Divided by 15% and multiplied by 85% - to give estimated user fee revenue	TSh 1,576,196,178
Added to estimated membership revenue - to give estimated total CHF revenue in these councils	**TSh 1,854,348,444**
Crudely extrapolated on per council basis:	
Total revenue divided by 16 (councils)	TSh 115,896,778

[20] S Musau (2004). *The Community Health Fund: assessing implementation of new management procedures in Hanang District, Tanzania.* The Partnerships for Health Reform project. Bethesda, MD: January 2004

And multiplied by 41 councils operating CHF	
- to give **very** crude national estimate	**TSh 4,751,767,889**

The usefulness of these figures is questionable, given the extent of variation in the reported council data - from TSh4m to almost TSh45m in terms of council membership revenues, representing a range of annual revenues from TSh 10 pc in Mbinga DC to TSh 295 pc in Songea DC.

It appears indisputable, however, given original intentions and projected coverage levels, that performance has been disappointing to date. In addition to the poor upward and downward accountability indicated by the lack of reliable data on income and expenditure under the CHF, far more detailed information would required regarding benefit packages, utilisation of members compared with non-members, administrative costs etc in order to determine the broader value of the CHF and its opportunity cost. A more detailed evaluation of the scheme's overall performance is long overdue, and should be undertaken before the next PER update.

More discussion of available information on cost-sharing at the local government level is given in Section 3 below, where a rapid analysis of councils' own data is reported.

Off-budget external funding

The estimates used for off-budget external funding come from the database maintained by the External Finance Department of the MOF. For the FY05 update, the MOH submission was used. Unfortunately, much potentially useful information in this database is not updated regularly, notably the column which indicates whether the particular source of external funding is on- or off-budget. In the face of time constraints, it has therefore been necessary to make a very crude assumption that the value of off-budget external funding is the total value assigned to Health (as opposed to HIV/AIDS), less the total value of foreign development (including the recurrent basket funding) included in the on-budget part of the Master Table.

In addition, as in previous years, data on disbursement/expenditure in the past is very weak, and the same assumption has been used as in the past, ie that disbursement is 20% higher than projections. This is clearly unsatisfactory, and begs the question of whether it is worth including such figures at all. A more detailed assessment of this component of sectoral expenditure is long overdue.

Bearing in mind the above caveats, for FY05 there is a dramatic increase in the value of the off-budget external funding to the sector, from an estimated TSh69bn in FY04, to almost TSh 133bn, a rise of 93%. This takes this particular component of the overall resource envelope to over 29% of the total, and is likely to be due to a combination both of increased funding, and better capture of existing funding. However, as also noted, a more detailed review of this source of funding is merited. This should consider as a minimum:

- the accuracy and completeness of the data
- the extent to which it is captured in the budget; and
- actual disbursement/expenditure figures for comparison with projections.

Ideally, such an analysis should also explore the extent to which such funding contributes to priority outcomes, particularly given its increasing importance according to the figures presented.

2.4 Budget performance

Ideally, we would be able to analyse in detail actual spending performance for each 'component' of the health sector, ie central level (including regional offices), hospitals and other tertiary institutions, and district health services[21]. However, data does not yet permit this. Firstly, PER data is used to show overall (on-budget) budget performance, together with variations between recurrent and development spending. Further analysis is then undertaken of the MOH recurrent budget using the FY04 IFMS report, looking at performance by sub-vote.

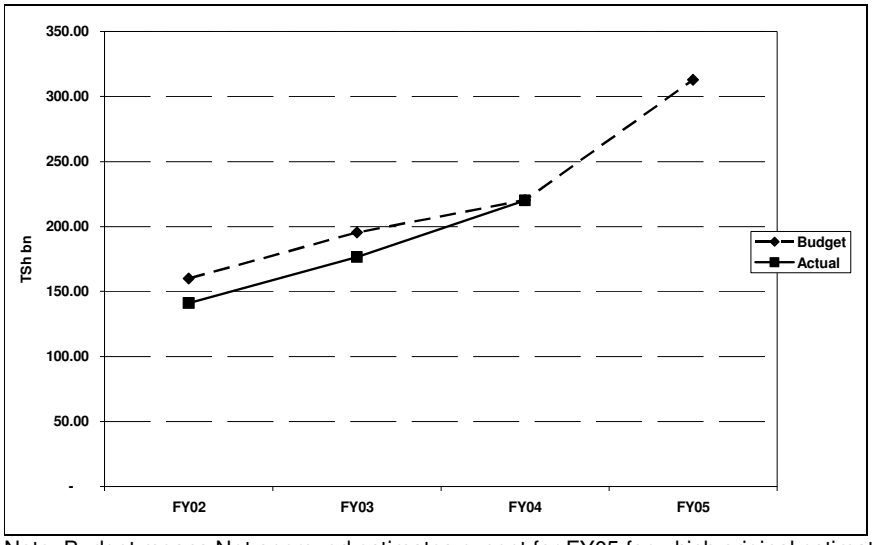
As in previous years, detailed appropriation accounts were not obtained from PORALG for Regional spending, although summary data by sub-vote was made available and are presented below. The only data on secondary and tertiary level hospitals comes through the IFMS and therefore accounts for that proportion of their budgets and expenditures corresponding to the government subvention. No details are available on what this actually covers, and this only forms a part of their revenue, leading to concerns regarding accountability as these remain public institutions. A very brief analysis is undertaken of the GOT subvention.

At the LGA level, arguably the most relevant and significant in terms of delivering on the PRS/MKUKUTA goals as it is at this level that the most essential health service delivery takes place, there still remains no comprehensive and quality assured expenditure data, either through the IFMS or through the internal health sector physical and financial implementation reports produced each quarter by the councils. Releases are considered equivalent to expenditure, despite long-standing evidence to the contrary. Further discussion of LGA spending is included in Section 3, and the ongoing recommendations regarding other means of assessing performance in this area are discussed further in Section 5.

2.4.1 On-budget sectoral total

Analysis of budget performance, both total and separately for the recurrent and development budget, is undertaken using data collated for the PER update. Comparison of actual expenditure compared with the net approved budgets is presented below in Figure 12.

Figure 12 Budgeted and actual on-budget health spending, FY01 – FY04



Note: Budget means Net approved estimates except for FY05 for which original estimates are used.

[21] As defined in MOH (2003) *Second Health Sector Strategic Plan (July 2003 – June 2008) "Reforms towards delivering quality health services and clients satisfaction"*: , Dar es Salaam: April 2003

Figure 12 shows that for the first time in recent years, overall actual expenditure matched the net approved estimates in FY04. This is due to two factors – firstly, the higher than budgeted release of funding to the NHIF through the AGO, and secondly, the improved release and expenditure of the MOH headquarters development budget during the course of the year. The difference in performance between the on-budget recurrent and development components of health spending is shown in Table 12 below.

Table 12 Budget performance (expenditure/budget), FY02 – FY04

	FY02	FY03	FY04
Recurrent	95%	93%	101%
Development	66%	81%	97%
Total	**88%**	**90%**	**100%**

2.4.2 MOH headquarters recurrent spending by sub-vote

Table 13 below shows MOH headquarters budget, release and expenditure as captured by the IFMS. The equivalent table for FY03 is included as Table 34 in Annex C for comparison. As in previous years, budget performance is measured by release as a percentage of budget estimates, while ministry absorption capacity is measured by expenditure as a percentage of releases. In contrast to the FY02 and FY03 PER updates, the lack of a central basket allocation for recurrent expenditure means that performance is reviewed only for GOT spending at this level[22].

Table 13 MOH recurrent expenditure: budget and capacity performance FY04

Department		Budget	Release	Expd	Release/ budget	Expd/ release	Expd/ budget
1001	Admin & General	1,630,817,751	1,619,524,570	1,606,372,366	99.3%	99.2%	98.5%
1002	Finance & Accounts	394,662,681	389,233,066	387,649,041	98.6%	99.6%	98.2%
1003	Policy & Planning	717,923,618	713,923,618	695,283,845	99.4%	97.4%	96.8%
2001	Curative (Hospital)	60,762,160,196	59,093,933,992	58,980,168,464	97.3%	99.8%	97.1%
2002	Chemical Laboratory	714,018,726	702,720,065	702,253,357	98.4%	99.9%	98.4%
2003	Chief Medical Officer	255,903,645	255,903,524	237,592,632	100.0%	92.8%	92.8%
3001	Preventive	16,489,810,742	16,252,527,235	16,041,846,958	98.6%	98.7%	97.3%
4001	TUKUTA	401,320,952	390,879,587	390,566,102	97.4%	99.9%	97.3%
5001	Human Resource Devt	6,301,394,197	6,156,281,488	6,139,433,119	97.7%	99.7%	97.4%
Total MOH headquarters		**87,668,012,508**	**85,574,927,146**	**85,181,165,882**	**97.6%**	**99.5%**	**97.2%**

Table 13 shows that MOH headquarters budget performance in FY04 was better than in previous years. Releases from the MOF reached 97.6% of the total budget, compared with 89.6% for FY03 (and only 86.4% for the GOT share of the total).

As usual, there was some variation between MOH sub-votes, ranging from a low of 97.3% in the Curative Services Department to 100% release to the office of the Chief Medical Officer (CMO). This contrasts sharply with previous years where the CMO has been a particularly poor performer in terms of releases (59.6% in FY03 and 64.3% in FY02 – GOT and basket combined).

In terms of absorption capacity, MOH performance has also improved on FY03, rising from 97.9% (98.8% GOT and 95.2% basket) to 99.5% in FY04. Here however, the CMO sub-vote has performed relatively poorly, achieving only 92.8% expenditure. The other relatively poor performer is the Department of Policy and Planning at 97.4%. However, these account for

[22] Although please note that elsewhere in the report the TSh 1.89bn allocated from the basket fund (development) to contraceptive procurement has been considered as recurrent.

relatively small shares of the MOH total, with the Preventive and Curative Departments both achieving around 99% absorption.

This year it was also possible to analyse performance for the first half of FY05, shown in Table 14 below. Although basket funds are recorded in the Development Budget, the clear demarcation of support to recurrent activities within the central basket has enabled a return to the format of the FY02 and FY03 PER updates, whereby performance can be monitored separately for the two funding sources.

Table 14 MOH recurrent expenditure: budget and capacity performance FY05 – first half

Department	Source	Budget	Release	Expd	Release/budget	Expd/release	Expd/budget
	Govt	1,422,803,800	672,510,317	377,685,370	47.3%	56.2%	26.5%
1001 Admin & General	Basket	250,000,000	227,778,266	73,425,460	91.1%	32.2%	29.4%
	Total	**1,672,803,800**	**900,288,583**	**451,110,830**	**53.8%**	**50.1%**	**27.0%**
	Govt	359,051,100	176,466,047	96,117,718	49.1%	54.5%	26.8%
1002 Finance & Accounts	Basket	200,000,000	199,799,900	74,454,417	99.9%	37.3%	37.2%
	Total	**559,051,100**	**376,265,947**	**170,572,135**	**67.3%**	**45.3%**	**30.5%**
	Govt	662,884,100	314,059,760	152,618,172	47.4%	48.6%	23.0%
1003 Policy & Planning	Basket	1,580,000,000	1,517,930,868	76,396,000	96.1%	5.0%	4.8%
	Total	**2,242,884,100**	**1,831,990,628**	**229,014,172**	**81.7%**	**12.5%**	**10.2%**
	Govt	72,076,530,000	34,975,912,206	33,110,229,175	48.5%	94.7%	45.9%
2001 Curative (Hospital)	Basket	7,000,000,000	5,845,857,683	3,103,089,259	83.5%	53.1%	44.3%
	Total	**79,076,530,000**	**40,821,769,889**	**36,213,318,434**	**51.6%**	**88.7%**	**45.8%**
	Govt	767,010,000	351,025,376	351,025,376	45.8%	100.0%	45.8%
2002 Chemical Laboratory	Basket	300,000,000	234,033,000	148,553,000	78.0%	63.5%	49.5%
	Total	**1,067,010,000**	**585,058,376**	**499,578,376**	**54.8%**	**85.4%**	**46.8%**
	Govt	7,233,472,100	5,337,405,418	5,264,971,405	73.8%	98.6%	72.8%
2003 Chief Medical Officer	Basket	388,000,000	225,749,000	27,593,000	58.2%	12.2%	7.1%
	Total	**7,621,472,100**	**5,563,154,418**	**5,292,564,405**	**73.0%**	**95.1%**	**69.4%**
	Govt	16,461,093,600	8,246,322,472	4,154,928,930	50.1%	50.4%	25.2%
3001 Preventive	Basket	12,410,646,900	5,206,239,600	728,715,772	41.9%	14.0%	5.9%
	Total	**28,871,740,500**	**13,452,562,072**	**4,883,644,702**	**46.6%**	**36.3%**	**16.9%**
	Govt	345,049,800	157,370,375	157,370,375	45.6%	100.0%	45.6%
4001 TUKUTA	Basket	500,000,000	459,481,434	88,624,034	91.9%	19.3%	17.7%
	Total	**845,049,800**	**616,851,809**	**245,994,409**	**73.0%**	**39.9%**	**29.1%**
	Govt	5,137,484,700	2,580,268,777	2,323,398,678	50.2%	90.0%	45.2%
5001 Human Resource Devt	Basket	2,171,000,000	1,448,919,000	911,963,677	66.7%	62.9%	42.0%
	Total	**7,308,484,700**	**4,029,187,777**	**3,235,362,355**	**55.1%**	**80.3%**	**44.3%**
	Govt	104,465,379,200	52,811,340,747	45,988,345,200	50.6%	87.1%	44.0%
	Basket	24,799,646,900	15,365,788,751	5,232,814,619	62.0%	34.1%	21.1%
Total MOH headquarters	**TOTAL**	**129,265,026,100**	**68,177,129,498**	**51,221,159,818**	**52.7%**	**75.1%**	**39.6%**

Table 14 shows that by the halfway point in the FY05, ie end of December 2004, total releases to the MOH were on course, with slightly over half the GOT release (50.6%) and 62% of the annual basket release having been made. This is encouraging, as it facilitates the implementation of MTEF activities according to the projected cash flow and helps to prevent a spending spree at the end of the FY, thereby strengthening the credibility of the planning and budgeting process.

Budget performance varies by sub-vote and funding source. For GOT funds, the CMO's office had received almost three-quarters of the annual allocation (73.8%) by the end of December 2004, while other sub-votes were at or around 5% below the 50% mark. This may be due to the budgeting of anti-retroviral drugs under this sub-vote and the early release of funding to facilitate the procurement process.

For basket funds, the administrative sub-votes had all received the majority of the annual allocation (91.1% to 99.9%), and the release to Curative Services was also well over the halfway mark at 83.8%. However, the release to the Preventive Services Department was under target at 41.9%, in part as funding for procurement had been programmed across quarters rather than as a lump sum.

Spending of GOT funding is given priority over basket funding, with quite different absorption rates (87% and 34% respectively). However, this is not particularly surprising given the different spending rules which govern these two sources whereby, at the end of the financial year, unspent GOT funding is returned to the Treasury and effectively lost to the sector, while

unspent basket funds may retained in the holding account and carried forward to the following year.

2.4.3 Summary regional budget performance

Data on approved estimates and actual expenditure for FY04 were provided by PORALG for the Regions, broken down by sub-vote. These are shown in Table 15 below.

Table 15 Regional sub-vote budgets and expenditure, FY04 – FY05 (TSh)

	FY04			FY05
	Estimates	Approved Estimates	Actual expd	Estimates
Curative	9,080,993,908	9,185,251,924	9,051,806,204	9,346,238,000
Preventive	324,517,300	2,873,930,891	2,848,381,582	329,923,600
Total regions	**9,405,511,208**	**12,059,182,815**	**11,900,187,786**	**9,676,161,600**

The table shows a substantial increase between the original estimates published at the time of the budget, and the Approved estimates obtained from the PORALG Appropriation Account summary, amounting to TSh 2.65bn. Virtually the whole of this is due to an increase in the Preventive sub-vote, by TSh 2.55bn or almost 800%. Of this, most is in the OC component which rose from TSh151m to TSh 2.7bn. No explanation has been found for this increase, which appears to be a one-off as the budget estimate for the regional Preventive sub-vote for FY05 reverts to only slightly higher (1.7%) than the original FY04 estimate, while the Curative sub-vote estimate increases slightly more (by 2.9%).

Overall, budget performance as measured by actual expenditure as a percentage of approved estimates in FY04 was high at 98.7%, with both sub-votes performing well (98.5% and 99.1% respectively for curative and preventive sub-votes). PEs performed slightly better than OCs.

2.4.4 Budgets and expenditures for larger hospitals

The government subventions to the larger hospital institutions are captured as transfers in the MOH headquarters recurrent budget, and can be retrieved from the IFMS. However, very little information is provided as to how the funds are actually used, or of what proportion of the total budget of these institutions the government subventions represent. Table 16 below shows the approved budget, releases and expenditure for FY04 for those larger hospitals which are included in the IFMS.

Table 16 Budget performance for larger hospitals, FY04

Sub-item	Description	Budget	Release	Expd	R/B	E/R
280308	Mbeya Referral Hospital	556	556	556	100%	100%
280309	Mirembe and Isanga Institution	431	428	428	99%	100%
280310	Kibongoto Hospital	339	292	292	86%	100%
280529	Muhimbili Medical Centre	11,950	11,725	11,725	98%	100%
280530	Muhimbili Orthopaedic Institute	2,620	2,493	2,493	95%	100%
280531	Ocean Road Cancer Institute	919	863	863	94%	100%
280708	Kilimanjaro Christian Medical Centre	2,710	2,670	2,670	99%	100%
280709	Voluntary Agencies - Hospital	2,563	2,563	2,563	100%	100%
280711	Bugando Medical Centre	2,175	2,175	2,175	100%	100%
Sub-total hospitals		**24,263**	**23,765**	**23,765**	**98%**	**100%**
Total sub-vote 2001 Curative Services		60,762	59,094	58,980	97%	100%
Hospitals as % of sub-vote		39.9%	40.2%	40.3%		

Budget performance in terms of release as a percentage of budget was less than 100% for some institutions, varying from 94% for the Ocean Road Cancer Institute to 100% for Buganda, Mbeya and the Voluntary Agencies sub-items. However, releases were fully

expended in all facilities, indicating 100% absorption capacity. This is likely to be due to the fact that these funds represent only a share of what is needed to run these high level facilities.

2.5 Analysis of particular recurrent expenditure categories

This section first presents more detailed analysis of two areas of recurrent spending. Firstly, as in previous years, analysis is undertaken of spending on drugs and supplies. However, significant data gaps and queries persist in this area, and the outstanding recommendation for a more detailed tracking study on this expenditure item is reiterated. Secondly, a brief comment is provided on the allocation specifically for anti-retroviral drugs.

2.5.1 Drugs and supplies

By central MOH department

Drugs and supplies are an important area of spending in several departments of the MOH, and with the resumption of the central level recurrent basket funding, continue to benefit from substantial government and partner funding. Table 17 below shows the breakdown of actual expenditure by MOH Department (sub-vote) for FY02 – FY04, together with the budgeted breakdown for FY05. A more detailed table, showing the breakdown by sub-item (ie by type of medical supply), and including expenditure during the first half of FY05, is given in Annex D.

Table 17 Spending by MOH department on drugs and supplies, FY02 - FY05 (TSh m)

		FY02 expd		FY03 expd		FY04 expd	FY05 bgt	
		GOT	Basket	GOT	Basket	GOT	GOT	Basket
2001	Curative/Hospital services	11,270.00	2,905.67	10,508.00	8,208.07	23,770.59	28,660.13	5,042.20
2002	Chief Government Chemist	2.60	-	2.60	33.00	0.75	3.00	
2003	Chief Medical Officer	-	-	-	-		2,084.21	
3001	Preventive services	1,614.11	4,038.82	2,658.90	2,634.49	5,404.35	7,405.46	6,985.83
4001	Tukuta	30.51	0.58	7.37	1.35	54.50	4.50	
5001	Human Resource Devt	-	-	6.30	-	13.12	13.00	0.26
Total MOH Departments		**12,917.23**	**6,945.06**	**13,183.18**	**10,876.91**	**29,243.31**	**38,170.30**	**12,028.29**

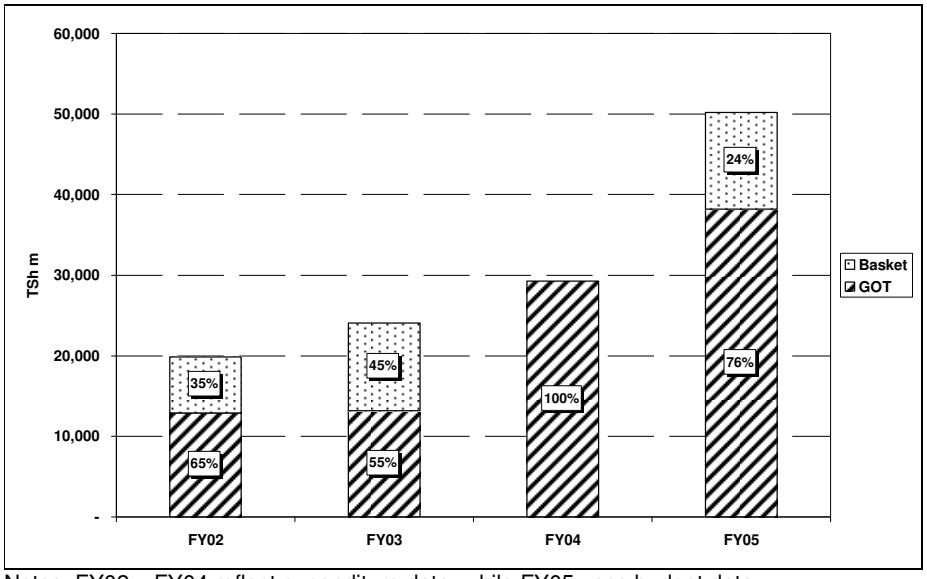
Table 17 shows the rising trend in the nominal allocation to drugs and medical supplies, which is commented on more below. The majority of drugs and supplies remain within the Curative/Hospitals Services Department, unsurprisingly, although for FY05 there has been a significant jump in the allocation under the Preventive Services Department which, when both GOT and basket funds are taken into consideration, has jumped by 166% from TSh 5.4bn to TSh 14.4bn. This reflects largely vaccine costs in the GOT component, together with contraceptives and injection supplies. It should be noted that Table 17 excludes the TSh 1.89bn allocated from the basket (development) to emergency contraceptive procurement during FY04. It is also not clear whether it includes the reallocation from other activities towards ARVs as it is not possible to obtain this information from the IFMS data.

The table also shows the re-assignment, from FY05, of drugs and supplies related to HIV/AIDS to sub-vote 2003, the office of the Chief Medical Officer. Of this, according to the Cash Flow, TSh 700m is for STI drugs, and there are various sums for storage and distribution of drugs, reagents, and other medical supplies. It should be noted that anti-retroviral drugs are not included in this figure (as they are classified under 260409 HIV/AIDS epidemics rather than 260402 Drugs and medicines), but represent an additional TSh3.5bn[23].

[23] It should be noted that there are inconsistencies between the figures in the IFMS, which is the source for Table 17, and those in the Cash Flow for FY05. It is assumed here that the IFMS represents the most up to date and accurate information, but it should be borne in mind that this cannot necessarily be clearly linked with activities as per the Cash Flow (cross-checking the activity codes does not always reveal consistency).

Figure 13 below shows that the nominal recurrent spending on drugs and medical supplies has continued its recent upward trend with a significant jump in the FY05 budget, from expenditure of TSh29.2bn in FY04 to a budgeted allocation of TSh 50.2bn for FY05. Together with the budgeted figure of TSh3.5bn for ARVs under the CMO (excluded from the table and figure), this comes to a total of TSh53.5bn, ie representing an increase of almost 83% on the FY04 budget.

Figure 13 Nominal MOH headquarters spending on drugs and supplies, FY02 – FY05



Notes: FY02 – FY04 reflect expenditure data, while FY05 uses budget data

The graph also breaks this total down by source of funding, ie GOT recurrent budget and basket fund. In FY04, there was no central level recurrent basket funding due to the switch by DFID to general budget support, but there was a corresponding increase in the GOT recurrent budget which enabled maintenance of the upwards trend in the nominal total[24]. For FY05, the increase in the basket with the inflow of World Bank funding has enabled resumption of the central level recurrent basket support, although it is reflected for IFMS purposes in the Development budget as project 6275.

Table 18 below shows the significance of drugs and medical supplies (including Tsh3.5bn on ARVs under the CMO in FY05, but probably excluding any additional spending on ARVs during FY04 together with the emergency basket contraceptive procurement) in terms of various measures of sector spending.

[24] Again, please note that this figure excludes the allocation of TSh 1.89bn from the (development) basket for the emergency procurement of contraceptives.

Table 18 Drugs and medical supplies as a share of MOH/sector spending, FY02 – FY05

	FY02 Actual	FY03 Actual	FY04 Actual	FY05 Budget
MOH HQ recurrent spend on Drugs and Medical supplies	**19,862,292,201**	**24,060,089,291**	**29,243,309,474**	**53,698,584,500**
MOH OC expenditure	55,511,793,930	67,905,923,523	80,210,784,881	123,822,019,300
MOH recurrent spending	58,992,704,669	72,021,538,913	85,180,665,882	129,265,026,100
Sectoral recurrent expenditure	117,472,785,437	143,144,409,608	173,307,066,442	241,040,450,720
MOH 2604 as % MOH OC	*35.8%*	*35.4%*	*36.5%*	*43.4%*
MOH 2604 as % MOH recurrent	*33.7%*	*33.4%*	*34.3%*	*41.5%*
MOH 2604 as % sector recurrent	*16.9%*	*17.0%*	*16.9%*	*22.3%*
Population	33,390,850	34,420,722	35,482,358	36,576,738
Average exchange rate US$1: TSh	934	1,001	1,078	1,071
Spend in US$ per capita	*0.64*	*0.69*	*0.76*	*1.37*

Table 18 shows that the share of the budget assigned to drugs and medical supplies in FY05 has risen substantially to almost one quarter of the sector recurrent budget (22.3%) and over two-fifths of the OC component (43.4%). In per capita US dollar terms, the projected figure has almost doubled from the FY04 actual expenditure figure, at US$1.37 compared with US$0.76. Only a small proportion of this is due to anti-retrovirals (although the reallocation of funds to ARVs during FY04 is unlikely to be captured in the data shown).

By level of the health care system

The allocations for hospital drugs and supplies appear to have been distributed by level according to pre-defined shares in each quarter, as shown in Table 19[25]. Neither the basis for any particular share nor any reasons for variation between the quarters are clear. Given the efforts made to improve the objectivity and transparency with which the block grants are allocated, efforts to clarify the picture regarding drug allocations are now overdue. At present it appears that decisions regarding such allocations remain the preserve of the Department of Hospital Services rather than being agreed as part of sector strategy.

Table 19 Allocation of hospital drugs by level, FY04

Hospital type	Q1	Q2	Q3	Q3 add	Q4	Alloc'n, TSh bn	Annual share %
	Percentage						
District	60.0%	45.0%	40.0%	40.0%	50.0%	5.98	51.1%
Regional	20.0%	35.0%	35.0%	35.0%	25.0%	3.17	27.1%
Referral	12.5%	12.5%	17.5%	17.5%	17.5%	1.68	14.3%
Specialised	7.5%	7.5%	7.5%	7.5%	7.5%	0.88	7.5%

Additional analysis of the allocation of drugs and supplies by level and by geographical area has not been possible in this PER update due to incomplete information supplied. This should be taken up in a separate study in order to provide a more comprehensive analysis of absolute levels of spending in this key area, and the extent to which funds are allocated in accordance with priorities, ideally also by key intervention areas (eg HIV/AIDS care and treatment, malaria prevention and control, immunisation etc).

2.5.2 Spending on anti-retroviral drugs

There has been much work done in the last two years to develop and agree a strategy for expanding access to care and treatment for AIDS patients, and substantial flows of funds are expected to help finance the rollout of antiretroviral treatment in the country form a number of

[25] It should be noted that files from the Chief Pharmacist indicate that a second additional allocation was made during Quarter 3, but no information is available on the breakdown by level. This would clearly affect the final shares, although the total allocation was small (TSh37.5m)

sources. At the same time, there is a concern that such care and treatment should not come at the expense of existing activities to prevent the spread of HIV and to mitigate the effects of the disease.

HIV/AIDS has been identified as a national emergency, and care and treatment is viewed to a large degree as a political imperative and a development issue rather than a pure health sector activity. Despite the inflows of (supposedly) additional external resources, increasing domestic funds are now being earmarked for ARVs, and this should be monitored in relation to the sector's spending priorities.

During FY04, a substantial reallocation of funds took place within the budget to provide funds to purchase ARVs. This occurred during the supplementary budget which withdrew funds from the sector in order to meet other national priorities. Of a total of TSh3.7bn which was to be contributed, Tsh2bn was reassigned to ARVs, therefore remaining in Health. The contribution of different departments to this internal reallocation is shown in Table 20 below[26].Details of the activities which had their budgets reduced or cut completely as a result, as indicated in the Annual Report, are given in Tables 35 and 36 in Annex C, while major cost items (ie those suffering a cut of more than TSh25m) are shown in Table 37.

Table 20 Internal MOH budget reallocations in favour of ARVs during FY04

Sub-vote		Amount	%
1001	Admin & General	28,663,830	1.4%
1002	Finance & Accounts	18,146,202	0.9%
1003	Policy & Planning	52,374,974	2.6%
2001	Hospital Services	981,379,696	48.5%
2002	Chemical Laboratory	29,886,066	1.5%
2003	Chief Medical Officer	20,890,575	1.0%
3001	Preventive Services	873,831,288	43.2%
4001	TUKUTA	18,927,369	0.9%
5001	Human Resources	-	0.0%
Vote 52 total		**2,024,100,000**	**100.0%**

Note: of the Preventive Services reallocation, TSh 331m came from within the National AIDS Control Programme budget.

For FY05, as indicated above, the budget for ARVs under the CMO is for TSh 3.5bn. Further analysis would be useful to determine what the total figure is from all sources, particularly given the multitude of HIV/AIDS funding sources, and the ongoing confusion in terms of their incorporation into either the Health or TACAIDS MTEF and Cash Flows, and thus official government accounts.

Available estimates indicate that, in addition to GOT resources, by February 2005 there had been a tender for drugs to the value of US $3.5m from Canada, plus the approximate US$3.5m from GOT. A further US$1.3m had been received for the purpose of purchasing ARVs from Norway, while under PEPFAR approximately US$4.7m was ready for procurement to begin in March 2005[27]. As the Care and Treatment programme gathers pace, expenditure in this area can be expected to expand, and tracking of such expenditure should be undertaken from the outset.

[26] It should be noted that the total reallocation was for TSh 2.024bn with the other TSh24m being allocated to Water bills.
[27] Information provided by Tim Rosche, John Snow International Deliver project.

3 Local government spending

3.1 Local government health sector spending

3.1.1 Trends in the level of government subventions to LGAs

In line with the general increase in the sector budget for FY05, the allocations to the councils have also risen, with initial estimates indicating a total LGA health budget of TSh 63.57bn, as shown in Table 21[28]. This represents an increase of 37% on the LGA releases for FY04. Unlike the previous year, when a 14% increase over FY03 was due entirely to a rise in the PE component of the LGA budget, the increase for FY05 is largely driven by a rise in the value of the OCs, which has grown by 56% from a release of TSh13.3m in FY04 to a budget of TSh17.4m for FY05. This is welcome given the importance of the complementary inputs to enable health workers to perform. However, the low increase in PEs is still a cause for concern given the human resource constraints facing the sector, the implications of which have been made explicit in the MOH submission to the Budget Guidelines for FY06.

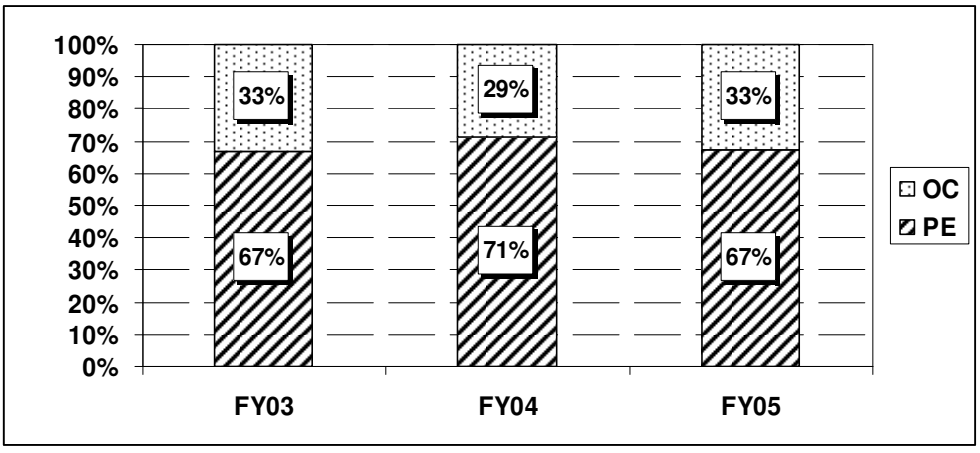
Table 21 GOT health subventions to LGAs, FY03 – FY05 (TSh m, current prices)

	2002/03 Releases			2003/04 Releases			2004/05 Estimates		
Council	**PE**	**OC**	**Total**	**PE**	**OC**	**Total**	**PE**	**OC**	**Total**
Urban	5,706	2,529	8,235	6,961	2,597	9,557	8,416	3,303	11,718
District	21,414	11,065	32,479	26,259	10,671	36,929	34,447	17,393	51,840
Total	**27,120**	**13,594**	**40,714**	**33,219**	**13,267**	**46,487**	**42,863**	**20,695**	**63,558**
Year on year growth				22%	-2%	14%	29%	56%	37%

In real terms, this represents year on year growth in the total LGA allocation of 31%. In per capita terms, the nominal FY05 LGA recurrent allocation for health sub-votes (GOT PE and OC) comes to roughly TSh 1,738 which converts to an approximate US dollar per capita figure of US$ 1.62.

The large increase in the OC allocation for FY05 has resulted in a return to a rough two-thirds: one-third split between PE and OC within the LGA subvention between the two categories of spending, as shown in Figure 14 below, following a jump in the PE share in FY04, although of course it remains to be seen whether this will be borne out in practice.

Figure 14 PE: OC allocation at LGA level, FY03 – FY05



[28] Please note that review of the Vol III Estimates "as passed by" rather than "as submitted to" the National Assembly show a slight increase, to TSh63.57bn. This figure reflects a slight decrease in the PE allocation (to TSh 42.853 bn) which is more than compensated for by an increase in the OC figures (to TSh 20.721bn). The earlier figures have been kept in the Table for consistency with previous financial years. In the future, if the timing of the PER should change, the later figures should be used.

Interestingly, analysis of this breakdown between urban and district councils shows that this reversal has occurred only in the district councils, with urban councils maintaining the higher PE share at 72% in FY05[29]. It is not clear why this discrepancy should occur, but one potential explanation would be the likely relative over-staffing in urban facilities due to staff preferences for employment in such areas.

Initial determination of the block grant for each council was based on use of the same weighted allocation formula applied from FY04 to basket funding. Councils were then given the freedom to allocate the total between PEs and OCs as necessary, so it is no longer possible to see the link between population figures and either the PE or OC allocations separately. In addition, a subsequent addition to the PE element was not allocated according to the formula, so the impact of the formula on the objectivity of the total block grant allocation has also been reduced.

The use of the formula for all LGA block grant funding is necessary in order for councils to be able to make appropriate decisions regarding the most efficient and cost-effective mix of inputs for their particular needs. However, this assumes both capacity and willingness to undertake such prioritisation which may not yet be present. In addition, it would be useful to monitor the share which councils allocate to PEs, and to calculate basic indicators related to population at least, in order to assess geographical variation and the degree to which the decisions made are appropriate.

3.1.2 Health share within the total LGA budget

In previous years, it has been customary (and indeed necessary for the Health sector financing indicators) to determine the share of the overall GOT budget for LGAs which is allocated to the four Health sub-votes. Although this is possible at an aggregated level for all councils, and at a disaggregated level for individual urban councils, an error in the publication of the original Estimates books for FY05 means data was only available for a subset of individual district councils (those in regions 70 Arusha to 77 Mbeya and 95 Manyara). The aggregated information for FY05 is shown in Table 22. It should be noted that this excludes the General Purpose Fund allocations (GPF)[30]. The Health share for all councils, and for total urban and total district, again broken down by PE and OC, is shown in Figure 15 below.

Table 22 Health subventions in relation to total LGA PE+OC, FY05 (TSh m)

	Estimates - health			Estimates - total LGA		
	PE	OC	Total	PE	OC	Total
Urban councils	8,592	3,451	12,043	52,405	14,506	66,911
District Councils	34,271	17,244	51,515	229,146	65,711	294,857
Total	**42,863**	**20,695**	**63,558**	**281,551**	**80,217**	**361,768**

[29] See Table 37 in Annex D for details.

[30] The General Purpose Fund is a grant to LGAs which, originally based on past revenue collection, was revised in order to replace various “nuisance taxes" abolished in the FY04 budget. The grant is to be budgeted and used by villages/mitaa, either in the form of cash transfers or indicative planning figures, depending on the level of local financial management capacity. From FY06, the grant is to be allocated according to a formula based on population (70%), poverty headcount (20%) and land area (10%).

Figure 15 LGA health sub-vote allocations as % of total LGA PE and OC, FY05

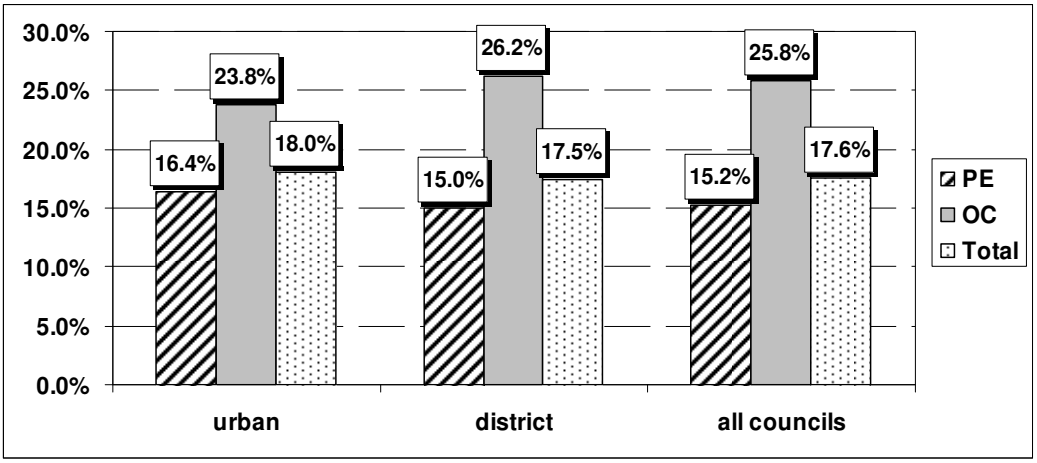


Figure 15 shows that overall in FY05, health sub-votes account for 15.2% of the LGA PE allocation and 25.8% of the OC allocation, resulting in a 17.6% share overall. This varies according to whether the council is urban or district. For urban councils, health PEs account for a slightly higher share of the total than in the district councils, while the OC share is slightly lower. This is probably due to relative over-staffing in urban councils, with the OC allocations now regulated by the introduction of the allocation formula. Further work to confirm this would be useful.

It should be noted that the later Estimates book – "as approved by" the National Assembly - combines the GPF with the OC allocation, and therefore is not consistent with these initial estimates. Revised figures are shown in Annex Table 38. As this is likely to be the case in the future, this is an area where the MOH will need to revalue its indicator on % share of LGA funding allocated to Health due to the break in series.

Among the individual councils for which the original data were available, both the PE and OC shares vary quite widely, as shown in Table 23. It will be interesting to see whether this remains the case once other sectors have also moved to a needs-based allocation formula.

Table 23 Variation in Health share of LGA allocations, FY05

	High		Low		Mean
Urban councils					
Health as % PEs	31.1%	Bukoba TC	8.8%	Songea TC	16.4%
Health as % OCs	65.6%	Bukoba TC	12.0%	Tanga MC	23.8%
Health as % total LGAs	40.5%	Bukoba TC	11.4%	Songea TC	18.0%
District councils					
Health as % PEs	28.6%	Mafia	8.2%	Bunda	15.4%
Health as % OCs	41.0%	Mkuranga	18.2%	Kibondo	27.9%
Health as % total LGAs	30.6%	Mafia	11.0%	Mafia	18.0%

3.2 FY04 budget performance at LGA level

3.2.1 Changes in the OC estimates

The data obtained for LGA OC releases for FY04 indicates a substantially different figure for the annual estimates from that which appeared in the original estimates documents for FY04, ie a total of TSh14.4bn compared with the total from the Volume III Estimates (details) which gave a total of TSh16.9, or a reduction of 14.5%. In addition, this variation is not uniform

across councils, but varies substantially, with some councils or even whole regions remaining as per the original estimates (eg Dodoma, Ruvuma and Manyara) while others suffered substantial cuts, as shown in Table 24.

Table 24 Regional variation in FY04 OC estimates by source (TSh m)

Region	Original estimates	Revised estimates	% reduction
Arusha	778.12	665.10	14.5%
Coast	841.21	850.21	-1.1%
Dodoma	664.59	664.60	0.0%
Iringa	936.88	772.22	17.6%
Kigoma	686.07	547.18	20.2%
Kilimanjaro	1,022.31	776.65	24.0%
Lindi	608.39	613.59	-0.9%
Mara	677.18	545.37	19.5%
Mbeya	1,197.33	931.87	22.2%
Morogoro	828.08	674.37	18.6%
Mtwara	504.97	511.69	-1.3%
Mwanza	1,093.24	826.90	24.4%
Ruvuma	577.03	577.03	0.0%
Shinyanga	1,074.29	867.85	19.2%
Singida	672.94	559.15	16.9%
Tabora	911.25	739.54	18.8%
Tanga	901.78	700.06	22.4%
Kagera	691.12	602.43	12.8%
Dar	810.11	772.38	4.7%
Rukwa	745.56	571.12	23.4%
Manyara	647.19	648.19	-0.2%
Total Tanzania	**16,869.64**	**14,417.47**	**14.5%**

Note: negative number implies increase following revision

Unfortunately, no data was obtained on the total revised LGA budget to determine whether this had changed in such a way to require revision of the sectoral indicator on Health as % LGA allocations.

3.2.2 LGA budget performance FY04

Overall budget performance

For LGAs, budget performance is measured only in terms of release compared with approved estimates as there is no reliable information on expenditures to be able to assess absorption capacity (or indeed that the funds released were received and spent within the health sector).

Information from MOF and the Treasury were obtained separately for PEs and for OCs, and indicate the following overall performance.

Table 25 LGA releases in relation to estimates, FY04

	Estimates	Releases	BP
Urban	9,295,420,000	9,557,207,628	102.8%
District	36,716,128,140	36,929,453,083	100.6%
Total	**46,011,548,140**	**46,486,660,711**	101.0%

Both urban and district councils performed close to target, with total releases just 1% over the estimates provided by MOF (note that these had changed from the original estimates published after the budget). Urban councils were slightly favoured, with releases 2.8% higher than budget, while district councils were only 0.6% over their estimate as a subset.

Personal emoluments

For PEs, no revised estimates were obtained, so the release data is compared with original PE estimates as per the Volume III Estimates (details) entered for the FY04 PER update. Given the substantial variation between the original and final OC estimates, this may not be accurate, and figures should be therefore treated with some caution.

Table 26 below shows budget performance in terms of releases against estimates for the PE component of the subvention to LGAs, again disaggregated by urban and district councils. As in FY03, actual releases exceeded the original estimates, by 5%. There is also a clear difference between the performance of urban and rural councils, with PE releases in urban councils being almost 8% higher than estimate, compared with a 4.5% excess in district councils.

Table 26 LGA PE releases in relation to estimates, FY04

	Estimates	Releases	BP
Urban	6,462,887,800	6,960,625,584	107.7%
District	25,131,190,040	26,258,803,113	104.5%
Total	**31,594,077,840**	**33,219,428,697**	**105.1%**

Other charges

For the Other Charges component of the GOT subvention, a less positive picture emerges, as shown in Table 27.

Table 27 LGA OC releases in relation to estimates, FY04

	Estimate	Release	BP
Urban	2,832,532,200	2,596,582,044	91.7%
District	11,584,938,100	10,670,649,970	92.1%
Total	**14,417,470,300**	**13,267,232,014**	**92.0%**

Budget performance of OC releases to urban and district councils were broadly similar, with both achieving about close to 92% of their estimates. The figure was slightly higher for district councils.

3.3 Fiscal decentralisation and allocation formulae

With effect from July 2004, the financial years for the central and local governments have been harmonised, with one intended effect of simplifying the task of preparing a consistent review of sectoral spending each year. LGAs were required to prepare a Comprehensive Council Health Plan (CCHP) for the first six months of 2004, and a second one for FY04. The allocation formula which had been in place for basket funding for councils since the start of 2004 was applied to the OC element of the block grant from July 2004, thus improving the consistency and transparency of resource allocation from central to local government.

As mentioned above, it had been intended that the formula would be applied both to the PE and the OC elements of LGA funding, as part of the broader strengthening of the intergovernmental transfer process. This would have the effect both of improving the objectivity of the full allocation of GOT funding and, equally importantly, devolving more responsibility to LGAs in terms of determining the most appropriate allocation between different inputs. Although the formula was in fact applied to the initial block grant allocations (PE and OC combined), a subsequent upward revision to PE figures was not based on the

formula[31]. The relationship between the formula and the final block grant figures has therefore been blurred. However, this is believed to have been a teething problem, and there is optimism that the formula will have a positive impact in the future.

3.4 Resource allocation at the council level

3.4.1 Intra-council allocation of GOT block grant by sub-vote

GOT block grant subventions to the councils are allocated between four sub-votes[32], loosely corresponding to levels of the district health system:

- 5010 Health services – largely expenses at the council hospital;
- 5011 Preventive services – covering public health activities;
- 5012 Health centres and 5013 Dispensaries –running costs for the primary level facilities within the council.

Figure 16 below shows the overall breakdown of the total LGA subvention (ie PE and OC) between these four sub-votes for FY05.

Figure 16 Breakdown of GOT recurrent subvention to LGAs by sub-vote, FY05

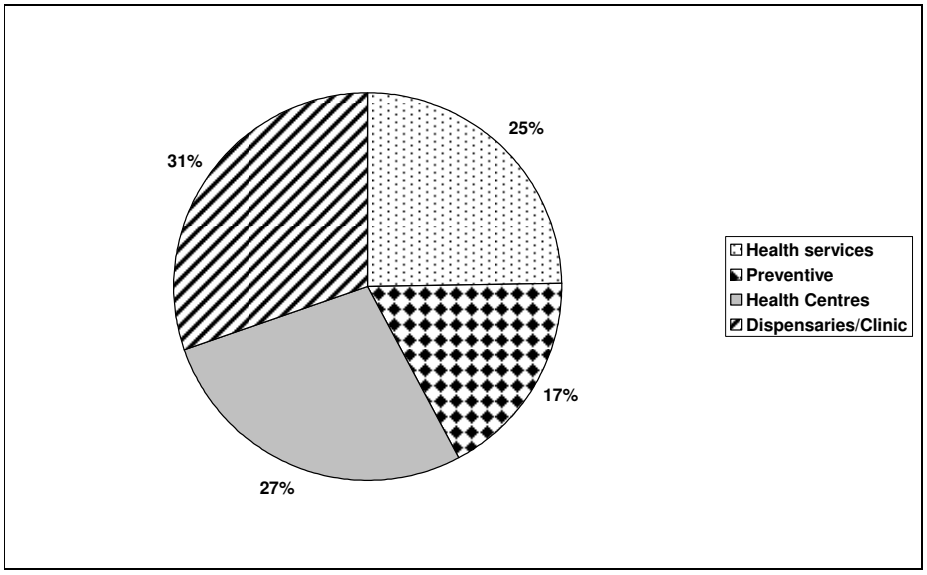


Figure 16 indicates that on average, quarter of the LGA allocation is assigned to the council hospital, while over half, or 58%, is nominally intended for the primary level, ie staff and services at dispensaries and health centres. In practice, this is something which cannot currently be verified as there is no mechanism for health facility and thus health system level financial monitoring[33]. Cash releases to individual facilities from the block grant take the form of imprest payments rather than known allocations based on objective criteria.

The disaggregated data would enable some crude analysis of staff distribution around the country at primary level facilities, through a comparison of per capita staff costs at this level. This could be used as an indicator of geographical variation in access to health workers. Unfortunately, time has not permitted such an analysis within this PER update.

[31] Personal communication, technical advisor on the Local Government Reform Programme.
[32] In some councils, one or more of these sub-votes may be missing due to the absence of facilities at the relevant level. For example, where a council is served by the regional hospital, generally there is no sub-vote 5010.
[33] Although see Section 3.4.2 on council own data below.

3.4.2 Sub-district analysis using council level data

More detailed information on the intra-council allocation of resources is, in principle, available from the annual CCHPs and the physical and financial implementation reports (PFIR) which councils are required to produce each quarter. In particular, the fourth quarter report should provide a summary of total resources received within the council, by source, together with a similar summary of expenditure by level of the health system. This latter breakdown is more detailed than that used in the GOT budget estimates, covering 6 levels, as below:

- Council health department
- Council hospital
- Health centres (sometimes distinguishing between urban and rural)
- Dispensaries
- Community
- Unallocated (sometimes used for any voluntary agencies which are not serving as District Designated Hospitals)

However, apparently no aggregation or analysis of these potentially useful sources of information is undertaken within the MOH. Summary review of the CCHPs and the quarterly reports suggests that there remain shortcomings in terms of completeness and consistency, both within and between councils. Some of this is attributable to the confusion in the past between the LG and central government financial years, and it is hoped that this will no longer be an issue with the harmonisation of the two FYs.

Although it was beyond the scope of this PER to review council level data, limited data are available from an exercise undertaken during the course of the FY04, and are presented below for illustrative purposes only. Secondly, some work was undertaken to review allocations within a small subset of councils during the first phase of the African Development Bank-funded Three Regions Health Study (TRHS). Both of these, reproduced below, are subject to data concerns, but are included to illustrate the potential of these routinely produced report.

Analysis of data from Mara, Mtwara and Tabora on allocation of council resources by level

The fourth quarter PFIR for 2003 were obtained from 12 of the 16 councils in the Three Regions, and data extracted from the summary tables within these, and are used to illustrate the type of analysis which could be undertaken for comparison at the regional or national level, or between urban and rural councils, or as in this case, for specific geographical areas. However, many inconsistencies remain, with discrepancies evident between central level and council reported data on block grant and basket funding, (unexplained) differences between original budgets from all sources in the CCHP and the final summary of annual income from all sources in the PFIR, and even differences between summary tables within the CCHP. These all need considerable strengthening if the reports are to serve a useful purpose in monitoring council level spending in relation to priorities.

Figure 17 Per capita income and expenditure, selected councils, 2003

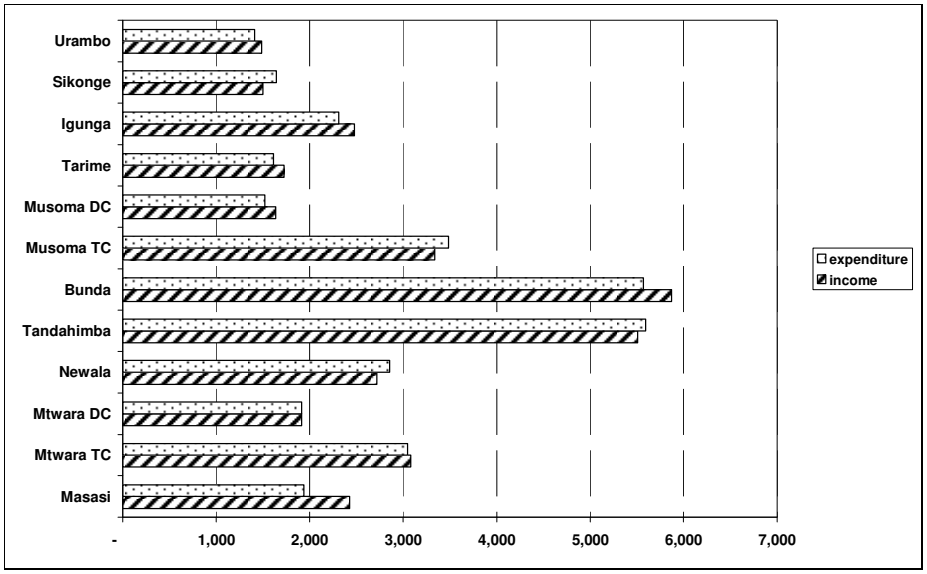


Figure 17 shows the wide variation in per capita income and expenditure at council level once funding sources other than GOT and basket funding are included in the analysis. Per capita income ranges from TSh 1,485 in Urambo to TSh 5,871 in Bunda, almost four times as high. Unsurprisingly, per capita expenditure follows income quite closely. Further analysis would be required to determine whether such variations are genuinely related to the availability of resources, or whether they reflect differential reporting.

Figure 18 below shows total reported revenue in the 12 councils, disaggregated by source of funding.

Figure 18 Selected councils' reported income 2003, by source

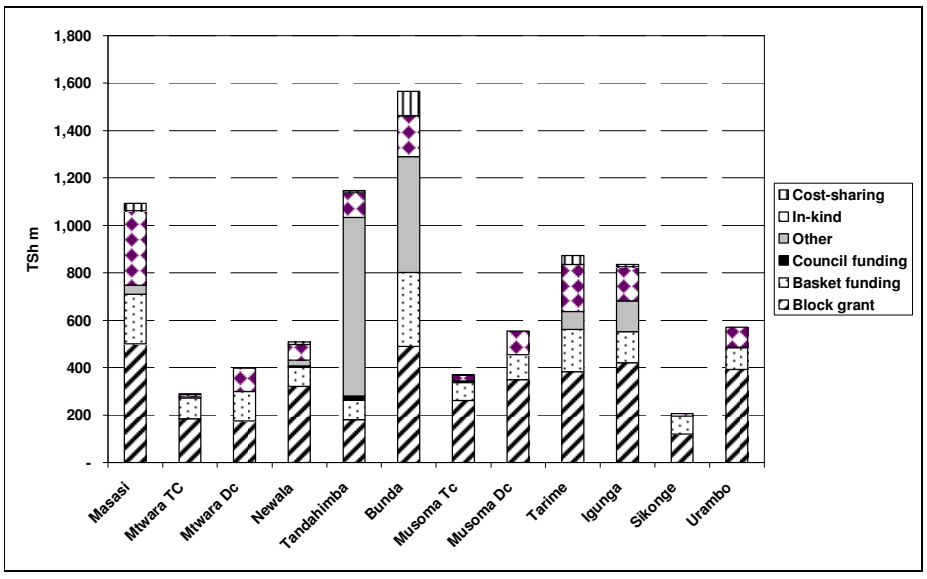


Figure 18 clearly shows the influence of the "Other" funding, particularly on the Bunda and Tandahimba per capita income figures. In the case of Bunda, the funding comes largely from the Catholic Relief Services, and is earmarked for the hospital. Other factors of note are the relatively limited contribution of reported cost-sharing revenues to the council

resource envelope (see also Section 3.5.1 below), and of any councils' own funding. The in-kind contribution generally refers to the value of drugs and supplies procured on the councils' behalf by the MOH, but these are not always reported correctly.

Figure 19 below shows reported per capita expenditure, allocated by level of the district health system.

Figure 19 Selected councils' per capita spending, by level, 2003

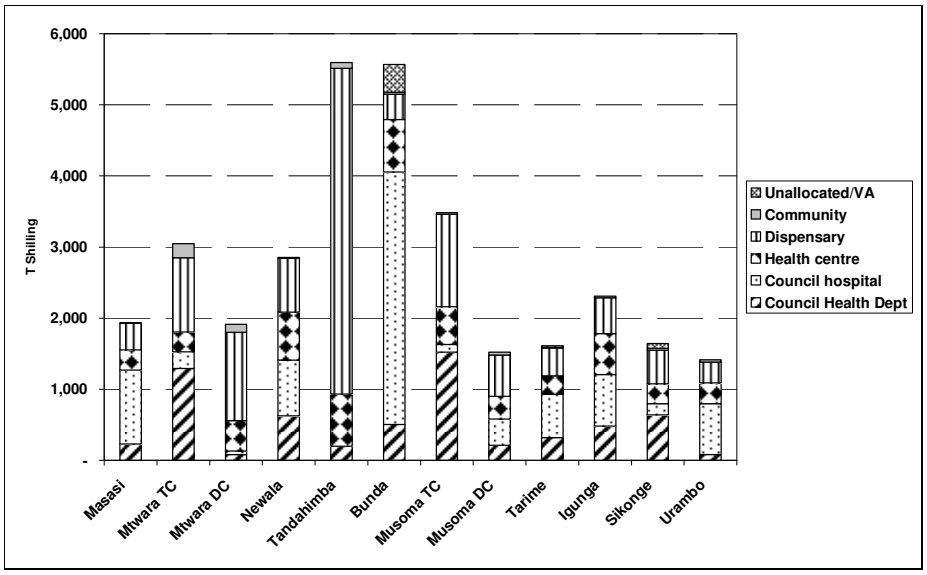


Figure 19 illustrates the wide variation in the way that available funds are deployed within the district. Although guidelines exist for the allocation of public funds (ie block grant and basket), this will clearly influence the overall allocation only to the extent that these represent the major sources of funding. Where individual donor or NGO projects provide earmarked funding for specific areas or activities, there is little guarantee that the overall allocation will remain efficient (or equitable between geographical areas). This confirms the importance of the CCHP which is intended to ensure that all available funds are employed to their maximum effectiveness, but given the above variation, it seems likely that capacity to actually ensure and monitor this is limited.

Ideally, such data could further be used in comparison with indicators of health sector outputs, to determine whether increased inputs have a measurable effect on level and quality of service delivery at the various levels.

3.5 Other analysis using council data

One other attempt was made to use council data during the course of the year, through a rapid analysis of available fourth quarter PFIRs to determine the contribution of cost-sharing in those councils.

3.5.1 Reported cost-sharing revenues in selected councils

In light of the fact that it always proves difficult to obtain information from central level sources on the contribution of cost-sharing at the primary level, an attempt was made to source this data from council PFIR. A total of 20 reports were available at the time of the analysis in addition to the 12 already analysed for the TRHS. The availability of the required reports was random, and the sample cannot claim to be representative of the situation country-wide. However, it does present more information than has been available hitherto.

Of the 32 councils for which fourth quarter reports were reviewed, only 23 reported any cost-sharing income. Only four of these offered any supplementary information as to whether the income was from the Drug Revolving Fund, Community Health Fund or Health Services Fund. It seems unlikely, given the figures, that HSF revenues were included consistently. The available data are presented in Table 28.

Table 28 Data on cost-sharing from a sample of council PFIR, 2003

Region	Council	Cost-sharing	Total Resources	C-S as % Resources	Population 2003	pc CS revenue
Tanga	Tanga MC	55,936,415	514,183,803	11%	247,964	226
Tanga	Korogwe DC	43,358,911	910,483,596	5%	265,702	163
Tanga	Muheza DC	44,809,046	848,215,064	5%	284,453	158
Tanga	Handeni DC	27,050,894	716,091,831	4%	146,957	184
Lindi	Nachingwea DC	1,066,752	154,717,088	1%	164,350	6
Lindi	Ruangwa DC	5,457,352	357,376,601	2%	126,259	43
Lindi	Kilwa DC	15,221,364	642,594,281	2%	174,256	87
Lindi	Liwale DC	14,728,218	338,023,710	4%	76,604	192
Coast	Mkuranga DC	965,772	578,163,292	0%	191,926	5
Coast	Rufiji DC	8,028,444	907,366,464	1%	207,976	39
Coast	Mafia DC	5,209,280	261,915,110	2%	41,780	125
	Mahenge DC	18,376,500	826,735,404	2%	-	
Morogoro	Kilosa DC	37,123,607	1,035,587,276	4%	502,240	74
Kigoma	Kibondo DC	50,390,087	1,392,494,797	4%	434,673	116
Tanga	Pangani DC	19,385,562	292,463,180	7%	44,901	432
Mara	Bunda DC	101,263,754	1,564,496,124	6%	266,500	380
Mara	Musoma TC	848,500	370,207,559	0%	110,948	8
Mara	Tarime DC	37,446,365	872,083,642	4%	505,118	74
Mtwara	Masasi DC	31,422,580	1,092,838,221	3%	450,097	70
Mtwara	Mtwara TC	4,305,589	290,068,733	1%	94,176	46
Mtwara	Newala DC	11,152,440	508,755,539	2%	187,057	60
Mtwara	Tandahimba DC	5,582,600	1,146,234,275	0%	208,127	27
Tabora	Igunga DC	9,872,570	835,256,199	1%	337,267	29
TOTAL		**549,002,602**	**16,456,351,789**	**3%**	**5,069,332**	***105***
Tanzania mainland population 2003					*34,644,021*	

Note: TSh 105 is mean rather than total pc cost-sharing revenue figure. Mahenge revenues excluded from the calculation of the mean as population not available.

The data in Table 28 indicate that on average in these councils, cost-sharing revenues amounted to 3% of the available resource envelope, ranging from a low of 0.2% in Mahenge and Musoma TC to a high of 11% in Tanga MC. Cost-sharing generated a mean of TSh 105 per capita, again ranging quite widely from TSh 5 in Mkuranga to Tsh432 in Pangani. As these councils accounted for 15% of the population, the mean per capita figure could be crudely extrapolated to estimate total cost-sharing revenue at around TSh3.6bn[34].

This data should again be treated with some caution, notably as it is known that not all councils are charging at the primary level (this tends to be associated with establishment of the Community Health Fund) and also as it excludes the urban councils of Dar es Salaam region which have a longer history of charging, and are known to generate substantial (absolute) amounts.

However, if such reports were complete, consistent and accurate, the ongoing debate on cost-sharing could be much better informed by routine data rather than by costly surveys and studies, and it would also be more likely that the district populations, who are both paying and in theory benefiting, could be kept informed on the value and use of their contributions.

[34] It should be borne in mind, however, that 7 of the limited sample of 32 councils reported no cost-sharing revenues. Balancing this, urban councils in Dar es Salaam region are not included, and are known to generate substantial revenues from cost-sharing.

4 Sectoral performance

4.1 Health sector performance in relation to the PRS

4.1.1 Health as a priority sector

Discussion of the allocation to Health as a Priority sector is covered in Section 2.2.1. This indicated that in contrast to the picture presented in the sectoral FY04 PER update, the sector has in the last year benefited from a substantial increase in both its absolute (nominal and real) allocations and in terms of its share of the overall discretionary budget. This is due both to a supplementary budget and reallocation during FY04, and a continued increase in the allocation in FY05, largely but not exclusively driven by external funding. This is taken up again in Section 5.

4.1.2 Primary health as a priority item

The picture in terms of Primary Health as a priority item is less clear, and data gaps prevent a full analysis of the picture. As shown in Sections 2.3.3 and 2.3.4, much of the increase in the overall sectoral total cannot clearly be broken down between levels of the health system, and the Tsh4bn additional allocation to the NHIF in FY04 does not contribute to the Priority item.

Table 29 presents an updated table for recurrent spending according to the definition of PRS priority items, but some queries remain regarding the allocation to drug kits and the indent system at primary level facilities for FY04. LGA drug figures included up to FY04 are those provided for kits, indent, District Hospitals and Designated District Hospitals. The FY05 allocation for LGA drugs is taken from the MOF *Budget Review* of October 2004 (Annex II) and its basis is not known.

Table 29 Recurrent spending on PRS priority items, FY02 to FY05 (TSh million)

	FY02	FY03	FY04	FY05
Total subvention to LGAs	35,393	43,548	42,754	63,503
Preventive service subvote at RAS	302	304	310	330
LGA drugs budgeted under MOH	9,108	12,478	15,812	15,592
MOH HQ Preventive services subvote	7,574	7,253	15,187	16,072
Total Health Priority items	**52,376**	**63,582**	**74,063**	**95,496**
Total Priority sector spend/budget	141,330	175,638	222,520	312,811
Priority items as % sectoral spend	*37%*	*36%*	*33%*	*31%*

Table 29 shows that the absolute (nominal) value of budget/expenditure on priority items within the on-budget Health resource envelope has risen consistently in recent years, increasing by over TSh 11bn between FY04 and FY05, and the slowing in the growth rate between FY03 and FY04 (from 21% to 16%) has been reversed, at 29%. Comparison with the defined priority sector total shows that the share of priority items within this total was relatively stagnant since FY02, at around 36%, until an apparent fall to 33% for FY04 which has continued into FY05 where the estimated share was 31%. More complete and detailed figures on drug spending would be useful to shed light on this.

4.2 Health sector financing performance indicators

As in previous years, the PER provides the opportunity to update selected performance indicators for the health sector as a whole. There are five indicators related to financing issues, although as in FY04 it has unfortunately not been possible to update each aspect of all of these due to time and data constraints. Table 30 shows the updated figures, in Tanzania shillings (current prices), for three of the indicators, and the percentage share of

LGA allocations budgeted for health in the coming year. The cost-sharing indicator has not been updated. Comments on this indicator remain as in the FY04 PER update.

Table 30 Finance-related health sector performance indicators

	Indicator	Level	Baseline	FY04		FY05
				Budget	Actual	Budget
1	Total GOT public allocation to health per capita (central, regional, and district)	Central	1,245	2,699	2,799	3,230
		Regional	172	356	351	298
		District	848	1,442	1,375	1,804
2	GOT and donor allocation (budget and off-budget) to health per capita	National average	5,100	8,156	8,747	12,389
3	Per capita GOT recurrent expenditure broken down by level (central, hospital services, preventive services)	Central	190		565	
		Hospital	1,077		1,716	
		Preventive	894		1,678	
7	% of GOT funds available for budgeted and actual district health activities against the total overall funds available for district activities	Budget	18%	16.6%		17.6%
		Actual	15%			
12	Cost-sharing fees collected by public health facilities in year x as a proportion of the 1998 targets	National average	0.46		n/a	

Note: Figures in Tanzania shillings unless otherwise indicated.
Indicator 3 is taken from Table 8 and as such does not include the NHIF allocation. Inclusion of NHIF would raise the central administration value to TSh 863 per capita (in the absence of a reallocation to the beneficiary level, data for which is not available). It is also subject to the other exclusions as noted in Section 2.3.4.

Table 31 below provides US dollar values for indicators 1 to 3, in order to facilitate comparison with other countries and with the figure of US$9 which is frequently referred to in discussions about the costs of the sector.

Table 31 Selected finance-related health sector performance indicators, in US dollars

	Indicator	Level	Baseline	FY04		FY05
				Budget	Actual	Budget
1	Total GOT public allocation to health per capita (central, regional, and district)	Central	1.49	2.50	2.60	3.02
		Regional	0.21	0.33	0.33	0.28
		District	1.02	1.34	1.28	1.68
2	GOT and donor allocation (budget and off-budget) to health per capita	National average	6.12	7.57	8.12	11.57
3	Per capita GOT recurrent expenditure broken down by level (central, hospital services, preventive services)	Central	0.23		0.52	
		Hospital	1.29		1.59	
		Preventive	1.07		1.56	

Notes:
- Exchange rates used are those of the latest Economic Report Feb 05.
- Central level value for Indicator 3 **including** NHIF is US $0.80.

Indicator 1 monitors the GOT commitment (including GBS) to health sector spending at each level of the health system. Table 30 shows that although actual nominal spending fell slightly short of budgeted figures for FY04 at regional and LGA level, there was a small increase in the central level allocation over initial spending plans. Comparison of budget figures for the current and previous FYs shows an 18.5% increase in the total per capita GOT allocation. This comprises a 20% increase in the central allocation and a 25% increase in the district allocation, with the regional level suffering a 16% fall. Table 31 shows similar magnitudes of change in the US dollar figures, due to the limited change in the exchange rate between FYs.

Indicator 2 measures total resources per capita for health spending, including off-budget funds. As such, the actual figures need to be treated with caution in the absence of improved information from MOF on off-budget external expenditure in the sector as this is currently based on a crude assumption. However, budget figures can be compared, and show a 58% increase in the nominal shilling value from FY04 to FY05, much higher than the 8% reported in the FY04 PER update. The US dollar value of this has also risen by a similar proportion, reaching a figure of US$ 11.57.

Indicator 3 is based on the actual breakdown of spending between categories reflecting the three components of the HSSP, as shown in Table 8. However, minor data queries remain with this table, as indicated in Section 2.3.4 above, and further refinement of the definitions of each category would be worthwhile. The data as presented show that since the base year, the nominal value of the central level allocation has risen by almost 200%, while hospital and preventive allocations have risen by 59% and 88% respectively. In US dollar terms, the increases are 130%, 23% and 45% respectively for each category.

Indicator 7 shows the level of government commitment to the health sector at the local government level, monitoring the share of spending at that level which is allocated to the four health sub-votes. Unfortunately, only the budgeted figures can be monitored as data on overall LGA releases were not available. Table 30 shows that in contrast to FY04 when there was a 1.1% fall in the sector share, for FY05 this is almost fully recovered with a projected 1% increase which is encouraging. However, it should be noted that this still remains short of the baseline figure of 18%. As noted in Section 3.1.2, changes in the measurement of funding to LGAs to include the GPF means that this indicator will need to be revalued with effect from this year. The share of Health in the FY05 LGA budget subvention including GPF is 16.4%, as shown in Annex Table 39.

5 Discussion, recommendations and next steps

5.1 Key issues and recommendations

5.1.1 Overall sectoral spending

The data in Section 2 show a broadly positive picture this year, with both official GOT estimates and PER collated data showing a substantial rise in both nominal and real absolute values of the resource envelope (on- and off-budget) for the health sector. The GOT data also show a reversal of the fall in the share of the sector which was experienced last FY. Although these are encouraging findings, it should be noted that the budgeted health sector share for FY05 has not yet regained its FY02 high of 11% of actual expenditure (excluding CFS), and that even that level falls short of the Abuja commitment of 15%.

In absolute terms, although no recent costing has been undertaken of strategies and activities required to achieve sectoral goals, as per the HSSP, it is clear according to international estimates (eg the 2001 figures from the WHO Commission for Macroeconomics and Health, the recent costings by the Millennium Project), that funding to the sector continues to fall far short of requirements.

With the move to a cluster approach in the MKUKUTA, close monitoring of health sectoral allocations will remain important as several of the key development goals remain largely within the remit of the health. The need to mobilise both additional domestic funding (in terms of both the level and share of government spending) and external funding must continue to be a focus for government and development partners alike. At the same time, efforts should intensify to ensure that existing funding is used both to maximum efficiency, and to target those identified as most in need.

5.1.2 Sub-sectoral spending: meeting priorities

Analysis of sub-sectoral spending patterns using PER data shows a temporary increase in reliance on external funding in FY05. However, this largely reflects the fact that different labelling of the same funding source results in definitional rather than actual changes, ie World Bank funding appears as external funding for FY05 but a large part of this is expected to be reflected as domestic once switched to the Poverty Reduction Support Credit from FY06 (as happened with DfID funding for FY04). Continued monitoring will be necessary to ensure that the GOT allocation (including GBS) rises accordingly.

Commitment to the local government level remains questionable with the fall in the budgeted share of the on-budget total from 33% in FY04 to 27% in FY05 (as per Figure 9). However, again, there are definitional problems with the assignment to these levels (notably relating to drugs and supplies, and the NHIF), and it is therefore recommended that further work be undertaken during the coming year to strengthen and clarify this analysis.

Projected spending on drugs and other essential health supplies has risen substantially between FY04 and FY05, both due to an increase in the allocation of GOT funding to this key input, and to the resumption of a significant central level health basket fund. The increase in budgeted funds from FY04 to FY05 was 83% (including anti-retrovirals), with a large jump in the budget for such supplies under the Preventive Services Department, covering vaccines and family planning commodities among other items.

The full picture of spending on drugs and supplies is still not clear, however, with the PER analysis covering only recurrent spending through the GOT and basket funds. Further supplies are funded through a number of bilateral and multilateral partners, including the funding provided under the Global Alliance for Vaccines and Immunisations (GAVI) and the

Global Fund for AIDS, Tuberculosis and Malaria (GFATM) which are not systematically identifiable in budget documents (MTEF or Cash Flow). Other funding or direct provision comes through external funding which remains outside the budget, and there is of course some spending by LGAs which is not captured here. In addition, there are gaps in terms of the information required to provide more confident estimates of both the allocation by level of the health system, and of variations in the geographical allocation of supplies which are known to exist and which require further analysis to determine whether they are in accordance with needs or reflect past allocation patterns. As in previous years, a key recommendation of this PER update is that a more detailed assessment of spending on drugs and supplies should be undertaken, to improve the comprehensiveness of the data, and to provide better information on how the totality of funds are allocated through the system and country (and potentially also priority disease areas).

5.1.3 Budget performance and absorption capacity

In contrast to previous years, the on-budget sectoral total showed budget performance matched expectations in FY04, with total expenditure at 100% of budget. This was largely due to the TSh 4bn overspend in the AGO allocation to the NHIF, which compensated for the fact that the development budget performed at only 97%. However, this latter figure still represents a notable improvement on FY03 when development expenditure was only 81% of budget, suggesting an improvement in planning and integration of project funding into the MTEF and timely release of partner funding.

In terms of MOH recurrent spending, IFMS data indicate that there was an improvement in both budget performance and absorption of GOT funding in all MOH departments, which is very encouraging. Releases for FY05 were on course at the halfway point in the financial year, at 50.6% for GOT and 62% for basket funds. Expenditure (ie absorption) was lagging behind somewhat, particularly for basket funding.

Full analysis of budget performance and absorption capacity is possible only for some levels of the health sector, with the notable weakness being at local government level which is arguably the most important in terms of achieving health sector outcomes. Releases continue to be equated with expenditure despite evidence to the contrary. The sourcing of better data for analysing actual spending at this level should therefore remain a priority. Although ultimately the IFMS is expected to be functional at the LGA level, in the interim further work to strengthen health sector PFIRs would be a useful step, as would central level analysis of these reports to provide an overview of performance and its variation to facilitate targeted support.

There were some findings related to budget performance which have yet to be explained, notably why the release to the NHIF was higher than budgeted in FY04 (and why the budget has subsequently slightly fallen for FY05). Another query regards the dramatic in-year increase in the Approved Estimates for the Preventive sub-vote at the Regional level (almost 800%, from TSh 0.32bn to TSh 2.87bn). If this was due to requirements having been under-estimated, there remains a query as to why this is not reflected in a larger budget for FY05 which has increased only 1.7% from the original FY04 estimate.

5.1.4 Local government financing issues

There has been an encouraging increase in the absolute level of the GOT allocation to the health sector at LGA level, from releases of TSh 46.5bn in FY04 to a budget of TSh63.6bn for FY05, representing a 37% increase in nominal terms and a real increase of 31%. In per capita terms, this converts to a nominal figure (PE+OC) of US$1.62. In FY04 prices, this comes to US$1.56, which represents a 28% real increase on FY04 releases.

However, such values represent very low levels of effectively "flexible" resources in the hands of LGAs, despite supplementation through the health basket, and the observation that the share of the sectoral resource envelope allocated to this level (through fiscal transfers rather than in-kind) has fallen in FY05, as seen in Figure 9, raises concern about the commitment to decentralisation[35]. This is particularly the case to the extent that LGAs do not yet have control over their entire PE allocation, although it is accepted that there are outstanding capacity issues in relation to human resource management which will need to be overcome before this can be rectified.

Regarding the health sector share of the overall GOT allocation to LGAs, there has been a slight reversal of the decline seen in recent years, up from 16.6% of the LGA budget in FY04 to a projected 17.6% of the LGA budget in FY05. Unfortunately, it is not possible to compare the FY04 budgeted figure with actual releases due to lack of data on the total LGA release[36]. However, the 14.2% downward revision in the OC estimates for LGAs is of concern, and it would be worth checking whether this happened across sectors. Unfortunately, the final quarterly MOF Budget Execution Report for FY04 (BER Q4) does not break down expenditures at the regional and sub-regional level, indicating only that all sectors are *"recorded as per total Exchequer issues, apportioned by each sector's budget estimate"*[37].

For the health sector, MOF data from the BER Q4 indicates that the total sub-national (ie Region + LGA) OC estimates performed at 95.8% compared with PE estimates achieving 99.8% of budget in FY04, based on the assumption above. However, PER data for the LGA level (Section 3.2.2) indicate that overall budget performance (release as proportion of budget) for that level was 101% (taking the revision in original estimates into consideration), and that PEs releases exceeded budget by 5.1% while OC releases were only 8% less than the revised budget figures. This suggests that the MOF assumption regarding final use of funds is not justified, and raises again the concern that better data on final expenditure must be a priority at the LGA level.

Councils produce quarterly reports which could potentially provide a very useful source of such expenditure data, as illustrated by the examples in Section 3.4.2. However, much of the data is poor quality, both in terms of its completeness and its consistency, and further strengthening of such sources is necessary. In addition, it appears that little analysis of the data is undertaken, representing a missed opportunity both to determine variations in council performance, and to better target support as a result. However, it is clear that quality issues contribute to the lack of use of these reports at central level.

The introduction of the allocation formula for the OC component of the health block grant to councils has had a clear impact in favour of district (rural) councils, implying better targeting of government (and basket) funds towards more needy areas (given the known higher prevalence of poverty ins such areas. However, clarification is still required as to whether formula was also applied to the PE component of the transfer as the figures obtained would suggest that this was not the case. If not, which would be understandable given capacity concerns, it would be useful to know the proposed timeframe and actions to improve capacity and move forward in this area which is important in terms of strengthening LGA responsibility for local allocation decisions.

5.1.5 Cost-sharing

It appears indisputable, given original intentions and projected coverage levels, that CHF performance has been disappointing to date. In addition to the poor upward and downward

[35] Notwithstanding the caveats raised in Section 2.3.3.
[36] This should be possible for the PER, but was not done in this update due to time constraints.
[37] Ministry of Finance (2004). *Budget for fiscal year 2003/04: Quarterly budget execution report, fiscal quarter 4, April – June 2004*. Dar es Salaam: October 2004. Annex Table F on p vi, Note 1.

accountability indicated by the lack of reliable data on income and expenditure under the CHF, far more detailed information would required regarding benefit packages, utilisation of members compared with non-members, administrative costs etc in order to determine the broader value of the CHF and its opportunity cost. A more detailed evaluation of the scheme's overall performance is long overdue, and should be undertaken before the next PER update.

More could be made of HSF data. Gaps remain in relation to individual facilities, as do queries regarding the build up of balances and use of funds.

In contrast to the FY04 update, when detailed figures were available from the National Health Insurance Fund, it has not been possible this year to analyse the breakdown of spending either geographically, by type of provider, or in terms of the type of services reimbursed. As the GOT subvention to the NHIF represents a substantial proportion of sector on-budget resources, it is important to monitor that these are spent in accordance with the priorities of the sector and that this is an efficient use of funding. More efforts should be made to obtain this information from the NHIF in future updates[38].

5.1.6 Off-budget external funding

The need for a review of the completeness and accuracy of the data source for off-budget external funding has been articulated in successive PER updates, without any action being taken. At present, the incompleteness of the submission from the MOH to MOF in terms of reconciliation with the official development budget, together with the very crude and untested assumptions made regarding disbursement, expenditure, and future projections, undermine the value of any analysis of this particular (and potentially highly significant) source of funding for sectoral activities. Analysis of such funding in terms of its contribution to poverty–reduction and towards achieving priority health outcomes would also be useful.

Such an analysis is particularly merited in the context of the various and confusing sources of funding for HIV/AIDS interventions – especially with the move to scale up Care and Treatment and access to costly anti-retroviral treatment. In addition, Global Health Initiatives are increasing in importance as funding sources, such as the GAVI which has been subsidising immunisation costs in recent years, yet is unlikely to prove sustainable in the longer term, and the GFATM for which high value agreements have been signed but are not fully reflected in the MTEF and therefore within government accounts.

5.1.7 Drugs and supplies

The allocations for drugs and other essential health supplies, while always a significant element of the sectoral budget and expenditure, have grown particularly fast for FY05. For GOT recurrent and basket funding alone, there was a rise of almost 83% from the FY04 expenditure[39]. This represents a jump in (nominal) per capita US dollar terms from US$ 0.76 to US$ 1.37, only a small part of which is due to ARV purchases, and which can therefore be expected to impact positively on access to and quality of health services. This is a very welcome achievement.

However, major gaps in the analysis of drugs and supplies remain, with various sources not taken into consideration (eg MOH development budget, direct from project, a clear analysis of ARV contributions through TACAIDS, and purchases at LGA level, among others). In addition, some potentially useful analysis, of the allocation by level of the health system, and

[38] It should be noted that while NHIF officials did respond to requests for this data, they were unable to provide responses to clarifications before the report was finalised.

[39] Note, as indicated in Section 2.5.1, this excludes the TSh 1.89bn emergency procurement of contraceptives through the basket and the reallocation to ARVs during FY04. The increase would be slightly lower if these were included, but is still significant.

by geographical area, has not been possible this year due to incomplete and inaccurate data provided by the Chief Pharmacist. The need for a more thorough tracking study which takes into account the additional resources provided to this key area is hereby reiterated. A more detailed reconciliation of the various MOH data sources on on-budget drug spending would also be worthwhile.

The basis for allocation of drug and medical supplies budgets by level and by geographical area remains unclear, and requires urgent review in order to improve transparency and objectivity. It had been expected that for LGA allocations, this would be harmonised with the formula for OC block grant allocations and the health basket for FY05, but this does not appear to be the case.

5.1.8 The PER process

It is unclear what the future of the sector PER will be given the move to the cluster approach with the MKUKUTA. However, it is likely that some sectoral analysis will be required for partners (and is recommended) which if the timing were managed well, could feed into a cross-sectoral review for the MKUKUTA.

For the FY05 PER update, many of the same data problems were encountered as in previous years, both in terms of gaining timely access and its completeness and consistency. If this exercise is to continue, more needs to be done on a quarterly basis in terms of liaising with Finance and LG on releases (for the regions and the LGAs (PE, OC, and by sub-vote) in the absence of IFMS reporting from other levels.

The timing of the PER update is not particularly useful at present in terms of feeding into budget process except in broad aggregate terms of the GOT allocation levels. There is a continuing disconnect between the PER as a retrospective review of spending against priorities and outputs on which to base the preparation of the new budget and MTEF.

5.2 Immediate next steps

Arguably the first task in relation to the health sector PER update for FY06 is for sector partners to determine what they require of the PER for their own review purposes, and for the overall PER group to determine what form, if any, sectoral PER updates will take next year given the switch to the cluster approach within the MKUKUTA. On the assumption that cross-sectoral PERs will be required to monitor MKUKUTA progress, the timing will then need to be carefully determined in order to ensure both data availability from the various sources (notably MOF and PORALG) and a timetable determined to enable the sector PER findings to feed into the cross-sectoral reporting.

The Health PER Task Team should take their experience regarding the difficulties in accessing routine data from MOF, Treasury and PORALG to the overall PER Working Group in order to request a clear mandate for early and simple release of the necessary data. Ideally, much of this could be collated during the financial year (eg quarterly) so that the task of data collection is not so onerous at the end of the FY.

A more functional PER Task Team, including desk officers from MOF and PORALG, holding regular meetings during the course of the FY, should also facilitate such a process. The Sector Working Group could require a quarterly update against budget for the sector as a means of encouraging this work, but this may be over-optimistic given the continued reliance on external support in the preparation of the PER update.

6 Annexes

Annex A Sources of information, key assumptions and other notes

Data for all tables and figures are included in a single accompanying file, **PER tables FY05**, and the various "tabs" within this worksheet are, it is hoped, self-explanatory. However, much of the data in this file has been copied in from other working files, and has been copied as values rather than showing the various formulae or more detailed source data. The description of sources below therefore refers to the original source documents within the working files in folder **PER FY05\Data**, rather than the relevant tabs within the file **PER tables FY05**, although these also generally specify the source data.

PER Master Table (Annex B)

Several of the figures and tables below are based on data within the PER Master Table given in Annex B. The data for this are taken from several sources, as far as possible noted within the Table in the form of comments. The majority of data from previous years is used as it appeared earlier, the exception being where final estimates differ from originals due to reallocations during the FY or where actual expenditure data has become available to replace estimates or release data. These instances are indicated by comments in the table, and in the text below.

MOH recurrent budget data for FY05 was drawn from *Volume II Estimates of Public Expenditure (Consolidated Funds Services (Section 1) and Supply Votes (Ministerial) for the year 1 July 2004 to 30 June 2005 as submitted to the National Assembly*. Revised estimates and actual recurrent expenditure data for FY04 were taken from an electronic version of the the Appropriation Accounts of the MOH, **file \Original files\Appropriation Acct June 2004 – Sally**. These were all entered into file **Working files\MOH HQ FY05**. It should be noted that there are slight discrepancies with the data the Itemised Daily Balance report produced by the Accounts Department from the IFMS Platinum (supplied to the team in Excel), data from which is contained in **files \Working files\Platinum manipulations FY04** and **Working files\Platinum manipulations Jul-Dec FY05**.

Regional recurrent budget data was taken from an electronic version of the *Volume III estimates of public expenditure Supply Votes (Regional) for the year 1 July 2004 to 30 June 2005 as submitted to the National Assembly*, contained in **file \Original files\vol 3 rec exp regional supply votes-detail**, and entered into **file \Working files\Regional data FY05**. Recurrent expenditure data is taken from an electronic version of the *Regional Appropriation Accounts* summary provided by PORALG, **file \Original files\PORALG AFYA Regions 2004**. It should be noted firstly that this file distinguishes between Preventive and Curative sub-votes only, with no information on sub-items, and secondly that there are errors in addition and/or data entry which have not yet been corrected. These are not expected to significantly alter the substantive findings given the low share of the regions in the sector total.

FY05 estimates for local government recurrent budget figures were taken from an electronic version of *Volume III Estimates of Public Expenditure Supply Votes (Regional), Details on Urban and District Council Grants and Subventions for the year from 1st July, 2004 to 30th June, 2005 as submitted to the National Assembly* for FY05, found in **file \Original files\vol iii detailed budget**. This was entered into **file \Working files\Local Govt FY05, tab "recurrent by item FY05".** In contrast to previous years, time constraints meant that only PE and OC totals were entered for each LGA sub-vote rather than each individual sub-item, which has limited some of the later analysis (eg spending on drugs and supplies, allocations

for HIV/AIDS. Data for FY04 and FY03 remain as release data, provided by the Budget Department MOF, and is contained in **files \Original files\Afya council 2003-04** (for OCs) and **\Original files\health200304** (for PEs), subsequently entered into **file \Working files\Local government FY05, tab "sectoral estimates"**.

Basket funding figures for MOH headquarters for FY04 were taken from a number of sources. Although the reduced central allocation meant that all basket funds for MOH were entered originally into the development budget, a reallocation for emergency procurement of contraceptives is reflected in the MOH recurrent budget, as per hard copy of submission to the April 2004 Basket Financing Committee **(Agenda No 7 and 8 (a))**. Also reflected in the recurrent budget is the allocation to "holding harmless" the council basket allocations, which are also referred to in the agenda note above, allocated between urban and district councils as per the original formula estimates (contained in **file \original files\final basket for 2004 (matrix 27.10.03)** provided for the FY04 PER update.

The estimates of the total net approved expenditure and actual expenditure for the Basket were taken from the MOH Basket income and expenditure statement prepared by the MOH Accounts Department[40]. It should be noted that there are discrepancies between the figure for the total expenditure given in this statement and the totals obtained both by summation from the MOH Appropriation Accounts, and that reported to the Basket Financing Committee, which it has not been possible to clarify, as per the text.

Data on actual basket releases to councils in FY04 was drawn from hard copies of the Exchequer release statements, together with Agenda items from the Basket Financing Committee regarding later releases for councils not meeting initial deadlines, together with personal communication with Ms J Mahon, Chair of the Health Development Partners Group. Budget data for FY05 was obtained from an MOH document **\Summary to be submitted to BFC 2004-2005**, located in **folder \Original files.** Manipulations are located in **file \working files\LG basket FY05**.

Budgeted development spending for FY05 is taken from the various volumes of Kitabu cha Nne according to whether it is central, regional or local government. For MOH and the Regions, this was from electronic **file \original files\vol 4 dev exp by item**, while for the LGAs, this was taken from an electronic version of Kitabu cha Nne, MS Access file **\Vol4B 0405**. It should be noted that the value of FY05 LGA development estimates differs according to the source within that Access file, and the value used is taken from an exported version of the Table **"Figures"** as this also includes expenditure data for the two previous FYs. These two estimates differ as well from the figure in the hard copy Volume B which was obtained later.

Actual development expenditure for MOH HQ in FY04 was taken from **file \original files\ MOH Appropriation Acc. June 2004 - Sally** to obtain the total, and the separation between Basket foreign and Other foreign was made using the expenditure from the Health Basket Income and expenditure statement for FY04. Actual development expenditures for the regions for FY04 were taken from summaries of the PORALG Appropriation Accounts, provided in electronic form by PORALG (**file \PORALG AFYA Regions FY04**. Development actuals for the LGAs came from the Access file, table "Figures" as exported into Excel and manipulated in **file \working tables\LGA FY05 figures, tab "health".**

Health Services Fund data on hospital cost-sharing is included within the MOH Appropriation Accounts, although as this was incomplete at the time of publication of the Appropriation

[40] From a hard copy. This is usually reflected in the MOH *Health basket funds: Income and expenditure account for the year ended 30th June 200X* which was not finalised at the time of PER analysis.

Accounts, updated information was subsequently obtained from the Accounts Department. The final data obtained still has some minor queries which are not expected to substantially alter the expenditure figures, but there are also gaps and this should be treated as an under-estimate. The original data provided and the manipulations are located within **file \working files\HSF FY04 manipulations.**

Information on the Community Health Fund was provided by the World Bank Tanzania office in the absence of any information from the CHF coordination team (although they had supplied this information to the World Bank), located at **file \original files\CHF grant contracts between MOH and LGAs**. It is incomplete, and was provided in a format which did not permit breakdown by financial year except through assumption and extrapolation, as indicated in the text.

As in previous years, data on estimates of off-budget external financing are taken from the information provided by MOH to the External Finance Department of the Ministry of Finance which is updated on an annual basis. This is located in file **\original files\MOH-External Financing – 2005 – 2006, tab "MTEF"**. No information was available on actual expenditures, which have been assumed at 120% of budget. This assumption needs to be reviewed.

Figures

Figure 1 Sectoral spending as a proportion of the total GOT budget, FY00 – FY05
This graph uses data from the 2004 Ministry of Finance publication *Budget Review: Recent developments in budget execution and formulation*, Dar es salaam: October 2004 (Table 2 page 4) on Central Government Expenditure 1998/99 – 2004/05. Data manipulations are located in **file \working files\Health as % GOT FY05, tab "BR data on GOT expd"**.

Figure 2 Nominal on-budget health spending and rate of growth, FY01 – FY05
Data on nominal spending/budget is taken from same source as Figure 1, the MOF Budget Review. Calculations are located in **file \working files\Health as % GOT FY05, tab "manipulations"**.

Figure 3 Increase in nominal spending FY04 to FY05, by component (TSh bn)
Figure 4 Changing component shares within the Health allocation, FY04 and FY05
Other data provided by the MOF Health desk officer provided the basis for Figures 3 and 4. The original figures provided are located in the same working file as Figures 1 and 2 above, **tab "RM MOF data"**, while the manipulations are shown in **tab "manip 2"**. Figure 3 shows the absolute values while Figure 4 shows the shares of each spending component.

Figure 5 On-budget share of domestic and foreign funding, FY02 - FY05
Figure 5 data are taken from the PER Master Table (**file \PER tables FY05, tab "Master table"**, reproduced in **tab "Table 7"** of the same file**)**. Domestic includes government spending at AGO, MOH, regional and council level, while Foreign includes basket funding (recurrent and development, central and council) and on-budget non-basket foreign spending in the development budget (central and regional). There is undoubtedly development spending at local government level which is not currently or accurately captured in the PER as it is not reflected in the official estimates, although it may be reflected in the off-budget estimates.

Figure 6 Role of foreign funds in increased (nominal) sectoral budgets, FY02-FY05
Figure 7 Health budget, percentage breakdown by type of funding, FY00 – FY05
The data on which Figures 9 610 are based are taken from the PER Master Table **(file \PER tables FY05, tab "Master table"**, and reproduced in **tab "F6 + 7 data))**. Basket includes

both recurrent and development, central and LGA, while Other foreign reflects non-basket, on-budget foreign spending at any level.

Figure 8 Basket funding as a share of recurrent health spending, FY02-FY05
Data for Figure 8 are taken from the PER Master Table (**file \PER tables FY05, tab "Master table",** reproduced at **tab "Fig 8 data"**). Recurrent Basket funding includes both MOH HQ and council basket funding **(rows 11, 16 and 19)**, and total recurrent reflects the total on-budget recurrent spending **(row 20)**.

Figure 9 Proportion of estimated budget by level, FY02 – FY05
Figure 10 Proportion of actual expenditure by level, FY99 – FY02
Data for Figures 9 and 10 are also drawn from the PER Master Table. Central level includes MOH, AGO and the non-basket share of the PORALG allocation for PHC rehabilitation (proxying administrative/management costs as opposed to the rehabilitation costs). Basket funding for PORALG was included with Local government development. Figures include on-budget recurrent and development spending.

Figure 11 The trend in allocation by category of spending, FY01 – FY02
Figure 11 is based on the data and definitions from Table 8 in the PER report. MOH/Admin includes MOH spending not captured under Hospitals or Preventive, together with allocations to the National Institute of Medical Research and the Tanzania Food and Nutrition Centre. Figure 11 excludes the allocation to the National Health Insurance Fund.

Within the hospital category, data for district hospitals are proxied by subvote 510 (Curative) at the LGA level. PEs are taken from release data obtained from MOF which specified sub-votes, and are summed across all LGAs **(file \working files\LGA PEs FY05, tab "PE summary releases FY04".** OC allocations are estimated by applying the sub-vote share of the budget to the council release data obtained from MOF (**file \original files\LGA OC releases FY04, tab "LGA releases FY04 – MOF", cell L168**, as per manipulations in **file \working files\Breakdown by category**), plus the drugs allocation from the Chief Pharmacist's data **(file \working files\drug allocation info FY04 tab "DH and DDH – GOT",** based on data in **\original files\Mr Muhume files on drugs\Muhume files FY04)**.

Regional hospitals are proxied by the Curative subvote in the same way, with PE and non-drug OC data from **file \working files\Regional data FY05, tab ""Health rec- subvote + PE:OC",** and **tab "regional hosp – GOT"** in the **file \working files\drug allocation data FY04**. Data for the higher level hospitals are taken from a combination of the MTEF, Platinum reports in IFMS, and drug information from the Chief Pharmacist **(file \working file\drug allocation info FY04,** based on the same original files as for district hospitals, **tab "ref and spec hosp – GOT"**). No PE:OC split was undertaken for referral hospitals as salaries are paid direct by the MOH rather than transferred in a single subvention as for higher level hospitals.

The Preventive/Primary data reflect subvotes 511, 512 and 513 (Preventive, Health Centre and Dispensary) at LGA level, Preventive at Regional level, and the balance of Preventive services at MOH HQ after deduction of NIMR and TFNC. Drug data is added accordingly form the same summaries provided in **file \working files\drug allocation data FY04**. This data is subject to queries regarding completeness and accuracy, thereby reflecting on the accuracy of the final table as per comments in the text.

Figure 12 Budgeted and actual on-budget health spending, FY01 – FY04
Data for Figure 12 are taken from the PER Master table.

Figure 13 Nominal MOH headquarters spending on drugs and supplies, FY02 – FY05

Data for Figure 13 are taken from Platinum files from IFMS, provided by the MOH Accounts Department for successive PER updates. The original files for FY04 and FY05 are located at **\original files\itemised daily balance at June 2004-Sally** and **\original files\itemised daily balance – Dec 04** respectively, with manipulations shown in **\working files\Platinum manipulations FY04** and **\Platinum manipulations Jul – Dec FY05, tab "key items – 2604"**. The graph excludes the basket allocation for contraceptives in FY04, and it is also not clear whether it reflects the reallocations made to procure ARVs during the course of the year. For FY05, it excludes the TSh3.5bn for ARVs under the CMO sub-vote as this was entered under sub-item code 260409 for HIV/AIDS epidemics. (This figure has been added in elsewhere to analysis of drug spending as per text).

Figure 14: PE:OC split at LG level, FY03 – FY05
Data on the PE:OC split for councils is taken from successive budget and expenditure estimates, as entered in **file \working files\Local government FY05, tab "sectoral estimates"**.

Figure 15 LGA health sub-vote allocations as % of total LGA PE and OC, FY05
Data on the health share of PEs and OCs at the LGA level are again taken from successive budget and expenditure estimates, and can be found in **file \working files\Local government FY05, tab "sectoral %".**

Figure 16 Breakdown of GOT recurrent subvention to LGAs by sub-vote, FY05
The data for Figure 16 are taken originally from the electronic version of the Estimates book, **file \original files\ volume iii detailed budget**, and entered into **file \working files\Local government FY05, tab "Rec by item FY05"**.

Figure 17 Per capita income and expenditure, selected councils, 2003
Figure 18 Selected councils' reported income 2003, by source
Figure 19 Selected councils' per capita spending, by level, 2003
The data on which Figures 17 - 19 are based are taken from work undertaken by the external consultant as part of the African Development Bank-funded Three Regions Health Study. The source data is from council Physical and Financial Implementation Reports for 2003, and is located in **file \working files\TRHS data LGA expd 2003**.

Tables

Tables 1 and 2 are considered self-explanatory

Table 3 Additional measures of spending, MOF on-budget data FY01 – FY05
The data in Table 3 are based on the nominal values of health sector budgets and expenditure as presented in the October 2004 MOF Budget Review, located in file **\health as % GOT FY05, tab "BR data on GOT expd",** and analysis as in **tab "manipulations"**. US dollar figures were obtained using the Bank of Tanzania exchange rate given in the monthly Economic and Financial Indicators report. Rates for FY01 and FY02 were based on the mean of the September, December, March and June rates, while for FY03 and FY04 the mean of the monthly rates was used. For FY05, the figures reflect the monthly mean over the first six months. This data is included in file **\PER tables FY05, tab "Other data".** Per capita values were obtained using population data from the National Bureau of Statistics 2002 Census report, with the financial year population calculated as the mean of two calendar years. Real values were calculated using the general Consumer Price Index as deflator. For FY01 – FY03, the original base year of 1994 was changed to FY01, based on information available through the web (annual summaries of the CPI from www.tanzania.go.tz/statisticsf.html). This series was re-weighted and re-based in September 2004, and the revised inflation figures for FY04 and FY05 were used to estimate the deflator

for the later period. There may be some slight discrepancy due to the change of series, but no consistent data covering the whole period was found.

Table 4 Total health expenditure in Tanzania, FY02 – FY05 (TSh billion)
Table 4 is a condensed version of the PER Master Table (Annex C), with sources as above. Values have been divided by one billion.

Table 5 Additional measures of spending, overall MOH PER data FY02 – FY05
Table 5 uses similar data for obtaining real, US dollar and per capita values as Table 3, but is based on the total budgeted spending for the health sector, including both on- and off-budget sources, as calculated by successive PER exercises and itemised in the notes to the PER Master Table above.

Table 6 Breakdown between recurrent and development spending, FY00 – FY04
Table 6 data are taken from the PER Master Table, and reflect on-budget figures only.

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

Table 8 Summary of GOT health spending by level/category, FY01 – FY04 (TSh billion)
The data in Table 8 are the same as those in Figure 11 above. Please refer.

Table 9 On- and off-budget shares of health spending, FY02 – FY05
Data for Table 9 are taken directly from the PER Master Table. Definitions of what is on- and off- are the same as those provided for Table 7 above.

Table 10 Reported HSF revenues and expenditures, FY02 – FY04
Data on HSF activity is taken from the MOH Appropriation Accounts for FY02 and FY03, and from additional, more updated data provided by the MOH Accounts Department for FY04. Details are provided in **file \working files\HSF FY04 manipulations**.

Table 11 CHF data on membership revenues and numbers
Data in Table 11 are either taken directly from the information provided by the World Bank (as submitted by the MOH) or reflect manipulations thereof, as explained in the text in Section 2.3.5. The original data are located at **file \original files\CHF grant contracts between MOH and LGAs**.

Table 12 Budget performance (expenditure/budget), FY02 – FY04
The data in Table 12 are based directly on the PER Master Table.

Table 13 MOH recurrent expenditure: budget and capacity performance FY04
Table 14 MOH recurrent expenditure: budget and capacity performance FY05 - first half
Tables 13 and 14 are based on data from the Integrated Financial Management System, provided by the MOH Accounts Department in Excel format, manipulated to obtain summaries by item and sub-item. The original data is located in **files \original files\itemised daily balance as at June 2004–Sally** and **\Itemised daily balance – Dec 04** respectively, while the workings are in **\working files\Platinum manipulations FY04** and **\Platinum manipulations FY05 – first half**.

Table 15 Regional sub-vote budgets and expenditure, FY04 – FY05 (TSh)
Data on budget performance at the regional level is based on GOT budget and expenditure sources, and is located in **file \working files\regional data FY05 tab "Health rec- subvote + PE-OC"**.

Table 16 Budget performance for larger hospitals, FY04
Data is taken from the IFMS Platinum files for the respective hospitals, with sources as for Tables 13 and 14 above.

Table 17 Spending by MOH department on drugs and supplies, FY02 – FY05 (TSh m)
Data for this table are taken from successive MOH Platinum reports, and represent actual expenditure with the exception of FY05 budget data. Data from FY02 and FY03 are copied in from PER data for previous years, while the FY04 and FY05 figures are copied in from calculations in **tabs "key items – 2604"** in the relevant Platinum manipulation files referred to under Tables 13 and 14.

Table 18 Drugs and medical supplies as a share of MOH/sector spending, FY02 – FY05
The data on drugs and supplies budget/expenditure in Table 18 are taken from the Platinum reports for the respective years as per Tables 13 and 14 above. FY05 data include TSh3.5bn for ARVs under the CMO sub-vote, sub-item item 260409. MOH OC is calculated by taking the total of GOT and Basket recurrent funding less PEs and is taken from Platinum files for FY02 and FY03, and from the MOH Appropriation Account for FY04 (workings in **file \working files\MOH HQ Appropriation Account FY04, tab "Rec – by Dept, PE-OC"**). MOH Recurrent includes PEs and is taken from the same sources, while the Sector recurrent is defined as the on-budget recurrent total, and taken from the PER Master Table. Population figures are taken from the website www.tanzania.go.tz/populationf.htm, with the financial year calculated as the mean of successive calendar year projections. The exchange rate is taken from data in the Economic Report of January 2004, and located in **file \PER tables FY05, tab "Other data"**.

Table 19 Allocation of hospital drugs by level, FY04
Data for this table which shows the breakdown of hospital drug spending between type of facility is taken from files provided by the Chief Pharmacist, and located in **\original files\Mr Muhume files on drugs\Muhume files FY04**. The summary is located in **\working files\Muhume files summary FY04**.

Table 20 Budget reallocations in favour of ARVs during FY04
The data in Table 20 are summations of the various entries in the MOH Annual Report **(Excel file \Annual report 2003-2004 FINAL – all depts, tabs "DHS"** and **"DPS")** which indicated that they had suffered reallocations for the purchase of ARVs. The detailed activities themselves are given in Annex C as Tables 35 and 36.

Table 21 GOT health subventions to LGAs, FY03 – FY05 (TSh m, current prices)
Data are taken from **file \working files\Local government FY05, tab "sectoral estimates", rows 147 to 152**.

Table 22 Health subventions in relation to total LGA PE+OC, FY05 (TSh m)
Data for this table are copied in from **file \working files\Local government FY05, tab "sectoral %", rows 154-156**.

Table 23 Variation in Health share of LGA allocation, FY05
Data for Table 23 were also taken from **file \working files\Local government FY05 tab "sectoral %"**. It should be borne in mind that the district council information is based on a subset only of the councils for which the summary data was available in the hard copy book of estimates.

Table 24 Regional variation in FY04 OC estimates by source (TSh m)
Data on the original estimates for LGA OCs is as used in the FY04 PER update and based on the official GOT Estimates for that FY (volume iii details), and as entered into **working tables\Local government FY05**. The revised estimates are those provided to the PER Team by MOF together with the releases. These data can be found in Column C of **original files\Afya council 2003-04**.

Table 25 LGA releases in relation to estimate, FY04
Table 26 LGA PE releases in relation to estimates, FY04
Table 27 LGA OC releases in relation to estimates, FY04
The data for Tables 25-27 on LGA budget performance (release/revised estimate) are taken from various files provided by MOF itemising the PE and OC releases by council. These are **original files\Afya council 2003-04** and **Afya council q42003-4** for OCs and **original files\Health 200304** for PEs. This data is collated in **working files\LGA OC releases FY04** and **LGA PEs FY04**, with the summary provided in **PER tables FY05, tab "Tables 25-27**".

Table 28 Data on cost-sharing from a sample of council PFIR, 2003
The data for Table 28 are taken from a sample (based on availability of the reports) of council Physical and Financial Implementation Reports for 2003.

Table 29 Recurrent spending on PRS priority items, FY02 to FY05 (TSh million)
This table is incomplete due to pending data queries regarding the allocation to drug kits and the indent system at the primary level. Data reflect a mix of MOF data and those gathered as part of the PER process. LGA subventions are calculated as total actual expenditure in district and urban councils as per the Master Table, less budgeted total HIV/AIDS figures as calculated for past PERs. For FY05, the total budgeted spend on this item was taken from the figures in **working files\Local government FY05, tab "rec by item FY05", row 372**. The LGA drugs budget for FY05 is entered in from MOF data in the MOF October 2004 Budget Review (Annex II), while FY04 data remain a potentially incomplete estimate due to queries re the data supplies on drug kits and indent. MOH Preventive Department spend was calculated using the IFMS/Appropriation Account files for each year to FY04 and budget estimates for FY05, reflecting total spending less 260409 (HIV/AIDS Epidemics). As in the past, regional figures do not exclude HIV/AIDS spending as we were unable to locate sub-item data, but the inclusion is expected to be minor.

The figure for the Priority Sector total is calculated using PER data from the Master table and the most recent GOT definitions. It should be noted that the figures differ from the GOT estimates reported in the MOF October 2004 Budget Review Annex I.

Table 30 Finance-related health sector performance indicators
The indicators in Table 30 are calculated from various sources of PER data. Indicators 1 and 2 are taken from data in the PER Master Table, while Indicator 3 is based on data from Table 8 and Figure 11 data (please see above). Indicator 7 is calculated using information from **file \Local government FY05, tab "sectoral %"**.

Table 31 Selected finance-related health sector performance indicators, in US dollars
Table 22 reproduces information from Table 21 for Indicators 1, 2 and 3, but dividing by the exchange rate as defined for Table 3.

Annex tables:

Table 32 Sector budget by level, FY02 – FY05, and change from FY04
Table 33 Sector expenditure by level, FY02 – FY04, and change from FY03
Tables 32 and 33 are based on the same PER Master table data as for Figures 9 and 10, together with calculations for the year on year change which are found in \PER files FY05 tab "F9 +10 data", rows 32-37.

Table 34 MOH recurrent expenditure: budget and capacity performance FY03
Data for Table 34 are reproduced from the PER update for FY04, and were based on the IFMS Platinum data provided for that update.

Table 35 Reallocation to ARVs within Dept of Hospital Services, FY04
Table 36 Reallocation to ARVs within Dept of Preventive Services, FY04
As mentioned above for Table 20, data for Tables 35 and 36 were taken from the Excel file providing the detailed breakdown of FY04 spending contained within the MOH Annual Report for FY04, copied in to **PER tables FY05, tab "Table 20 (+)"**.

Table 37 Individual sub-items reallocated to ARVs, FY04
This table uses data calculated from the original request from MOH to MOF for the reallocation within the MOH from various departments and items, to cover a TSh2bn procurement of ARVs (at Government's behest) plus water bills (TSh 24m). The table itemises individual activity sub-items losing more than TSh25m as a result of the reallocation.

Table 38 PE:OC split at LGA level, FY03 – FY05
Data for Table 37 are calculated from the information in **file \working files\Local government FY05, tab "sectoral estimates", rows 147 to 152**, as for Table 21.

Table 39 LGA Health share as per the Vol III Estimates passed by the National Assembly, FY05
Data for Table 39 differ from those used in the body of the text (particularly Section 3) as they are drawn from a later version of the detailed LGA estimates in Vol III, ie those passed by, rather than those submitted to, the National Assembly. They differ in that the General Purpose Fund is included in the OC estimate, therefore inflating the total LGA allocation figure by some TSh25bn, and reducing the health share accordingly. It should be noted that LGAs are free to allocate their GPF funds between sectors, and it may be that the final expenditure share of the sector rises as a result.

Table 40 MOH recurrent spending on Item 2604 Medical supplies and services, FY03 – FY05
As for Table 17, data for Table 38 are taken from successive IFMS Platinum files and show a more detailed picture of budget/spending on drugs and supplies by MOH department.

Annex B PER Master table

	2001/2002		2002/2003		2003/04		2004/05
	Approved estimates	**Actual expenditure**	**Approved estimates**	**Actual expenditure**	**Approved estimates**	**Actual expenditure**	**Estimates**
Recurrent							
Accountant General's Office							
National Health Insurance Fund	8,972,544,500	5,290,824,771	6,915,980,248	5,525,000,000	6,616,450,152	10,564,000,000	10,116,000,000
Ministry of Health							
Government funds	49,087,814,200	48,165,359,880	62,882,343,876	53,973,768,637	85,574,927,146	85,180,665,882	104,465,379,200
Donor basket fund	12,509,980,444	10,827,344,789	19,278,807,437	18,344,250,378	1,894,970,000	1,894,970,000	34,527,134,400
Regional Administration							
Government funds	7,062,588,748	6,584,825,460	7,864,022,725	7,824,023,250	12,059,182,815	11,900,187,786	9,676,161,600
Urban councils							
Government funds	7,215,534,300	7,166,663,655	8,860,711,200	8,770,916,400	9,692,668,800	9,557,207,628	11,802,462,600
Donor basket fund	2,476,963,415	2,472,793,397	2,763,096,113	2,747,033,593	2,961,911,914	2,961,911,923	3,102,214,570
District councils							
Government funds	28,262,447,400	28,377,319,802	34,814,714,100	34,776,743,600	39,163,565,600	36,929,453,083	51,755,832,800
Donor basket fund	8,301,693,509	8,266,416,055	11,222,194,068	11,182,673,751	14,318,670,149	14,318,670,140	15,595,265,550
Total recurrent	**123,889,566,515**	**117,151,547,809**	**154,601,869,766**	**143,144,409,608**	**172,282,346,577**	**173,307,066,442**	**241,040,450,720**
Development							
Ministry of Health							
Government funds	3,245,000,000	3,197,327,926	3,843,728,200	3,236,004,165	3,552,448,200	3,544,473,857	3,552,448,200
Donor basket fund	5,856,811,717	4,615,471,717	3,841,820,500	3,644,903,594	6,552,310,322	5,672,304,664	15,108,773,000
Foreign (non-basket)	22,966,181,000	13,309,109,927	26,383,612,500	22,145,113,823	32,177,406,600	32,218,274,915	38,027,398,000
PORALG							
Government funds					20,000,000	20,000,000	20,000,000
Donor basket fund					319,494,698	319,494,698	2,600,200,000
Foreign (non-basket)							655,000,000
Regions							
Government funds	389,332,000	389,169,060	535,986,500	491,986,173	569,592,400	569,364,563	1,231,795,400
Foreign (non-basket)	1,962,380,000	892,908,611	4,449,580,400	1,990,505,266	2,619,675,400	2,133,790,641	8,152,265,900
Urban councils							
Government funds	359,669,000	267,914,000	333,828,700	287,828,700	456,106,200	427,106,200	406,232,400
District councils							
Government funds	1,344,211,000	1,185,182,000	1,411,232,600	1,415,049,600	1,851,281,600	1,889,282,400	2,016,873,650
Total development	**36,123,584,717**	**23,857,083,241**	**40,799,789,400**	**33,211,391,321**	**48,118,315,420**	**46,794,091,938**	**71,770,986,550**
Total on budget	**160,013,151,232**	**141,008,631,050**	**195,401,659,166**	**176,355,800,929**	**220,400,661,997**	**220,101,158,380**	**312,811,437,270**
Off budget expenditure							
Cost sharing							
Health Services Fund – Hospital		1,082,642,718		1,509,458,307		2,725,582,152	2,725,582,152
Community Health Fund – PHC		155,262,177		158,670,763		4,751,767,889	4,751,767,889
Other foreign funds	66,142,394,763	79,370,873,716	49,254,970,437	59,105,964,525	68,992,700,922	82,791,241,106	132,857,160,920
Total off budget	**66,142,394,763**	**80,608,778,610**	**49,254,970,437**	**60,774,093,594**	**68,992,700,922**	**90,268,591,147**	**140,334,510,960**
Grand total	**226,155,545,995**	**221,617,409,660**	**244,656,629,603**	**237,129,894,524**	**289,393,362,919**	**310,369,749,527**	**453,145,948,230**

Annex C Miscellaneous additional tables and figures

Table 32 Sector budget by level, FY02 – FY05 (TSh bn)

					change, FY04 - FY05	
	FY02	FY03	FY04	FY05	TSh bn	% growth
Central	102.64	123.15	136.71	206.47	69.76	51%
Regions	9.41	12.85	15.25	19.06	3.81	25%
Local Govt	47.96	59.41	68.44	87.28	18.83	28%
Total on-budget	**160.01**	**195.40**	**220.40**	**312.81**	**92.41**	**42%**

Table 33 Sector expenditure by level, FY02 – FY04 (TSh bn)

				change, FY04 - FY05	
	FY02	FY03	FY04	TSh bn	% growth
Central	85.41	106.87	139.41	32.55	30%
Regions	7.87	10.31	14.60	4.30	42%
Local Govt	47.74	59.18	66.08	6.90	12%
Total on-budget	**141.01**	**176.36**	**220.10**	**43.75**	**25%**

Table 34 MOH recurrent expenditure: budget and capacity performance FY03

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

Table 35 Reallocation to ARVs within Dept of Hospital Services, FY04

Activity	Initial allocation	Diversion to ARVs	% diversion
Department of Hospital Services			
Mbeya RH Ocs	563,350,000	39,478,335	7%
Mirembe RH Ocs	430,750,000	32,272,917	7%
Kibon'goto RH Ocs	319,019,000	33,169,785	10%
MNH OCS	6,277,450,394	224,987,039	4%
KCMC Ocs	729,208,000	60,600,127	8%
DDH Ocs	1,280,000,000	96,600,127	8%
BMC Ocs	995,160,000	82,930,000	8%
4WD for MRH, Mirembe and Kibong'oto	120,000,000	40,000,000	33%
Conduct joint supervision visits by DHS sections to public,voluntary agencies and private health facilities in 12 regions per year by June 2006.	26,260,000	6,565,000	25%
Develop and disseminate mental health guides for special groups/areas like education, prisons, intellectual dissability, police and workplace environment, HIV/AIDS and other physical health problems by June 2006.	25,330,000	25,330,000	100%
Monitor availability and utilization of health supplies (drugs, medical supplies, diagnostic supplies and dental supplies) in health care facilities at all levels by June 2006.	21,120,000	21,120,000	100%
Recruit staff for the (Traditional and Alternative Medicine) council Secretariat by June 2004.	9,450,000	9,450,000	100%
Conduct situational analysis on how to promote Public Private Partnership and disseminate the report to stake holders.	4,696,000	4,696,000	100%
Develop criteria for accreditation and guidelines for Contractual arrangements.	5,060,000	5,060,000	100%
Implement and monitor implementation of guidelines.	3,682,000	3,682,000	100%
Facilitate involvement of Umbrella professional associations in planning to improve services delivery, research and traditional medicine by 2006.	13,252,000	13,252,000	100%
Conduct quarterly meeting of National Secretariat PMTCT by June 2006.	22,680,000	5,670,000	25%
Conduct 12 quarterly National PMTCT Steering Committee meetings by June 2006.	29,080,000	7,270,000	25%
Conduct 3 annual meetings of diagnostic services personnell from regions and referral hospitals by June 2006.	35,580,000	35,580,000	100%
Conduct 6 bi-annual meetings of directors of level 3 hospitals by June 2006.	12,899,800	6,449,900	50%
Monitor availability and utilisation of drugs and medical supplies provided for PMTCT in all health facilities by June 2006.	14,872,000	14,872,000	100%
Develop/review indicators for M&E of PMTCT services and a simplified comprehensive PMTCT monitoring framework integrated into HMIS by June 2004.	6,370,000	6,370,000	100%
Develop annual plans and budget for DHS and conduct 12 quarterly progress review meetings by June 2006.	62,496,000	15,624,000	25%
Procure and maintain 2 Lap top and 6 desktop computers for HVP, HRD, HNH, HDS, HPS &HTM, 2 small photocopier for HVP& HNH by 2004.	36,500,000	9,125,000	25%
Provide office supplies communication and information services for DHS, COHU, MHRC, PHLB offices.	18,900,000	4,725,000	25%
Provide advanced computer training for 30 DHS staff by 2006.	14,900,000	14,900,000	100%
Reallocation within Department of Hospital Services		**819,779,230**	

Table 36 Reallocation to ARVs within Department of Preventive Services, FY04

Activity	Initial allocation	Diversion to ARVs	% diversion
Department of Preventive Services			
Conduct 2 supervisions to the ZTCs during professional courses on HIV/AIDS by June, 2004	58,890,896	58,890,896	100%
Conduct 14 training sessions of 2 days duration each in treatment of opportunistic fungal in fections for 500 health care workers from 100 Health facility sites under Diflucan partnership programme (DPP) by 2003/04	85,000,000	85,000,000	100%
Distribution of training kits, wall charts, brochures, feedback reports to RMOs, DMOs & Health facilities - under Diflucan Partnership Programme (DPP)	10,500,000	10,500,000	100%
Support 4 National Coordinators for the Diflucan Partneship Programme (DPP) to attend 4 different international meetings of 1 week duration including the Diflucan partnership Advisory panel (DAP) to discuss programm issues and training initiative by 2003/	26,400,000	26,400,000	100%
Conduct supportive supervision, coordination and monitoring of 10days each to Health facilities under Diflucan Partnership programme in 21 regions	43,080,000	43,080,000	100%
To develop and review policy and guidelines for acreditation of institutions and individuals that stock and dispense ARV's	11,880,000	11,880,000	100%
To accreditate institutions and individuals that stock and dispense ARV's	16,175,000	16,175,000	100%
To conduct inspection of ARV's outlets to verify compliance to safety, efficacy and quality standards for Ten dya in each region	42,570,000	42,570,000	100%
To establish and maintan database for ARV's by 2006	11,300,004	11,300,004	100%
To train TFDA staff on coordination of HIV/AIDS/STI drugs quality control abroad	27,200,000	27,200,000	100%
To develop and review guidelines for registration of ARV's	4,335,000	4,335,000	100%
Testing of ARV's quality safety and efficacy	20,000,000	20,000,000	100%
Develop and translate into Kiswahili Guidelines on Nutrition and HIV and print 6000 copies and Disseminate by June 2004	96,012,600	96,012,600	100%
Develop, distribute and disseminate 10000 copies of IEC Materials on Brestfeeding and HIV/AIDS	70,266,000	70,266,000	100%
Preparation of guideline for registration of dietary supplements.	8,975,000	8,975,000	100%
Surveillance of quality and safety of food suppliments.	39,047,500	39,047,500	100%
Preparation of bronchures and other IEC materials for educating community on importance of food safety towards minimising ill effects of HIV/AIDS.	75,306,000	75,306,000	100%
Sensitization of street food vendors on Food hygiene.	19,460,000	19,460,000	100%
Establish local HIV/AIDS response support teams to develop and implement work place HIV-AIDS intervention in 4 referral and 4 specialised hospitals by June 2006	21,397,000	21,397,000	100%
To print IEC materials developed for Saba Saba trade Fair for year 2004	5,800,000	5,800,000	100%
To participate in World Health Day Coomemoration for year 2004	7,605,500	7,605,500	100%
To participate in World AIDS day Comemoration for year 2003	13,600,500	13,600,500	100%
To design, develop, print and distribute Tanzania STI Newsletter 4 issues	43,476,000	43,476,000	100%
Identify and train 30 per educators from selected vulverable groups	2,520,000	2,520,000	100%
Conduct a workshops on needs assessment & identification with NGOs/CBOs & other agencies working in areas of STDs, VCT and continuum of care	4,777,000	4,777,000	100%
Identify and support technical/financial support to national/regional and local NGOs, CBOs and other agencies working with youth and sex workers in STDs VCT and antinuum of care	50,000,000	50,000,000	100%
Support the technical training of peer-educators for sensitization	5,231,000	5,231,000	100%
Support technically the development of assessment and evaluation system for these activities (Contract on instructor)	2,721,000	2,721,000	100%
Organise a workshops involving youth to develop its materials on STD, VCT & continuum of care	2,721,000	2,721,000	100%
Conduct a workshop to develop training guide for STD, VCT, continued of care for 4 Ministries	26,920,000	26,920,000	100%
Develop a booklet on continuum of care for youth	6,000,000	6,000,000	100%
Develop protocols and guidelines for youth friendly facility services	11,555,500	11,555,500	100%
One Staff to attend an International course on Applied Epidemilogy; Atlanta GA.	10,000,000	10,000,000	100%
To facilitate and support at least one scientific International/ Regional/professional conference/ meetings	9,330,000	9,330,000	100%
Reallocation within Department of Preventive Services		**890,052,500**	

Table 37 Individual sub-items reallocated to ARVs, FY04

Sub-vote	Sub-item	TSh m
2001	Muhimbili Medical Centre	291.4
	Mrembe and Isanga	30.0
	Buganda MC	33.0
	Dental supplies	52.3
	Hospital supplies	97.4
	Laboratory supplies	84.9
	Medical practicioners (Chinese)	302.9
3001	Per diems - domestic	43.4
	District councils	52.5
	Consultancy fees	124.5
	HIV/AIDS epidemics	330.6

It should be noted that the allocation away from Per diems (domestic) is not the full total contributed from this sub-item, but is the only sum over TSh25m related to a single activity.

Table 38 PE: OC split at LGA level, FY03 – FY05

	All councils			urban			district		
	FY03	FY04	FY05	FY03	FY04	FY05	FY03	FY04	FY05
PE	67%	71%	67%	69%	73%	72%	66%	71%	66%
OC	33%	29%	33%	31%	27%	28%	34%	29%	34%

Table 39 LGA Health share as per the Vol III Estimates passed by National Assembly, FY05

	Estimates - health			Estimates - total			H PE as %	H OC as %	H as % Tot
	PE	OC	Total	PE	OC	Total	Tot PE	Tot OC	LGA
Urban councils	8,582	3,315	11,898	52,405	20,727	73,132	16.4%	16.0%	16.3%
District Councils	34,271	17,406	51,677	229,146	84,489	313,635	15.0%	20.6%	16.5%
Total	**42,853**	**20,721**	**63,574**	**281,551**	**105,217**	**386,768**	**15.2%**	**19.7%**	**16.4%**

Note: This shows a lower share for Health, at 16.4% compared with the 17.6% implied by Table 21.

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

Drug spending at MOH central level

The majority of funding for Medical supplies and services is channelled through Vote 52, the MOH headquarters, and reflected under Item 2604 which for FY05 contains ten sub-items, with the inclusion of TB/Leprosy control as a separate sub-item (the justification for which is not clear as this implies a move towards verticalisation).

260401	Vaccines	260406	Post mortem supplies
260402	Drugs & medicines	260407	Laboratory supplies
260403	Special foods (diet food)	260408	Specialised supplies
260404	Dental supplies	260409	HIV/AIDS epidemics
260405	Hospital supplies	260410	TB/Leprosy control

For GOT and basket funds, the breakdown between these items, with the exception of 260409, for the period FY03 – FY05 is shown in Table 40 below. FY05 data is given both for annual budget and for half year expenditure to end December 2004.

Table 40 MOH recurrent spending on Item 2604 Medical Supplies and Services, FY03 – FY05

	FY03		FY04	FY05			
				Budget		Q1 + Q2 expd	
	GOT	Basket	GOT	GOT	Basket	GOT	Basket
2001 Curative services							
260402 Drugs and Medicines	10,067,883,667	4,000,000,000	20,660,971,591	25,682,062,500	4,000,000,000	12,841,031,250	
260403 Special foods (diet food)							
260404 Dental supplies	51,103,080	500,000,000	500,721,282	603,039,200	19,000,000	301,519,600	
260405 Hospital Supplies	176,925,000	1,000,000,000	1,484,710,441	1,015,909,600		507,954,774	
260406 Post Mortem Expenses							
260407 Laboratory Supplies	97,000,000	500,000,000	1,124,191,134	1,359,117,600		593,756,787	
260408 Specialised supplies		1,888,070,000			1,023,200,000		
Sub-total Curative	**10,392,911,747**	**7,888,070,000**	**23,770,594,448**	**28,660,128,900**	**5,042,200,000**	**14,244,262,411**	**-**
2002 Chief Govt Chemist							
260406 Post Mortem Expenses	433,674		750,000	3,000,000			
260408 Specialised supplies		33,000,000					
Sub-total Chief Govt Chemist	**433,674**	**33,000,000**	**750,000**	**3,000,000**	**-**	**-**	**-**
2003 Chief Medical Officer							
260402 Drugs and Medicines				700,000,000			
260407 Laboratory Supplies				1,384,214,600			
Sub-total Chief Medical Officer				**2,084,214,600**	**-**	**-**	**-**
3001 Preventive services							
260401 Vaccines	1,611,756,217		2,281,801,208	5,097,291,800	1,000,000,000		
260402 Drugs and Medicines		2,071,225,000	506,181,280	37,459,500			
260405 Hospital Supplies			15,373,270	19,552,000			
160407 Laboratory Supplies			852,400	781,000	30,000		
260408 Specialised supplies	1,046,678,286	549,236,139	2,600,136,868	1,520,871,700	5,035,800,000		
260410 TB/Leprosy control				729,500,000	950,000,000		
Sub-total Preventive	**2,658,434,503**	**2,620,461,139**	**5,404,345,026**	**7,405,456,000**	**6,985,830,000**	**-**	**-**
4001 Tukuta							
260407 Laboratory supplies	7,370,000	1,210,000	52,500,000	4,500,000			
260408 Specialised supplies			2,000,000	2,100,000			
Sub-total Tukuta	**7,370,000**	**1,210,000**	**54,500,000**	**4,500,000**	**-**	**-**	**-**
5001 Human Resource Devt							
260402 Drugs and Medicines			120,000		255,000		
260407 Laboratory Supplies	6,300,000		13,000,000	13,000,000			
Sub-total Human Resource Devt	**6,300,000**	**-**	**13,120,000**	**13,000,000**	**255,000**	**-**	**-**
Total MOH							
260401 Vaccines	1,611,756,217	-	2,281,801,208	5,097,291,800	1,000,000,000	-	-
260402 Drugs and Medicines	10,067,883,667	6,071,225,000	21,167,272,871	26,419,522,000	4,000,255,000	12,841,031,250	-
260403 Special foods (diet food)	-	-	-	-	-	-	-
260404 Dental supplies	51,103,080	500,000,000	500,721,282	603,039,200	19,000,000	301,519,600	-
260405 Hospital Supplies	176,925,000	1,000,000,000	1,500,083,711	1,035,461,600	-	507,954,774	-
260406 Post Mortem Expenses	433,674	-	750,000	3,000,000	-	-	-
260407 Laboratory Supplies	110,670,000	501,210,000	1,189,691,134	2,760,832,200	-	593,756,787	-
260408 Specialised supplies	1,046,678,286	2,470,306,139	2,602,136,868	1,522,971,700	6,059,000,000	-	-
260410 TB/Leprosy control				729,500,000	950,000,000	-	-
Total MOH	**13,065,449,924**	**10,542,741,139**	**29,242,457,074**	**38,171,618,500**	**12,028,255,000**	**14,244,262,411**	**-**