United Republic of Tanzania
Ministry of Health

Final Report

Health sector PER update FY 06

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Ministry of Health
Tanzania

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Acronyms

AGO	Accountant General's Office
AJHSR	Annual Joint Health Sector Review
AIDS	acquired immuno-deficiency syndrome
Bn	billion
CFS	Consolidated Fund Services
CHF	Community Health Fund
DPP	Department of Policy and Planning
DRF	Drug Revolving Fund
ESRF	Economic and Social Research Foundation
FY	financial year
GOT	Government of Tanzania
HIV	human immunodeficiency virus
HQ	headquarters
HRH	human resources for health
HSF	Health Service Fund
IFMS	Integrated Financial Management System
IMCI	Integrated Management of Childhood Illness
LGA	Local Government Authority
LGDP	Local Government Development Programme
MDG	Millennium Development Goals
MKUKUTA	[National Strategy for Growth and Poverty Reduction]
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NHIF	National Health Insurance Fund
OC	other charges
PE	personal emoluments
PER	Public Expenditure Review
PHC	Primary Health Care
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PRSC4	4th Poverty Reduction Support Credit 4
PRSP	Poverty Reduction Strategy Paper
TACAIDS	Tanzania Commission for AIDS
TB	tuberculosis
TFDA	Tanzania Food and Drugs Authority
TFIR	technical and financial implementation report
TSE	total sector expenditure
TSh	Tanzania shillings
US	United States
WHO	World Health Organisation

Acknowledgements

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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 Mkumbo, the Acting Head of Budget, provided useful input and support throughout, as did Ms Mahon of SDC. Mr Muhume, Chief Pharmacist MOHSW, provided useful and timely information on drugs and medical supplies, while Mr Lapper of the Local Government Reform Programme provided useful clarification on queries relating to the funding of councils.

Welcome comments and feedback were received from members of the Technical Sub-Committee of the Ministry of Health, and also by participants following presentation of the Briefing Paper at the annual Health Sector Review meeting in April 2006.

Errors in interpretation or calculation remain those of the authors.

Table of contents

List of Tables

List of Figures

Executive Summary

Introduction

The Public Expenditure Review update for FY2005/06 (FY06) takes a slightly different form from previous years. A summary briefing paper was provided for discussion at the Annual Joint Heath Sector Review, while this later report has been provided as input to the Cluster PER and the budget process for FY2007/08.

The change in timing had some negative consequences in that it overlapped with the final stages of the budgetary process for FY2006/07, making it more difficult than usual to access key individuals and data.

Previous PER findings

Review of the PER findings and recommendations for FY05 found that there had been some progress in the area of lobbying for additional funds for that year's budget, that it had been agreed to review the allocation formula for drugs and medical supplies, and that a tracking study on all drugs and supplies within the sector had been initiated. However, other recommendations had not been followed up, in part due to human resource constraints within the Department of Policy and Planning. Notable was the failure of the High Level committee on health financing, established during FY2003/04, to meet regularly and take forward the many issues in this area.

On-budget health spending: key findings

Health as % overall GOT spending	• Continued increase in the sector share from 9.7% to 10.2% (including CFS), and from 10.9% to 11.6% (excluding CFS) • Sector share still falls short of Abuja target of 15%
The level of spending on Health	• Continued rise in the nominal budget, from TSh413bn in FY04 to TSh 530bn in FY05. This implies a 38% increase year on year. • Main drivers of the increase were a 72% rise in MOHSW headquarters recurrent budget, and a significant increase in Development funding through both PMO-RALG and MOHSW. • The increase of 18% in the budget for LGAs implies a reduction in LGA share, despite a real, absolute increase in the volume of funding channelled to councils. • There was also a rise in the real total value of the budget (ie in FY03 prices) although at a lower rate than for nominal budget.
Per capita spending	• The FY06 budget shows a per capita US figure of US$9.92, up from the actual expenditure of US$7.21 in FY05. • The FY05 figure itself indicated an increase of US$1.51 from actual spending of US$5.70 in FY04. • While a long way from international estimates of required funding, this shows that on-budget spending is moving in the right direction.

Sub-sectoral spending: key findings

Allocation by health system level (budget data)	• Slight recentralisation of budgeted resources, with 68% at central level in FY06 up from 67% in FY05. • Increase comes at the expense of the Regional level. • LGA level constant at 28% of the on-budget total[1]. • More work required to disentangle those resources channelled through headquarters on behalf of lower levels.
Allocation of budget within the LGA	• There has been a slight but steady reduction in the share of budgeted block grant funding allocated to first line health facilities, ie health centres and dispensaries, from 63% in FY03 to 57% in FY06. • However, in the absence of a more complete analysis of all sources of funds, this tells us little about council level spending patterns.
Allocation by category of activity (MOHSW recurrent expenditure only)	• Slight but steady reduction in the administrative share over the past three years, from 16% in FY03 to 13% in FY05. • In contrast to FY04 when hospitals gained from the reduction, between FY04 and FY05 there was a 2% rise in the share of Preventive/Primary spending from 42% to 44% • This analysis still needs to be expanded to incorporate both GOT and foreign development spending at national level together with LGA basket spending in order to be more meaningful.

Expenditure in relation to budget: key findings

Aggregate sector total	• Improvement in recurrent budget performance from 96.7% in FY04 to 99.2% in FY05 • Large decline in Development budget performance from 97.2% in FY04 to 77.0% in FY05, partly due to delays in release of Joint Rehabilitation Fund and late release of fourth quarter basket funding.
MOHSW headquarters	• Overall budget performance for FY05 GOT funding was good at 99.1%. • For basket funding, release compared to budget was 98%, while 95% of releases were actually spent. • The Department of Policy and Planning performed relatively poorly, spending 89% of GOT releases and 88% of basket releases. Inadequate numbers of skilled human resources within the Department were cited as the main constraint.
Regions – recurrent GOT	• Data from PMO-RALG for Regional releases and expenditure were incomplete, with both gaps and errors in calculation. • Overall recurrent budget performance according to the data was 97%. • Performance of the Preventive OC sub-vote at Regional level was very poor at 30%, despite the low level of actual funding that this represents. No reasons have been given for this.
LGAs – recurrent GOT	• There are data concerns regarding LGA budget performance as figures taken from two separate sources in the absence of alternatives. • The data show expenditure 11% higher than approved estimates of the block grant, but this may be due to inclusion of other sources. According to this data, OC were overspent by 60% while PEs were underspent by 87%.

[1] The total here includes Joint Rehabilitation Fund resources which are channelled through PMO-RALG headquarters, hence the contradiction with the earlier key finding on reduced share.

Hospitals	• Data are available only for the extent of transfer from the MOHSW to the institutions, rather than for actual expenditure at the institutional level. • Subventions to the major hospitals were released in full, with the exception of the transfer to Voluntary Agency hospitals where release was 98% of the approved estimate.
National Health Insurance Fund	• Release by AGO as a % of approved estimates for FY05 was 163.4%. This overspend has been justified in terms of within-year adjustments for recruitment and salary increases. This was also the case in FY04 and implies poor budgeting. • Comparison of the AGO release with reimbursements from NHIF (ie actual expenditure) is disappointing, at only 25%. This is a fall from 36% in FY04.

Off-budget spending: key findings

Off-budget share of Total sector expenditure	• Total off-budget spending fluctuates quite widely between financial years. As as share of total sector expenditure between FY03 and FY05 it ranged from 18% to 32%. It represents 20% of the sector budget in FY06. • The majority of off-budget funds remain external resources.
Domestic off-budget spending	• The quality of data on domestic off-budget spending (ie cost-sharing through Health Service Fund, Drug Revolving Fund and Community Health Fund) remains very poor • Domestic off-budget spending for FY06 is projected to fall from 2.5% of Total sector spending in FY05 to 2.0%.
External off-budget spending	• The database maintained by MOF External Finance department is neither complete nor accurate. • However, data from the database suggest that in FY05 external off-budget resources accounted for 29.1% of total sector expenditure, while they are projected at 17.8% of the budgeted FY06 resource envelope. • It is not clear whether this reduction is due to improved capture within government financial systems.

Comparison of resource envelope with requirements

The FY06 PER update is intended to feed into development of the budget guidelines for FY08, ie with a year's delay. Projections of the resource envelope (RE) were therefore included in the TORs for the PER, to be estimated under two scenarios – a base scenario and a more optimistic scenario. The timing of the PER also coincided with the publication of an independent study of the resource requirements for meeting the health sector Millennium Development Goals, again under two scenarios - one of which provides for improvements in key prevalence rates, and one of which holds them constant.

Resource envelope projections	*Base scenario*	*Optimistic scenario*
	• FY07 TSh 633.1 bn • FY08 TSh 617.5 bn	• FY07 TSh 650.4 bn • FY08 TSh 694.4 bn
MKUKUTA costings (ESRF 2006)	*Constant prevalence*	*Falling prevalence*
	• FY07 TSh 534.4 bn • FY08 TSh 571.7 bn	• FY07 TSh 519.3 bn • FY08 TSh 541.0 bn
Comparison	• Both MKUKUTA costing scenarios fall within both sets of projections for the health sector resource envelope • However, the costings include direct costs only, and exclude much of the "residual" required for day to day running of the sector • Further analysis of the MTEF and CCHPs would be required to comment fully on these figures and to what extent the costs identified within the MKUKUTA figures are currently already funding either on- or off-budget.	

Summary of recommendations

This summary includes both pending recommendations from the previous PER update, together with new recommendations arising from this year's analysis.

Recommendation	Responsible	Time frame
Ensure that the High Level Committee on health financing is functional, ie meeting regularly with visible outputs	Permanent Secretary	Immediate
Follow-up with Ministry of Finance re apparent failure to compensate Health forward budget for lack of World Bank funds (to be channelled through General Budget Support)	DPP	Immediate
Creation of a specific Unit within the DPP to handle complementary financing, ideally with focal persons for each separate financing scheme (eg HSF, CHF, NHIF, and Drug Revolving Fund (DRF) as a means of improving information in this area	Permanent Secretary	By end 2006
Annual report to be provided by NHIF showing clearly the distribution of claims on a geographic basis (ie by council) and by level (primary facilities, district hospitals, regional hospitals, referral hospitals, national and special hospitals)	Permanent Secretary	Immediate, by financial year
Incorporate reports on CHF, DRF and NHIF into the Appropriation Accounts as with HSF	DPP, Chief Accountant	Starting FY2006/07
Separation of each financing source within the TFIR at council level in order to permit consolidated reporting at national level	TBD	Starting FY2007/08
Further work to analyse all on-budget spending according to beneficiary level	DPP	Current FY
Preparation of a comprehensive MTEF, as has been the intention, to incorporate all external funding, on and off-budget	PS	Effective from FY2007/08
High Level Committee on health financing to review full sector MTEF (ie not MOHSW alone) and determine desired shares for central, regional and local government by end of period	High Level Committee	For FY08 MTEF
Review and analysis of the MOF External Finance database for the Health sector for completeness and accuracy, and to determine the extent to which off-budget spending is in line with MDG and MKUKUTA goals	DPP	As part of budget preparation for FY08
Initiate annual analysis of council level spending patterns both for budgets (ie using CCHPs) and for expenditure (ie using fourth quarter TFIRs)	District Health Services section	Immediate
Analysis of CCHPs and MTEF to enable a consistent comparison of ESRF costing with actual budgets	DPP	Within FY
Review timing and process of the PER to fit with agreed changes in the planning and monitoring cycle	DPP (Technical Sub-committee?)	Jul – Sep 06
On basis of decision on PER timing, initiate process for FY07 update (ensuring linkage with NHA)	DPP (Technical Sub-Committee)	Jul – Sep 06

1 Introduction

Presentation of the Public Expenditure Review (PER) update is traditionally one of the standing items at the Annual Joint Health Sector Review (AJHSR) of the Ministry of Health and Social Welfare (MOHSW), and continues to provide sectoral information in advance of preparation of the cluster PERs as defined within the Poverty Reduction Strategy Paper. For the financial year 2005/06 (FY06), a different format was agreed, comprising a briefing paper submitted in advance of the AJHSR, and this second, more detailed document. Terms of reference for the PER update are reproduced in Annex A. The document is organised as follows.

Section 2 reviews the recommendations and follow-up actions from the PER update for FY05.

Sections 3 and 4 provides a review of budget and expenditure trends at the sectoral and sub-sectoral level respectively, looking at the share of Health in overall on-budget spending, nominal and real levels of spending, and the per capita allocation to the sector. Sub-sectoral analyses include a crude breakdown by administrative level, by category of spending, and of drugs and supplies.

Section 5 reviews budget performance, both at the overall sectoral level and for selected sub-sectoral components of the budget: MOHSW by Department, Regions, LGA block grant; hospitals; and the National Health Insurance Fund.

Section 6 looks at off-budget spending in the sector, both domestic and foreign.

Section 7 presents a tentative resource envelope for FY07/08, based on the MTEF projections for GOT funding, together with projections of external funding from the MOF database and assumptions regarding other external funding.

Section 8 discussed the findings of the earlier sections, and presents some recommendations for consideration by the sector during the coming budget cycle for FY2007/08.

2 Review of PER FY05 recommendations and actions

The main recommendations of the PER FY05, together with actions planned and/or taken during FY06, are presented in Table 1 below. Implications for the sector are discussed briefly below.

Table 1 Summary of action taken on PER FY05 recommendations

Recommendation	Action taken
Continued lobbying for additional domestic funding of the sector (both nominal and as a share of the total)	A high level meeting took place after the 2005 AJSHR to discuss the financing of the sector (and human resources), with the result that the sector received an additional allocation of TSh 20 billion which was allocated for additional procurement of drugs and supplies.
Continued monitoring of Health sector ceiling to ensure rises at least in line with switch from sector to general budget support (eg World Bank)	Monitoring is ongoing through routine budget analysis, the PER process, and discussion at the AJHSR. Attention also needs to be given to the composition of the budget as well as the total ceiling.
Further work to analyse allocations by ultimate beneficiary level	No action to date.
Tracking study/detailed assessment of spending on drugs and supplies, covering levels and sources of funding, and allocation (geographically, by programme/ disease, or by specific type of supply)	Not done during FY06, due to insufficient staff capacity within the Directorate of Policy and Planning. This was however agreed at the Joint Review as a Milestone for FY07, to include the possibility of devolving 20% of the drugs budget to the LGA level

Recommendation	Action taken
Work to strengthen Technical and Financial Implementation Reports (TFIRs) at council level	Ongoing. Joint field visits/supervision by Government of Tanzania and Development Partners are provided for, but need to be activated. Local Government Reform Programme able to provide some expenditure figures for FY2004/05 (all sources). Figures on basket funding do not tally with MOHSW data though. Must be seen in the context of the broader fiscal decentralisation efforts.
Central level analysis of council TFIRs to provide an overview of performance and its variation among councils	No analysis to date.
Detailed evaluation of overall performance of the Community Health Fund (CHF)	Not done. Presentation of progress at the May 2005 Health Financing Workshop. Decision at the workshop to develop a Medium Term Health Care Financing Strategy (covering tax financing, external resources, and complementary financing mechanisms including user charges, CHF and NHIF). It has been agreed that a Health Financing Strengthening Committee will be established but this is yet to happen.
Continued monitoring of spending by the National Health Insurance Fund (NHIF), as a major recipient of funds from within the MOHSW ceiling	Presentation of progress at the May 2005 Health Financing Workshop. See above. Update envisaged in PER FY06, and letter sent to request detailed information, but without a response so far.
Review of completeness and accuracy of the data source for off-budget external funding	Not yet done. Donors are not obliged to report to MOHSW, and a review of the Ministry of Finance (MOF) external finance database has not yet been undertaken.
Analysis of off-budget external funding in terms of its contribution to poverty reduction and towards achieving priority health outcomes	No analysis has yet been done.
Review of the geographical allocation formula for drugs and supplies	Not yet done. The kit system is currently being replaced by indent system, but with continuing lack of clarity as to the basis for allocation. The need to revisit the allocation formula for drugs and supplies was again confirmed in the 2006 Technical Review meeting[2].
Continuous data gathering for the PER, and meetings of the Task Team, throughout the financial year in order to lessen the task at year end	No evidence of this. The Task team does not meet frequently because of other engagements.

In addition to those noted above, a major recommendation of previous PERs, and indeed a milestone agreed at the 2004 AJHSR, has been that the existing high level committee on health financing which was established during FY2003/04 should be functional[3]. Although the specific milestone agreed in 2005 refers explicitly only to the need for this committee to meet once, *"to review PER and Health MTEF, and agree a medium term funding strategy for the health sector in the context of MKUKUTA"*, the expectation was that the committee would continue to meet regularly to take forward pertinent issues on financing the sector. However, this has not happened, with only one meeting taking place, despite the deliberations of the Health Financing Workshop held in May 2005.

On the whole, it appears that the recommendations of the previous PER have generally not been adopted, although it is recognised that the capacity of the Directorate of Policy and Planning is limited, in the sense that the available competent staff have many competing claims on their time. Efforts have been made to strengthen this capacity with the recruitment of two junior economists to assist in some of the identified tasks. However, such activities are unlikely to take place if not incorporated into the MTEF and assigned a responsible officer. It may be that some restructuring of the Department is warranted, through creation of a specific Unit concentrating full-time on health financing, with designated focal persons for the different mechanisms (ie Community Health Fund, National Health Insurance Fund, tax-based financing, external funding etc).

[2] See page 6 of the report on the Technical Preparatory Meeting held at Belinda Hotel, 21st to 24th March 2006.
[3] It should be noted that this High Level Committee on Health Financing is not the same as the currently proposed Committee on Health Financing Strengthening, although there may well be an overlap in eventual membership.

3 Overview of on-budget health sector spending, FY03 – FY06

In the following sub-sections, the performance of the health sector budget is shown in terms of three different measures:

- The sectoral share of total government budget/expenditure;
- Absolute levels of spending, both nominal and real;
- In per capita US dollar terms.

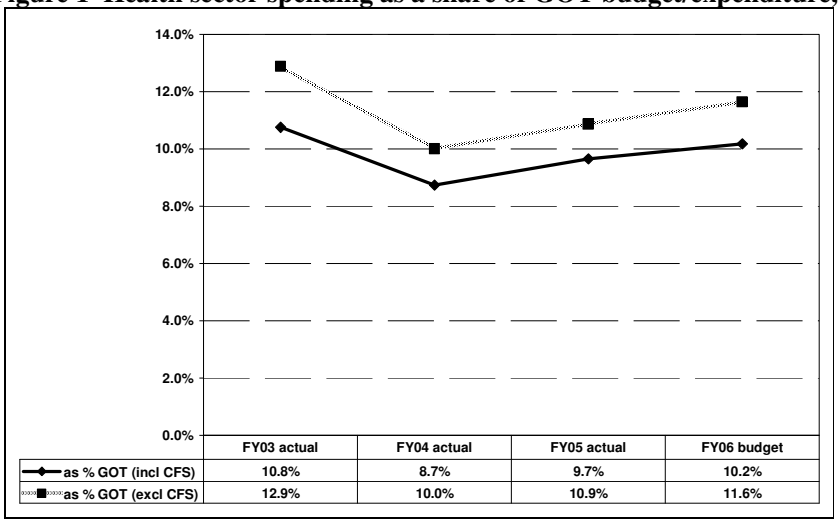
The following figures refer to on-budget health sector public spending only, with presentation of off-budget spending in Section 6. The detailed figures on which these graphs are based are shown in Annex B.

In previous PERs, figures have been presented both using the official Ministry of Finance data summarised in the annual Budget Execution Report[4], and data collated specifically for the sectoral PER exercise, ie built up from review of detailed MOH, PORALG, and off-budget data. The timing of this PER update coincided with budget preparation, resulting in additional difficulties in accessing data and relevant persons, despite the fact that complete expenditure data for FY05 should have been readily available by early 2006. There remain some inconsistencies with the official published figures for FY05 which we have been unable to clarify. Main data sources are listed in Annex C.

3.1 Health as a share of overall government spending

Figure 1 below shows the trend in terms of the sectoral share of total government budget/expenditure, both including and excluding Consolidated Fund Services, ie largely public debt.

Figure 1 Health sector spending as a share of GOT budget/expenditure, FY03 – FY06



	FY03 actual	FY04 actual	FY05 actual	FY06 budget
as % GOT (incl CFS)	10.8%	8.7%	9.7%	10.2%
as % GOT (excl CFS)	12.9%	10.0%	10.9%	11.6%

Figure 1 shows that the positive trend seen in last year's PER update has continued into FY06, with a slight increase in both measures of the sectoral share over the previous year[5]. However, the share will still remain below its FY03 level, even if expenditure matches budget estimates. On the assumption that the health sector contribution to HIV/AIDS is captured within the sector rather than under TACAIDS, the data also imply that the sectoral share falls short of the 15% committed to in Abuja.

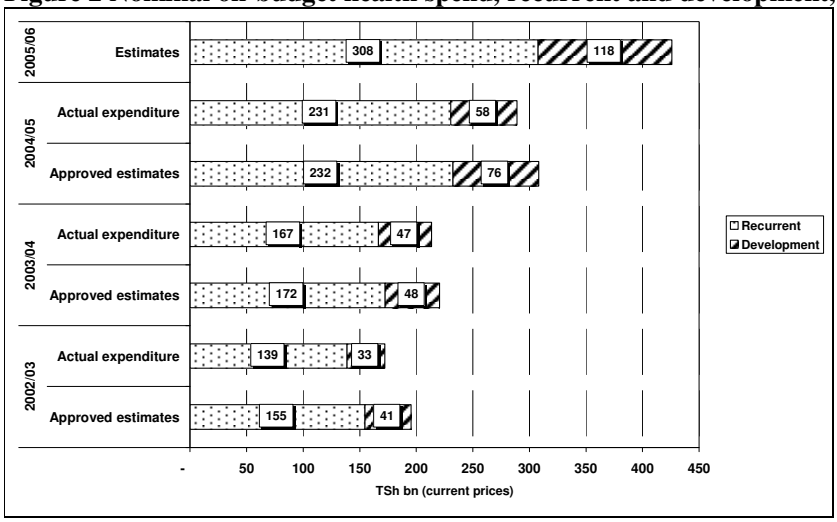
[4] The fourth quarter Budget Execution Report prepared by Ministry of Finance covers the cumulative data for the financial year (MOF, *Budget for Fiscal Year 2004/05. Quarterly Budget Execution Report Fiscal Quarter 4. July 2004 – June 2005*. October 2005.)

[5] It should be borne in mind that we are not comparing like with like, but rather current year's budget with previous year's expenditure.

3.2 Absolute levels of spending, nominal and real

Figure 2 below shows the absolute level of health sector spending in nominal terms, both budgeted and actual, since FY03. The graph shows a consistent rise in the nominal budget over the period under review, from TSh 195bn in FY03 to TSh 426bn in the current year. Although slightly lower than the previous year's growth, the year on year increase in the total nominal budget was significant at 38%, ie TSh 118bn. When compared with actual expenditure, the increase is slightly higher, at 47%.

Figure 2 Nominal on-budget health spend, recurrent and development, FY03 – FY06



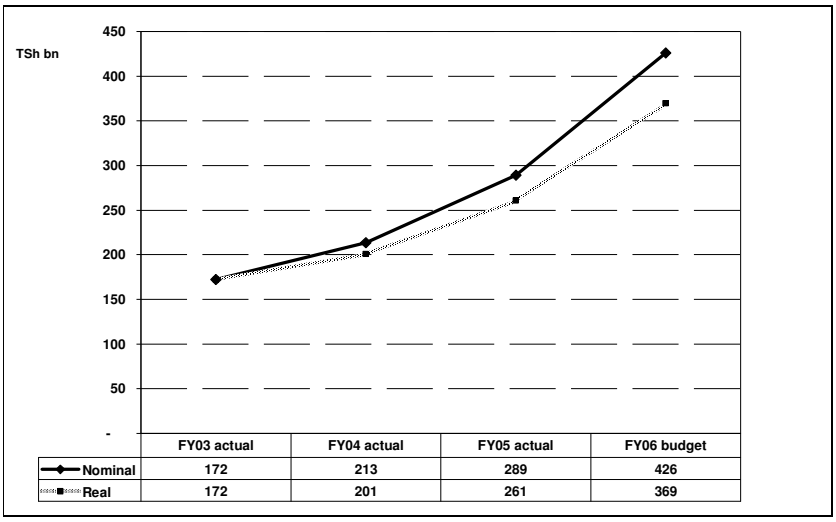
Other drivers of the increase in the nominal budget are the substantial increase in the MOHSW headquarters recurrent budget, which rose by 72%, and, to some extent, the doubling of the budgeted contribution to the National Health Insurance Fund.

The figures also show a slight change in the composition of sector spending, with a 3% increase in the share of the development budget, from 25% to 28%. This is largely due to the increase in allocation to PMO-RALG for rehabilitation of health infrastructure, funded by the basket. Together with a 37% increase in MOHSW foreign development funding (including basket funding), this resulted in a 56% increase in the year on year value of the Development budget, while the Recurrent budget increased by 32%.

Recurrent funding to Local Government Authorities increased by 18%. Although significant in nominal terms, and bearing in mind the comments above regarding funding captured elsewhere in the budget, this still implies a relative reduction in the share of sector funds over which councils have effective control or flexibility in terms of their allocation.

Figure 3 shows the trends in absolute spending, both in nominal and real terms.

Figure 3 Trend in nominal and real health spend, FY03 – FY06



Although the real value of the sector budget (in FY03 prices) is lower than the nominal value, it still shows a dramatic upward trend in recent years.

3.3 Per capita spending

The final measure of health spending presented in this section is the nominal value in per capita US dollars. This is shown in order to provide a crude comparison with spending in other countries[6], and to show the trend in relation to the various international costings developed over the years. Table 2 gives both the annual estimates, and the data used to produce them.

Table 2 Spending trend in per capita US dollars, FY03 – FY06

	FY03 actual	FY04 actual	FY05 actual	FY06 budget
in per capita US dollars	5.04	5.70	7.21	9.92
Nominal spend	*172,176,653,392*	*213,345,582,458*	*288,989,428,769*	*426,012,937,300*
Population estimates	*34,155,840*	*35,146,359*	*36,165,604*	*37,214,406*
Exchange rate	*1,001*	*1,065*	*1,109*	*1,154*

Table 2 again shows a positive picture, with a steadily rising per capita US dollar value of on-budget health sector spending, with the budgeted figure for the current financial year just short of US$ 10 per capita. While still a long way from estimates such as that calculated by the WHO Commission on Macroeconomics and Health, and by the Millennium Project, it shows that Tanzania is at least moving in the right direction. It is expected that the completion of the National Health Accounts exercise later in the year will provide additional data on out of pocket spending to complement this information and present a more complete picture of the available resource envelope for the health system, thereby enabling more meaningful discussion of both the source and the allocation of those resources, and potential for improvement.

4 Sub-sectoral spending

This section presents information on the sub-sectoral allocation of on-budget resources. In the absence of any redefinition of the categorisation to be followed in the analysis, the same breakdown has been followed as in recent PERs, with the exception of the addition of some data on MOH spending on priority MDG-related health programmes.

[6] Ideally we would present this in terms of purchasing power parities.

4.1 Allocation by level of the health system

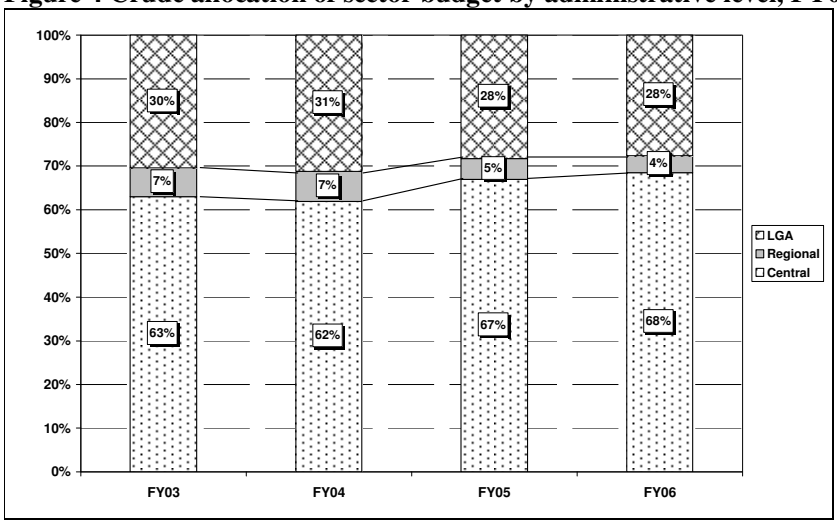
The allocation of the health budget between the three levels of government is shown in Figure 4. This figure is somewhat misleading as a significant proportion of the MOHSW headquarters budget reflects items intended for lower levels of the health system. Notable examples include:

- drugs and supplies, which continue to be reflected in the headquarters budget, yet are allocated to health facilities throughout the system;
- transfers to institutions at lower levels of government, eg Voluntary Agency and District Designated Hospitals; and
- technical programme activities implemented by LGAs yet captured under the central level programmes.

No attempt has been made to reallocate such items in this sub-section, with the exception of the basket fund for rehabilitation of PHC facilities, funds for which are channelled by PMO-RALG to councils according to set criteria. It would be useful to separate the beneficiary level within the MTEF in order to facilitate analysis in the future.

The information in this graph is still useful, however, as it provides a picture of the extent to which effective devolution of responsibility over resource management has taken place within the budget over the period under analysis. However, as per previous PER recommendations and Table 1 above, more systematic analysis of sector spending would be preferable in order to be able to show allocations by final beneficiary level[7].

Figure 4 Crude allocation of sector budget by administrative level, FY03 – FY06



In terms of budgetary commitments, Figure 4 shows that there has been a successive slight recentralisation of on-budget resources, with the central allocation accounting for 68% of the resource envelope. This has been at the expense of the regional level, while the LGA share has remained constant at 28%. A similar exercise for expenditures would also be useful for comparison.

It should be remembered that the absolute volume of resources being channelled to LGAs has increased significantly in recent years, ie budgeted recurrent funding (GOT plus basket) has risen from TSh 57.6bn in FY03 to TSh 95.1bn in FY06, ie an increase of 65% in nominal terms.

4.2 Allocation within the LGA

Within the LGA level, it is possible to track the relative shares of the budgeted block grant going to the four sub-votes. Ideally this analysis would be undertaken for the totality of the council resource

[7] Part of the NHIF allocation is also transferred to health facilities, although the latest data obtained by the PER Task Team showed that only between 25% and 26% of the government contribution has actually reached health institutions in the past three years. It was not possible to obtain the disaggregated data which would enable an appropriate allocation to be made.

envelope, and also would be compared with the actual expenditures, but data constraints prevent that for this year at least. Figure 5 shows the breakdown in recent years for Health services (broadly comparable to the district hospital), Preventive services, Health centres and dispensaries.

Figure 5 Budgeted allocations within the LGA, FY03 – FY06

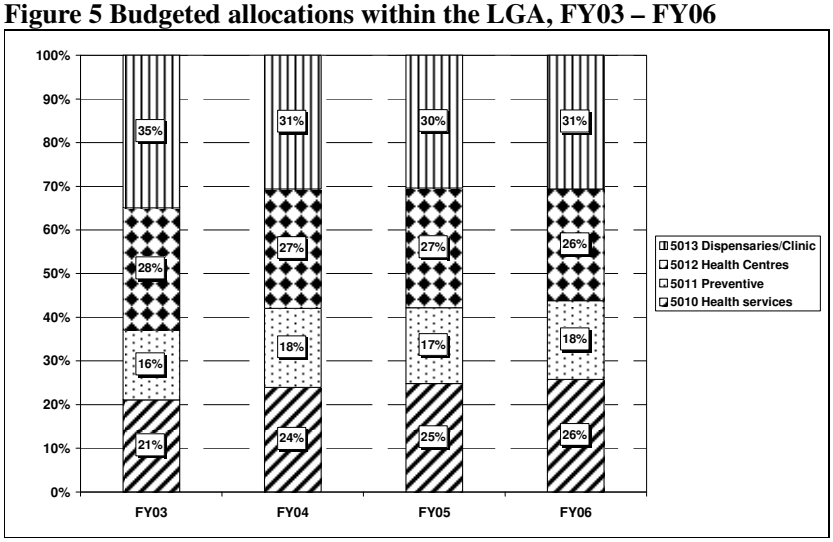


Figure 5 above indicates that within the LGA budget, the more administrative sub-votes (5010 and 5011) appear to be increasing slowly at the expense of the primary level health facilities. Taken together, the share of Health centres and Dispensaries has fallen from 63% in FY03 to 57% in FY06.

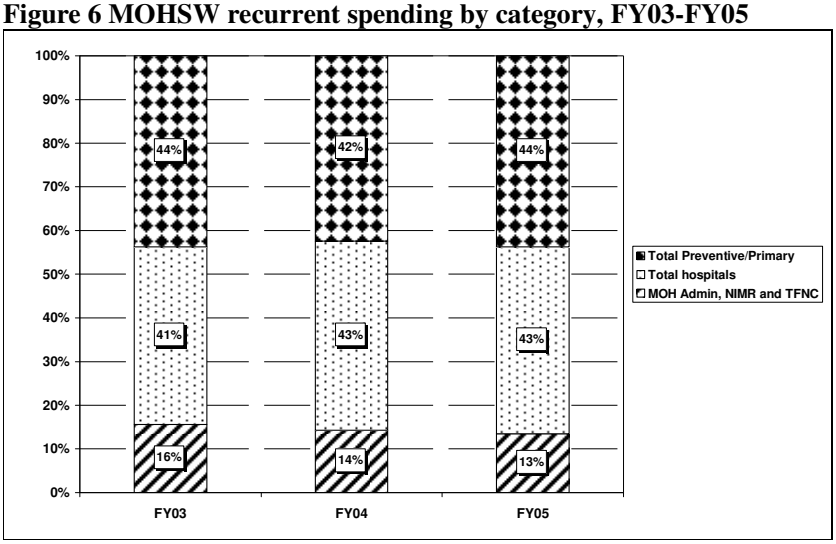
However, in the absence of a more complete picture of the LGA resource envelope - ie including other sources of funding, notably basket but also cost-sharing, local external resources, and councils' own contributions - this picture tells us little. In theory, such an analysis would be possible from the Comprehensive Council Health Plans but it does not appear that any aggregation of these is undertaken routinely by the MOHSW, as indicated in successive PER updates. This represents a missed opportunity for improved understanding and monitoring of council spending, but may be rectified with the progressive roll-out of the PlanRep software under PMO-RALG.

4.3 Allocation by category of activity

Potentially more useful than the previous analysis, is the breakdown between categories of spending. This should really cover all sources of funding, both recurrent and development. However, in the absence of detailed information on the allocation of non-GOT funds for drugs and medical supplies, a thorough review of the MTEF/Activity Implementation Report, and analysis of the council Technical and Financial Implementation Reports, this is not yet possible. As in previous years, a separate exercise is recommended in this area.

For the MOH central level recurrent (on-budget) allocation, the estimated breakdown between Administration, Hospital services and Primary level/preventive services is shown in Figure 6 below. Detailed figures are given in Annex G Table 15.

Figure 6 MOHSW recurrent spending by category, FY03-FY05



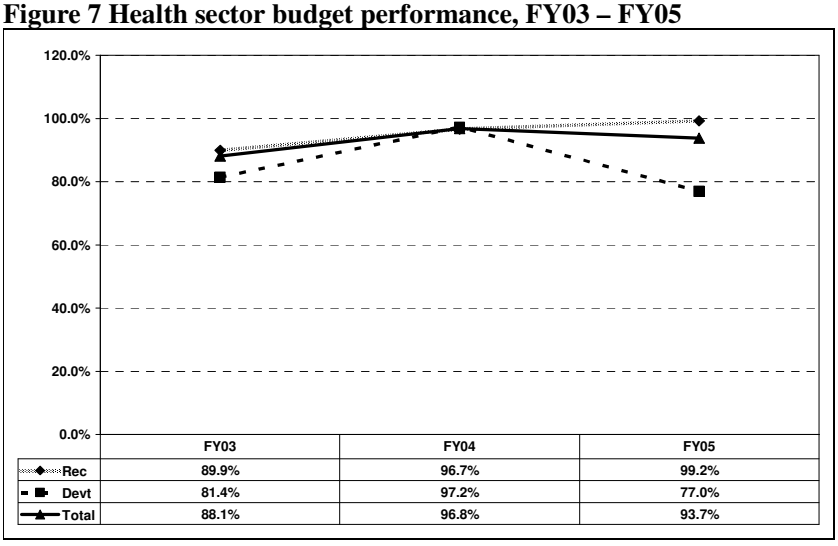
Comparison of the past three years shows a slight decrease in the administrative share. In contrast to FY04 when the hospitals gained from this reduction, and the primary/preventive category was squeezed, this latter category rose from 42% to 44% over the last year.

5 Expenditure in relation to budget

5.1 Aggregate on-budget sector total

Actual expenditure as a percentage of Approved Estimates for the past three financial years is shown in Figure 7 below, both for the total budget, and separately for the recurrent and development budgets.

Figure 7 Health sector budget performance, FY03 – FY05



	FY03	FY04	FY05
Rec	89.9%	96.7%	99.2%
Devt	81.4%	97.2%	77.0%
Total	88.1%	96.8%	93.7%

In FY05, total expenditure was almost 94% of the approved estimates, slightly less than in the previous year when almost 97% of the overall budget was spent. Data are not currently available to enable complete analysis of the extent to which the shortfall was due to lower releases by Treasury, or poor absorption capacity at the MOHSW[8].

[8] The annual Itemised Daily Balance report from the MOHSW Integrated Financial Management System indicates that 100% of domestic funding for MOHSW headquarters was released, of which 99% was spent, while for central level recurrent basket funding, 98% was released of which 95% was spent. These figures do not tally completely with those presented in the Appropriation Accounts, however.

Figure 7 clearly shows that the reduction is due to a significant under-spend on the Development budget, which was only 77% of Approved Estimates, while Recurrent expenditure was over 99%. This implies a return to a more typical picture whereby Development spending, particularly the foreign component, fails to match projections. Although it is not possible to clearly distinguish between Basket and other foreign funds in the Development budget, a tentative separation indicates that there were shortfalls in both components. With respect to the basket funds, there were delays in release of the rehabilitation funding and delays in drawdown of the World Bank credit led to late release of the late quarter LGA basket funds.

5.2 Ministry of Health headquarters

Data from the Appropriation Accounts of the MOHSW give only Approved Budget and Actual expenditure. Data from the IFMS give Release data in addition. However, as mentioned above, the figures for Actual expenditure differ slightly between the two sources. Table 3 shows how the individual departments or sub-votes at MOH headquarters performed.

Table 3 MOHSW headquarters budget performance, Appropriation Account data, FY05

Account code	Description	Approved estimates FY05	Actual expenditure FY05	Expenditure as % Budget
a	b	c	d	d/c * 100
521001	Administration and General	1,435,669,234	1,406,570,056	98.0%
521002	Finance and Accounts	364,757,360	358,016,150	98.2%
521003	Policy and Planning	626,369,148	558,507,292	89.2%
522001	Curative services	72,412,644,797	72,149,976,212	99.6%
522002	Chemical Laboratory	709,742,537	709,725,265	100.0%
522003	Chief Medical Officer	7,294,718,710	7,259,067,553	99.5%
523001	Preventive Services	16,635,111,287	16,448,931,203	98.9%
524001	TFDA	345,049,800	345,049,800	100.0%
525001	Human Resource Development	5,259,621,327	4,926,528,043	93.7%
Total		**105,083,684,200**	**104,162,371,573**	**99.1%**

Comparison of expenditure and budget, according to the Appropriation Accounts, indicates that for the MOHSW headquarters recurrent budget as a whole, performance was good, at 99.1%. Within the MOHSW, there was some variation between Departments with the Chemical Laboratory and TFDA performing at 100%, while Policy and Planning was the poorest performer at 89.2%. This is somewhat disappointing as the Department of Policy and Planning is responsible for many critical activities within the sector, and inadequate funding is frequently cited as a reason for non-performance in those areas. Human Resource Department was the second poorest performer, at 93.7%.

Table 4 below presents the expenditure figures from the Integrated Financial Management System (IFMS). These show that for the DPP, where the data from the two sources are similar, the problem was capacity to spend within the Department rather than failure to release by Treasury. This has been explained as due to human resource constraints, as the available staff within the Department are considerably over-stretched in relation to their workload. This calls for more realism at the planning stage, recruitment of additional staff, or sub-contracting of certain assignments.

For the HR Department, the data differ slightly, but the indication is that the problem is again absorption capacity within the MOHSW rather than budgetary shortfalls. This should be explored further to ensure that available resources are spent in full, as failure to do so diminishes the sector's case for increased allocations.

Further delays related to procurement. Once commitments are taken into account, the expected expenditure against budget and release (by end Sept 2005) was expected to be 100%.

Table 4 MOHSW budget performance, IFMS data FY05

Sub-vote	Source	Budget	Release	Expd	BP	AC
1001 Admin & General	GOT	1,435,669,234	1,435,669,109	1,335,796,817	100%	93%
	Basket	250,000,000	245,819,932	216,770,259	98%	88%
1002 Finance & Accounts	GOT	364,757,360	364,750,360	358,016,150	100%	98%
	Basket	200,000,000	199,799,900	197,625,141	100%	99%
1003 Policy & Planning	GOT	626,369,148	625,369,147	558,507,292	100%	89%
	Basket	1,580,000,000	1,572,190,868	1,389,262,263	100%	88%
2001 Curative services	GOT	72,412,644,797	72,389,127,407	71,938,014,511	100%	99%
	Basket	7,000,000,000	6,947,663,599	6,765,009,081	99%	97%
2002 Government Chemist Laboratory Agency	GOT	709,742,537	709,740,937	709,725,265	100%	100%
	Basket	300,000,000	290,525,000	290,525,000	97%	100%
2003 Chief Medical Officer	GOT	7,294,718,710	7,288,359,673	7,259,067,553	100%	100%
	Basket	388,000,000	299,719,000	282,056,540	77%	94%
3001 Preventive services	GOT	16,635,111,162	16,699,040,618	16,519,798,149	100%	99%
	Basket	12,410,646,900	12,063,265,737	11,458,290,425	97%	95%
4001 Tanzania Food & Drug Authority	GOT	345,049,800	345,049,800	345,049,800	100%	100%
	Basket	500,000,000	491,305,467	491,305,467	98%	100%
5001 Human Resource Development	GOT	5,259,621,327	5,229,930,028	5,158,041,587	99%	99%
	Basket	2,171,000,000	2,110,736,000	2,028,040,746	97%	96%
Total MOH HQ	GOT	**105,083,684,075**	**105,087,037,079**	**104,182,017,125**	**100%**	**99%**
	Basket	**24,799,646,900**	**24,221,025,503**	**23,118,884,921**	**98%**	**95%**
Grand total MOHSW HQ		**129,883,330,975**	**129,308,062,582**	**127,300,902,046**	**100%**	**98%**

5.3 Regions – recurrent

The quality and completeness of the data obtained for regions was poor, with both errors in calculation and gaps. It is not clear why this should be the case so late in the subsequent financial year. The overall picture for the Regions, based on the poor data, is shown in Table 5, disaggregated between preventive and curative sub-votes.

Table 5 Regional budget performance, recurrent, FY05

	PE	OC	Total
Curative	99%	98%	**99%**
Preventive	98%	30%	**65%**
Sub-total	**99%**	**88%**	**97%**

Bearing in mind the data concerns, Table 5 shows that overall expenditure by the recurrent Regional votes was 97% of approved estimates. However, the performance of the OC component of the Preventive subvote was very poor at only 30%. This is disappointing given the priority given to Preventive services within the sector and the MKUKUTA as a whole, and given the relatively low absolute amount that the approved budget actually represented, ie just over Tsh 400m (see Annex G Table 16 for nominal figures).

5.4 Local Government Authorities – recurrent

Data on the LGA recurrent budget performance were taken from two separate sources, and again should be treated with caution. Approved estimates are taken from the Volume III detailed appendix on LGA allocations for FY06, while the actual expenditure figures are taken from published PMO-RALG data[9].

Table 6 LGA budget performance, recurrent, FY05

	Approved	Expenditure	BP
PE	41,744,425	36,519,380	87%
OC	20,227,098	32,281,022	160%
Total	**61,971,523**	**68,800,402**	**111%**

[9] PMO-RALG. *Financial Statistics for Local government Authorities on mainland Tanzania.* Vol 3. December 2005.

Unfortunately, these two data sources are not comparable, due to the expenditure figures including other sources than the block grant. It has not been possible to determine the extent of this difference. The failure to obtain actual block grant releases is largely due to the timing of the PER exercise which meant that key officials were fully occupied with budget preparation.

The data as presented in Table 6, while not measuring expenditure against a single source of income, still show that expenditure was 11% higher than the approved estimates, thereby representing an optimistic picture for the sector. This is particularly encouraging given the importance of LGA expenditure for actual service delivery, although further exploration of the nature of spending would be useful. There are significant differences in the performance of the PE and OC component, with PEs underspent by 13% and the OC allocation overspent by 60%.

5.5 Hospitals

Budget performance for the referral and voluntary agency hospitals cannot be fully presented, as the data suffer the same problem as the AGO allocation to the NHIF, ie IFMS and the Appropriation Accounts indicate the transfer from the MOHSW to the institutions, but we lack information on actual expenditure. To date we have assumed that release/transfer is a proxy for expenditure, but it would be useful to check this assumption at some point. From an accountability point of view, given that the larger hospitals still consume a significant proportion of sector funding, some feedback on spending is desirable.

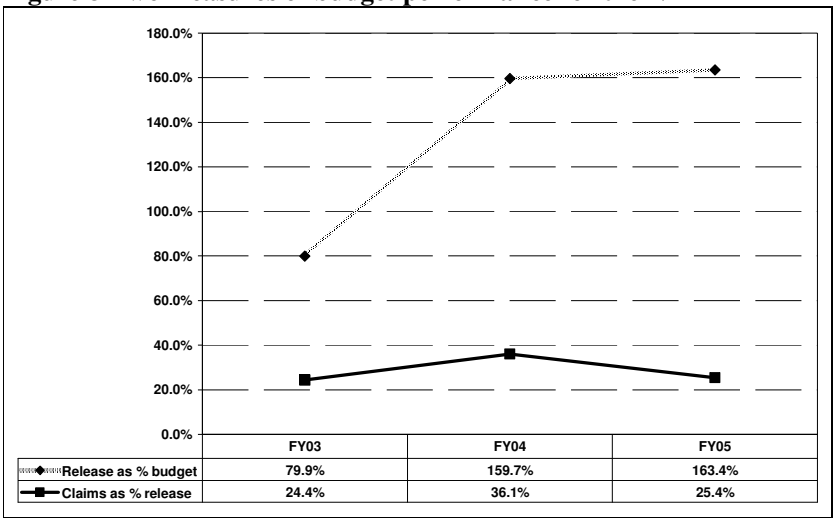
With the exception of the Voluntary Agency hospitals, funds were released in full from the Treasury to MOHSW and transferred on to the relevant institution. For the Voluntary Agencies, expenditure was 98% of the budget. Disaggregated data are shown in Annex G Table 17.

5.6 National Health Insurance Fund

NB The way in which NHIF expenditure is reported in this document has changed since the publication of the April 2006 Briefing Note. As a result, there have been implications for some of the findings of the overall review of sector spending in Section 2. A summary of disaggregated data using the original definition of NHIF expenditure is given in Annex G Table18..

Figure 8 shows the different pictures obtained according to the definition of NHIF budget performance used. When releases from the AGO are compared with budget, there is significant overspend. This has been explained in terms of within-year adjustments for recruitment and salary increases.

Figure 8 Two measures of budget performance for the NHIF



When the AGO release[10] is compared with the actual reimbursement of claims by accredited health facilities, the picture is more depressing. Not only is the level of claims reimbursement very low in FY05 at 25%, but it has fallen since FY04, when 36% of the AGO release was passed on to health facilities.

It remains to be clarified whether the transfer from the AGO to the NHIF represents only the 3% of the total public sector salary bill which is the government contribution to the Fund, or whether it also represents the 3% which is deducted from public servants, ie whether the PE component is reported gross or net of these deductions and transfers in the official budget estimates.

6 Off-budget spending

Financing of the Health sector in Tanzania is done using resources from four main sources, namely: (i) the government (central and local), (ii) donors through the budget, including through the health basket (iii) donors directly to the projects/programmes, not consistently captured within the government budget, and (iv) locally generated domestic revenues through cost-sharing, again largely off-budget. Earlier sections presented data on the first two of these sources, while the focus here is on the latter two sources, referred to as off-budget spending. Annex D discusses off-budget concepts further.

Table 7 shows the magnitude of estimated resources that are financing health-related services but which do not go through the budget process. The information on off-budget foreign resources is based on the MOF external finance database and is not comprehensive because of incomplete reporting by development partners. It should also be noted that it has not been possible to perform a complete reconciliation of data included within the health MTEF, the official Government Estimates, and the Appropriation Accounts, and some double counting or omission may therefore occur.

The domestic off-budget spending reflects cost-sharing revenues, emanating from public health facilities. At the hospital level these reflect reported contributions to Health Service Fund, while at the council level they reflect an extrapolated figure for the Community Health Fund, based on reported information on the matching grant previously provided under World Bank support, and now through the health basket[11]. In each case reporting is not comprehensive thus calling for careful interpretation of the figures. The problems of information on the volume and use of cost-sharing revenues obtained either at the facilities or communities were discussed in detail in Health PER FY05 and it is not our intention to repeat them here. Suffice to say that no improvement has been recorded in this regard.

Table 7 Off-budget contributions, FY03 – FY06

	FY03 actual	FY04 actual	FY05 actual	FY06 budget
Domestic	5.86	7.48	10.71	10.71
External	46.48	40.35	122.91	94.48
Off-budget sub-total	**52.34**	**47.83**	**133.62**	**105.19**
Total sector expenditure	***224.51***	***261.17***	***422.61***	***530.96***
Domestic as % TSE	*2.6%*	*2.9%*	*2.5%*	*2.0%*
External as % TSE	*20.7%*	*15.4%*	*29.1%*	*17.8%*
Off-budget as % TSE	*23.3%*	*18.3%*	*31.6%*	*19.8%*

As shown in Table 7 the contribution of off-budget resources to the provision of health services is of significant magnitude in absolute terms and, save for the provisional figure for FY2005/06, seems to be increasing over time. Over the period under review, estimated off-budget resources have contributed between 18% and 32% of total sector expenditure. More importantly, this contribution emanates mainly from the foreign off-budget resources, since domestic off-budget expenditure

[10] Which itself under-estimates NHIF income, as additional contributions are made through the MOHSW Development budget.

[11] In the absence of better data on total revenues, the extrapolation uses the matching grant as a proxy for membership premia, divided by 15 and multiplied by 100. This is based on the 2002 report on the CHF in Hanang district which found that membership premia accounted for 15% of total revenues, with user fees contributing 85% (G Chee et al 2002).

remains a minor contributor to total expenditure. It remains to be seen whether the reduction is due to success in capturing funds through the official government reporting channels.

It remains very difficult to obtain complete and accurate data on cost-sharing revenues, possibly in part due to the fact that there are few incentives to reveal the information. A workshop has recently been held with hospital in-charges to discuss the HSF reporting, and it is hoped that this will improve the quality of data in the future. Similarly, there has been additional pressure for reporting of CHF data since the Health Financing workshop of May 2005. However, this does not appear to have yet improved. Further discussion can be found in Annex E.

7 Comparison of estimated resource envelope with requirements, FY08

7.1 Estimated resource envelope FY08

Tables 8 and 9 below presents a tentative estimate for the sector resource envelope in FY2007/08. This is based where possible on data from the Budget Guidelines for the current year. It should be noted that it was not possible to obtain details for LGAs or for the Regions, so some of the figures are extrapolated from the current or past health share of the projected total. In addition, MOHSW projections for basket funds, and overall projections of external funding available through the MOF database (as per October 2005) are incomplete[12]. Assumptions are made regarding the potential growth of internal revenues from cost-sharing. A full description of the basis for these scenarios is given in Annex F.

Table 8 Tentative resource envelope for FY08 – base scenario (Tsh m)

	FY06	FY07	FY08
Recurrent	*307,247*	*393,262*	*429,433*
Development	*117,178*	*133,182*	*80,442*
On-budget total	424,425	526,444	509,876
Domestic	*10,710*	*11,646*	*12,669*
External	*94,483*	*95,000*	*95,000*
Off-budget total	105,193	106,646	107,669
Total base scenario	**529,619**	**633,090**	**617,544**
Total expd exc CFS	*3,647,906*	*4,377,862*	*4,389,465*
On-B Health %	*11.6%*	*12.0%*	*11.6%*

Table 8 indicates that the sector resource envelope is projected to fall slightly in nominal terms for FY08, and to return to its FY06 level in terms of the budget share. This is due to a significant fall in projected development budget funding which needs further exploration as it is not clear at present whether this is due only to the poor projections and/or short-term commitments of development partners, or whether it is a real possibility. In particular, this would imply that the switch of IDA funding from sector to general budget support has not been captured in the current forward budget.

Table 9 gives a slightly more optimistic scenario, based on a slight increase to 12.5% in the health sector share of the existing expenditure frame (as per Budget Guidelines), a constant share of the total resource envelope from off-budget external resources, and a higher rate of growth in cost-sharing revenues. Details are again given in Annex F.

Table 9 Tentative sector resource envelope for FY08 – high scenario (TSh m)

	FY06	FY07	FY08
On-budget total	424,425	526,444	548,683
Off-budget total	105,193	123,921	145,722
Total high scenario	**529,619**	**650,365**	**694,405**

[12] The current estimates for health basket funding are given in Annex G Table 19.

This shows an overall increase of 6.8% between FY07 and FY08, resulting in a TSh 44m increase in nominal terms. The on-budget component of this rises more slowly than the off-budget component, resulting in a very small increase in the off-budget share.

7.2 Sector requirements FY08

Due to resource constraints, there has always been a mismatch between resource requirements and actually available resources to meet expenditure needs. This has occurred in spite of the increase in government resources directed toward health expenditure. Neither approved budget not actual expenditure necessarily reflect the actual resource requirements. In the past, what was submitted as resource requirements was not based on any comprehensive costing of the core activities needed to achieve poverty reduction and MDG targets within the health sector but was rather based on simple estimations. An attempt to systematically cost such interventions was recently undertaken by ESRF (2006), based on a mixture of Millennium Project and local cost information, with local targets for coverage. The results of this exercise are used here to compare financial requirements for meeting MKUKUTA targets and resource availability for the sector.

The key interventions on which the costing is based are in conformity with MKUKUTA and the Health sector strategy. However, some of these interventions are multidimensional and touch various sectors and hence require various actors – e.g., education is important not only in creating awareness about diseases but also in producing skilled human resources. The costing or needs assessment quantifies the needs in terms of human resources, infrastructure, and financial resources required to fully implement MKUKUTA by 2010 and attain the MDG targets by 2015.

The major focus of the costing exercise was on health aspects that contribute most to the burden of disease including child health and nutrition, maternal health, malaria, HIV/AIDS and TB. These are spelt out as specific goals and targets for Cluster 2 of MKUKUTA. According to MKUKUTA within the health sector emphasis would be placed on public health and primary preventive strategies; implementation of universal and cost-effective basic health services; critical issues of mortality and morbidity, including IMCI, nutrition, maternal health care/emergency obstetric care, malaria prevention and treatment, diarrhoea diseases, TB, HIV and AIDS, and accident victims from roads, railways, water transport and others.

It is not the intention of this PER study to assess or criticise the outcome of the costing exercise undertaken by ESRF. Rather, it adopts these estimates as the basis for making an assessment of the resource envelope required to finance key interventions in the health sector in the context of MKUKUTA. Based on various assumptions and methodology, details of which can be found in ESRF (2006), the resource requirements for FY07 and FY08 for the highlighted areas are shown in Table 10 below converted to Tanzanian shillings.

Table 10 Summary of ESRF costing figures for FY07 and FY08

	FY07		FY08	
	Scenario 1	Scenario 2	Scenario 1	Scenario 2
Malaria	78,966	74,389	80,632	71,630
HIV/AIDS	61,075	61,075	61,254	61,254
Maternal health	23,242	23,242	27,045	27,045
Child Health	4,482	4,150	4,603	3,946
TB	1,195	1,195	1,315	1,315
HRH	123,854	113,682	172,921	151,856
Health facilities	241,576	241,576	223,944	223,944
Total TSh m	**534,390**	**519,309**	**571,713**	**540,990**

Note: Scenario 1 assumes that prevalence rates for malaria and child health remain constant and can be seen as a high cost scenario, while Scenario 2 assumes that prevalence in these areas declines to reach 50% of its current level by 2015.

The first five of these areas correspond to technical programmes under the Department of Preventive services. Time has not permitted a full review of the current (FY06) budget for these areas in order to be able to compare the specific costing with the estimated resource requirements, but it is worth

pointing out the costs included in the ESRF estimation are direct costs only, ie attributable drugs and supplies for the interventions in these areas. Many of these fall outside the programme descriptions in the MTEF and it would be difficult if not impossible to separate them out from the Medical supplies and services budgets under both Preventive and Hospital Departments. In addition, much of the activity is undertaken at the council level, and there is no consolidated MTEF or analysis of the individual council health plans which would enable us to know the allocation of funds at that level to each of these areas.

Table 11 presents the resource requirements for FY08 under each costing scenario (Table 10) as a percentage of the two resource envelope projections in Tables 8 and 9.

Table 11 Proportion of resource envelope required to meet estimated MKUKUTA costs, FY08

		Resource requirements	
		Scenario 1	Scenario 2
Resource envelope	Base	92.6%	87.6%
	High	82.3%	77.9%

While this is only a very crude comparison, it is clear that **if** the costing are accurate and complete, and **if** the projections are realistic, then there would be some possibility of meeting the needs. However, additional information is required to separate out the "residual" running costs, and to more clearly analyse the detailed sector budget in the context of the costing.

It should however be noted here that: first, the analysis here is not exhaustive because what was costed is only part of the various important interventions needed in delivering health services. The focus of the ESRF costing exercise was on MKUKUTA targets and the required interventions to achieve these targets and thus other important interventions were not costed, making it difficult to provide a sector-wide resource requirements based on systematic costing. Second, as mentioned earlier, achieving various health outcomes requires interventions from other sectors and other players. Such requirements and their synergy with health sector interventions may be difficult to trace, leave alone estimating their costs.

8 Discussion and recommendations

8.1 Key findings from the analysis

8.1.1 The level and share of health sector spending

Section 3.1 indicates a rise in the budgeted sector share in FY06 over FY056 actuals, for the second year running. In addition, Section 3.2 showed that there has been a consistent increase in the absolute level of funding to the sector both in nominal and real terms. These achievements should be recognised and applauded. However, the FY06 share of the budget was still below the Abuja commitment of 15%, and had not yet retained its FY03 level, so stakeholders should not be complacent. In addition, the per capita level of spending in relation to international estimates of requirements remains low.

8.1.2 Spending in line with priorities

The MKUKUTA indicates that the Health Sector Strategic Plan will be implemented in full. This is clearly not possible given well-publicised constraints in both financial and human resources. Stated priorities in the sector therefore remain as in PRSP I, ie a focus on preventive services and the district health system, together with a focus on those particular health services addressing the MDGs (eg child health, maternal health, malaria, tuberculosis and HIV/AIDS).

Section 4 shows that spending in these areas shows mixed progress. Although both national and sector documents refer to a policy of decentralisation by devolution, the channelling of resources is still dominated by flows to the central level (MOHSW and PMO-RALG). Section 4.1 shows that the central level accounted for 68% of the FY06 budget, up 1% on the previous year. The crude analysis of recipient of headquarters recurrent GOT spending in Figure 5 that 44% of actual expenditure was classified as preventive and primary in FY05, compared with 42% in FY04, representing another step in the right direction.

An attempt to analyse spending on the MDG priority programmes was hampered by inconsistencies between MTEF content and coding, and reports as per the Itemised Daily Balances[13], Activity Implementation Report, and the Appropriation Account. As scaling up of and improving quality within these programmes have been designated as priorities within the priorities, this is an area which should arguably be included within the PER and budget analysis each year, ideally with some attempt also to separate out specific inputs in terms of drugs and supplies (eg family planning commodities, insecticide treated nets etc) which are sometimes but not always clearly identifiable in the MTEF, to provide a better picture of the absolute volume of funding, budget and expenditure share, and budget performance. This is not to deny the critical importance of systems strengthening more generally, but to highlight those activities directly related to MDG conditions.

A weakness of the existing planning and reporting systems is worth noting here. There is apparently no strategic vision for the MTEF period in terms of the projected progress in terms of the levels of the health system. This is not articulated in the HSSP or apparently in any other document in any comprehensive manner. For example, the relatively basic question in the context of devolution of what might be the projected share of the sector budget that should be channelled directly through LGAs by the end of the MTEF period cannot be answered. One of the Milestones agreed at the Review indicates exploration of the possibility of devolving 20% of the medical supplies and services budget to LGAs. This is clearly a step forward, but the overall picture would be more meaningful.

8.1.3 Off-budget external funding

In principle off-budget spending may be viewed as an efficient way of financing service delivery given the fears regarding the capacity of the central government to manage public resources and deliver services. However, the practice can be criticised on a number of grounds. First, off-budget spending undermines the budget process by weakening the incentives for good budget management if significant resources for public tasks are available outside the formal budget process. Second, off-budget projects are usually considered to reflect the views of the donors on priorities; but not necessarily the views of the country and of the beneficiaries. As a result there is lack of ownership by the country and beneficiaries, and ultimately a lack of sustainability of project outputs and impacts. Third, the management of projects often involves expensive technical assistance with no or very little transfer of knowledge to the local actors. Fourth, the distribution of projects is often skewed and thus inequitable in nature with some areas of the country being favoured and others almost totally neglected. The distribution of non-governmental and community-based organisations providing health support within the country bears witness to this. Such distribution of projects has implications in terms of the distribution of the health services in the country. Fifth, there is often a lack of consistency between the policies assumed by the projects and what policies really are; for example construction of health facilities on assumption that these would be maintained. Sixth, for projects that are executed by sector ministries, heavy transaction costs are supported by the government, which has to comply with financial management procedures specific to each donor.

The significant volume of off-budget external support captured in Section 6 raises concerns about the effectiveness of such mode of assistance given the criticisms/disadvantages of off-budget support discussed above. Given the concerns regarding the quality and completeness of the data, it is difficult to comment in depth. However, these concerns are well-documented, and measures are being taken to

[13] This is one of the available IFMS reports, which shows on a daily basis, the cumulative release and expenditure against each budget line for GOT funds, and for many in the Development budget.

improve the coverage of such information by housing the collation of information on external finance at the Poverty Reduction Budget Support/General Budget Support Secretariat, for onward forwarding to Government[14].

Further work is merited in the MOHSW itself to review the classification and coverage for the PER as there were some surprising entries in the current version of the Health database, eg for forestry, financial sector deepening, and the Primary Education Development Programme to name a few. The database includes funding channelled to private sector and non-governmental organisations. This update excluded those with no obvious health connection, and included all entries in the Health database with the exception of those clearly indicated as Basket funds. As indicated in Section 6 this may result in some double-counting. However, it is not currently possible to unpack expenditure data from the Appropriation Accounts due to combined reporting of multiple donors.

In terms of immediate improvement in this area, the key is to improve the "on-planning" and "on-budget" and in particular, the "on-report" coverage of external resources. More detail is given in Annex E, but essentially this refers to the accurate inclusion of as many sources of finance as possible in both national and council level planning and reporting documents (eg the MTEF and Comprehensive Council Health Plans), their aggregation to provide a comprehensive sector total, and the subsequent follow-up and financial reporting against budgets at the end of the financial year.

8.1.4 Health insurance schemes

The Health Financing workshop of May 2005 broadly endorsed a move to extend coverage of the Tanzania population through either social or community health insurance in order to pool risks and to remove the need for payment at the time of service. However, the PER findings reinforce previously raised concerns regarding both the National Health Insurance Fund and the Community Health Fund.

National Health Insurance Fund

The NHIF accounts for not only 8.4% of the total on-budget OC[15] through the transfer of recurrent funding from AGO on behalf of public servants to cover their membership, but in addition, a significant contribution is made through the MOHSW development budget for investment and running costs (TSh 1.155bn in FY06)[16]. This corresponds to a total share of the on-budget sector total of 5.1% in FY06.

Poor budget performance, in terms of the proportion of membership dues effectively available to health facilities (ie reimbursement of claims) fell to 25% in FY05 from 36% in FY04. Although captured within government budget figures as an increasingly significant contribution to the health sector resource envelope, in fact three-quarters of the recurrent government allocation to the NHIF is not currently reaching health facilities, and therefore not currently available to the sector at present. Not only is this a poor picture, but it also appears to be worsening, rather than improving as would be expected with a fledgling institution. Technical assistance is however currently being provided to NHIF to strengthen their performance in reimbursement of claims, and future PER updates should serve to monitor progress in this area.

It is not clear how the actual distribution of benefits under the NHIF is monitored for the purpose of accountability and consistency with government policy. Previous PERs have noted that spending is predominantly hospital-based rather than at primary levels, and in line with MKUKUTA goals of reducing inequalities, it would be good to have some regular analysis of the geographical distribution of benefits (in terms of claims reimbursed). A standing report from NHIF that goes beyond the annual balance sheet would seem appropriate. Failing that, pressure from MOH (as the Ministry responsible for oversight of the NHIF) for the organisation to facilitate the necessary information for inclusion in

[14] Personal communication, Jacqueline Mahon, SDC
[15] See Annex G Table 20 for PE:OC split in the recurrent budget
[16] In addition, the location of the Development funding under the Preventive sub-vote is somewhat misleading, as the majority of claims reimbursed are for curative services, at higher levels of the hospital system, ie contrary to MKUKUTA priorities.

the PER should be seen as a minimum to ensure accountability, and transparency and for the monitoring of spending in relation to priorities.

Community Health Fund
Yet again, it proved virtually impossible to obtain information on the revenues and expenditures of the CHF, necessitating a reliance of assumptions and extrapolations. The only readily available data available related to the matching grant, which has been identified as a small proportion of the total revenue. Again, this scheme absorbs not only the locally generated revenues but a significant volume of development funds.

In the same way that hospitals are required to report the HSF financial position for inclusion in the Appropriation Accounts, it is therefore recommended that LGAs should be required to report total revenues and expenditures under the CHF (and NHIF, for purposes of reconciliation). While this is in theory included in the Technical and Financial Implementation Report at the council level, it is neither clear nor consistent. It is therefore recommended that income and expenditure from the various different complementary financing mechanisms be clearly distinguished in both council and national level plans, budgets and reports, and that the proposed Unit at headquarters be held accountable for providing a complete and accurate annual national summary on an annual basis.

8.1.5 Comparison of tentative resource envelope with estimated requirements

The report recommends that these costings be compared with the MTEF to ensure that allocation of sector funds is in line with the priorities as reflected in these MDG/MKUKUTA goals. However, this is not yet possible due to a number of factors:

- Firstly, the MTEF reflects only MOHSW headquarter allocations to the technical programmes, and the full budget for FY07 is not available in detail
- Secondly, the MTEF does not, in the majority of cases, indicate the costs of the direct inputs, ie drugs and supplies, the financial requirements for which are explicitly brought out in the costing. Drugs and supplies are funded largely through GOT/basket funding at headquarters, but also through external funding to specific programmes which to date is not well reflected in the MTEF/budget documents. This would therefore necessitate an additional exercise to uncover these and compare with the costing. This could be combined with the planned drugs tracking study.

Another weakness in the planning and reporting system is worthy of note here, related to targets. Frequently technical programmes refer to having trained *x* health providers in one or other skill through in-service training. Details of how these necessary but rather small achievements are related to national coverage with an agreed intervention package is lacking, and would ideally be necessary to enable the costing to be used fully.

8.1.6 Health sector PER process and timing

The alteration in timing of the sectoral PER update exercise for FY06, to better fit with the proposed process for the cluster PERs, created some problems as it coincided with the final stages of budget preparation for FY2006/07. This meant that several key government officials were not available, and as a result some data that is usually used in the PER update either took a long time to source, or was not obtained at all. All data from the previous FY, ie FY2004/05 in this case, should have been available by December 2005 at the latest, and this would not be a problem if the process were either begun earlier, or was sufficiently institutionalised within the sector ministry to enable follow-up early in the calendar year.

The sectoral PER is a standing item at the Annual Joint Health Sector Review. The decision this year to move that review to September/October rather than April will clearly have implications for the PER as it is unlikely that the necessary data will be available in time to present a full picture within three months of the closing of the previous financial year. This means that expenditure data will be a year out of date while commentary on the new budget is generally undertaken through different means.

Health sector partners are therefore urged to review the purpose of the PER, and to consider when it might be timed both to provide the required information and to ensure that government officials are available. Based on previous experience, in terms of both accessibility of the necessary data, and competing claims on Task Team time, it would seem that November – March might be the most appropriate timing. This would enable the draft PER report to be discussed at the same forum as proposed for the draft MTEF, with arguably more scope for discussion of the details and a broader participation in the review and strengthening of the document. If this timeframe is agreed, early action to review the TORs and process and to initiate the exercise is also recommended.

8.2 Summary of recommendations

Recommendation	**Responsible**	**Time frame**
Ensure that the High Level Committee on health financing is functional, ie meeting regularly with visible outputs	Permanent Secretary	Immediate
Follow-up with Ministry of Finance re apparent failure to compensate Health forward budget for lack of World Bank funds (to be channelled through General Budget Support)	DPP	Immediate
Creation of a specific Unit within the DPP to handle complementary financing, ideally with focal persons for each separate financing scheme (eg HSF, CHF, NHIF, and Drug Revolving Fund (DRF) as a means of improving information in this area	Permanent Secretary	By end 2006
Annual report to be provided by NHIF showing clearly the distribution of claims on a geographic basis (ie by council) and by level (primary facilities, district hospitals, regional hospitals, referral hospitals, national and special hospitals)	Permanent Secretary	Immediate, by financial year
Incorporate reports on CHF, DRF and NHIF into the Appropriation Accounts as with HSF	DPP, Chief Accountant	Starting FY2006/07
Separation of each financing source within the TFIR at council level in order to permit consolidated reporting at national level	TBD	Starting FY2007/08
Further work to analyse all on-budget spending according to beneficiary level	DPP	Current FY
Preparation of a comprehensive MTEF, as has been the intention, to incorporate all external funding, on and off-budget	PS	Effective from FY2007/08
High Level Committee on health financing to review full sector MTEF (ie not MOHSW alone) and determine desired shares for central, regional and local government by end of period	High Level Committee	For FY08 MTEF
Review and analysis of the MOF External Finance database for the Health sector for completeness and accuracy, and to determine the extent to which off-budget spending is in line with MDG and MKUKUTA goals	DPP	As part of budget preparation for FY08
Initiate annual analysis of council level spending patterns both for budgets (ie using CCHPs) and for expenditure (ie using fourth quarter TFIRs)	District Health Services section	Immediate
Analysis of CCHPs and MTEF to enable a consistent comparison of ESRF costing with actual budgets	DPP	Within FY
Review timing and process of the PER to fit with agreed changes in the planning and monitoring cycle	DPP (Technical Sub-committee?)	Jul – Sep 06
On basis of decision on PER timing, initiate process for FY07 update (ensuring linkage with NHA)	DPP (Technical Sub-Committee)	Jul – Sep 06

9 Annexes

Annex A Scope of Work for the FY06 health sector PER update

Phase I (5 page briefing note to be circulated for the Joint Review)

a) Review the PER Health FY05 findings and actions taken by the Sector in response to those findings, indicating unaccomplished/pending actions and reasons as well as implications and the way forward. Identify follow-up actions planned in FY06
b) Analyse the recurrent and development budget performance for the past three-years (aggregate actuals vs budget)

Phase II (20 page report to be presented by 3rd July)

a) Establish trends of government allocation and expenditures to the health sector at sectoral and sub-sectoral level, including the central-local government split and specific health care interventions. This should include doing an analysis of the core/priority areas/items of expenditure as highlighted in the HSSP and MKUKUTA
    i) Assess whether and how far these trends reflect policy objectives with practical suggestions for improvement;
    ii) Review deviations in overall budget performance (budgeted, release vs actual expenditure) indicating clear justifications for such deviations and factors constraing the allocations of resources
b) Determine the extent of off budget spending and suggest way to improve coverage of this kind of spending within the budget.
c) Provide estimates to feed in to budget guidelines for 2007/08 including:
    i) Estimated resource envelope (all sources of financing on/off-budget, including revenues collected & retained in the health sector), high and medium scenarios
    ii) Compare the financial requirements for meeting MKUKUTA targets to projected resource availability for the sector (see f(i) above) and present options for restructuring expenditure to meet the targets. This should also take account of the "residual" required to cover normal running costs. Spell out the implications of these options and recommendations (e.g. scaling back targets, improving efficiency, mobilization of additional resources etc).

Annex B Disaggregated data as at 3 July 2006

	2002/2003		2003/04		2004/05		2005/06
	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
Recurrent							
Accountant General's Office							
National Health Insurance Fund	6,915,980,248	1,345,852,463	6,616,450,152	3,808,424,078	10,116,000,000	4,204,623,264	20,456,910,000
Ministry of Health							
Government funds	62,882,343,876	53,973,768,637	85,574,927,146	85,180,665,882	105,083,684,200	104,162,371,573	180,305,853,900
Donor basket fund	19,278,807,437	18,344,250,378	1,894,970,000	1,894,970,000	24,799,646,900	24,178,465,404	
Regional Administration							
Government funds	7,864,022,725	7,824,023,250	12,059,182,815	11,900,187,786	10,130,000,000	10,547,394,253	11,521,571,851
Local Government Authorities							
Government funds	43,675,425,300	43,547,660,000	48,856,234,400	46,486,660,711	63,587,000,000	68,800,402,413	75,081,381,900
Donor basket fund	13,985,290,180	13,929,707,343	17,280,582,064	17,280,582,063	18,697,480,120	18,697,480,120	20,074,739,000
Total recurrent	**154,601,869,766**	**138,965,262,071**	**172,282,346,577**	**166,551,490,520**	**232,413,811,220**	**230,590,737,028**	**307,440,456,651**
Development							
Ministry of Health							
Government funds	3,843,728,200	3,236,004,165	3,552,448,200	3,544,473,857	3,552,448,200	3,090,224,254	5,000,000,000
Donor basket fund	3,841,820,500	3,644,903,594	6,552,310,322	5,672,304,664	62,863,658,500	44,441,467,487	28,485,806,000
Foreign (non-basket)	26,383,612,500	22,145,113,823	32,177,406,600	32,218,274,915			57,376,942,400
PORALG							
Government funds			20,000,000	20,000,000	20,000,000	20,000,000	100,000,000
Donor basket fund			319,494,698	319,494,698	2,569,490,000	4,460,000,000	19,737,959,000
Foreign (non-basket)							19,837,959,000
Regions							
Government funds	535,986,500	491,986,173	569,592,400	569,364,563	1,159,000,000	1,134,000,000	1,169,269,600
Foreign (non-basket)	4,449,580,400	1,990,505,266	2,619,675,400	2,133,790,641	3,290,000,000	2,896,000,000	3,880,004,200
Local Government Authorities							
Government funds	1,745,061,300	1,702,878,300	2,307,387,800	2,316,388,600	2,409,000,000	2,357,000,000	2,579,453,200
Total development	**40,799,789,400**	**33,211,391,321**	**48,118,315,420**	**46,794,091,938**	**75,863,596,700**	**58,398,691,741**	**118,329,434,400**
Total on budget	**195,401,659,166**	**172,176,653,392**	**220,400,661,997**	**213,345,582,458**	**308,277,407,920**	**288,989,428,769**	**425,769,891,051**
Off budget expenditure							
Cost sharing							
Health Services Fund – Hospital		1,509,458,307	1,509,458,307	2,725,582,152	2,725,582,152	2,697,528,653	2,697,528,653
Community Health Fund – PHC		4,348,754,231	4,348,754,231	4,751,767,889	4,751,767,889	8,012,153,333	8,012,153,333
Other foreign funds	49,254,970,437	46,478,731,233	65,956,600,429	40,348,092,685	97,423,057,035	122,912,095,705	94,483,467,268
Total off budget	**49,254,970,437**	**52,336,943,772**	**71,814,812,968**	**47,825,442,726**	**104,900,407,076**	**133,621,777,691**	**105,193,149,254**
Grand total	**244,656,629,603**	**224,513,597,164**	**292,215,474,965**	**261,171,025,184**	**413,177,814,996**	**422,611,206,460**	**530,963,040,305**

Notes: Light shaded areas indicate figures where queries remain; bright shaded areas represent outstanding gaps.

Annex C Main data sources and notes

Limited changes have been made to data from FY03 and FY04 since the last PER update. Sources of (on-budget) data for FY05 and FY06 are indicated in the table below, presented in the order in which the different components of the sector appear in the table in Annex A. Comments and outstanding queries are also included in the table.

Data	Year(s)	Source	Comments
Recurrent funding			
Accountant General's Office – National Health Insurance Fund	Estimates FY06 and Approved estimates FY05	Estimates Book FY06 Vol II	
	Actual expenditure FY05	FY05 Budget Execution Report Annex F page xv	Rounded to the nearest million
MOHSW – government funds	Approved estimates and Actual expenditure FY05	MOH Appropriation Accounts for FY05	Slight difference between Appropriation Account and IFMS Platinum figures for expenditure
	Estimates FY06	Estimates Book FY06 Vol II	
MOHSW – donor basket fund	Approved estimates and Actual expenditure FY05	MOH Appropriation Accounts for FY05	Slight difference between Appropriation Account and IFMS Platinum figures for expenditure
Regions – government funds	Approved estimates FY05	FY05 Budget Execution Report, Annex E page xiv	
	Actual expenditure FY05	File from MOF (**\Afya 2005)**	
	Estimates FY06	MOF summary table of priority sector spending FY06	Provided to PER consultant
Local Government Authorities – government funds	Approved estimates FY05	FY05 Budget Execution Report, Annex E page xiv	
	Actual expenditure FY05	File from MOF **(\Afya 2005**)	Differs from figures in the CD/webfile on local government spending which indicates TSh 68.8 bn – *for clarification*
	Estimates FY06	MOF summary table of priority sector spending FY06	Provided to PER consultant
LGA – donor basket fund	Approved estimates FY05	Basket Financing Committee documents	
	Actual expenditure FY05	Disbursement assumed equal to expenditure in absence of expd data	Final release made in Q1 of FY06 resulting in divergence with data provided by MOF. Financial regulations provide for expenditure within Q1 of subsequent FY. Delay due to late request by MOHSW.
	Estimates FY06	Basket Financing Committee documents	
Development spending			
MOHSW – local	Approved estimates and Actual expenditure FY05	MOHSW Appropriation Accounts FY05	Figure for Actual expenditure corrected for minor error in original (TUKUTA)
	Estimates FY06	Kitabu cha Nne FY06	
MOHSW – foreign	Approved estimates and Actual expenditure FY05	MOHSW Appropriation Accounts FY05	Similar adjustment to TUKUTA figures (indicated as foreign when in fact local). Includes all foreign less recurrent basket.
	Estimates FY06	Kitabu cha Nne FY06	
PMO-RALG – local	Approved estimates and Actual expenditure FY05	FY05 Budget Execution Report	
	Estimates FY06	Kitabu cha Nne FY06	
PMO-RALG – foreign	Approved estimates FY05	Kitabu cha Nne FY06	Differs from both PMO-RALG Appropriation Account figure provided to PER Consultant and the MOF summary table \Afya 2005, even after deduction of LGA basket funding – *for clarification*
	Actual expenditure FY05	Document from PMO-RALG on status of DHIRC FY05	Differs from Appropriation Account and MOF summary – *for clarification*

Data	Year(s)	Source	Comments
	Estimates FY06	Kitabu cha Nne FY06	Does not tally with figures from Basket Financing Committee – *for clarification*
Regions - local	Approved estimates and Actual expenditure FY05	File from MOF (**\Afya 2005**)	
	Estimates FY06	Kitabu cha Nne FY06	
Regions – foreign	Approved estimates and Actual expenditure FY05	File from MOF (**\Afya 2005**)	
	Estimates FY06	Kitabu cha Nne FY06	
LGAs – local	Approved estimates FY05	FY05 Budget Execution Report Annex E page xiv	Does not tally with the sum of individual LGA allocations obtained from Vol III Estimates (appendix) for FY06
	Actual expenditure FY05	FY05 Budget Execution Report Annex F page xv	Does not tally with data on CD "Local government
	Estimates FY06	Kitabu cha Nne FY06	

Specific notes, queries and assumptions made

Table 15 and Figure 6 Breakdown by category

In calculating the Hospital PE/OC breakdown for the larger hospitals, the total PE expenditure to the hospitals which was given only as a lump sum in the Expenditure Allocation file, was distributed pro rata with the shares given in the original MTEF. The total expenditure for each institution was taken from the Appropriation Accounts which detail each transfer but the actual split between PE and OC may therefore not be accurate.

We were unable this year to obtain actual LGA expenditure data, disaggregated both by subvote and by PE/OC. In calculating the breakdown at that level, we therefore applied the shares obtained from the FY05 Approved Estimates (in Vol III Appendix for FY06) to the total of spending at that level. This may also therefore not be a correct reflection of the intra-sectoral breakdown at LGA level.

Section 7.2 on MDG programmes

It had been hoped to map the MTEF budget figures on to expenditure figures from the Activity Implementation Report and the Itemised Daily Balances (IDB), these being the only forms of reporting available to us which give the activity codes. However, there were inconsistencies in a few cases between the MTEF and IDB coding, which means that we cannot be completely sure that we have captured fully the spending related to those activities. For EPI, we therefore excluded other activities bar purchase of vaccines, which we included despite inconsistent activity coding as it was the only activity using that sub-item.

Annex D Further discussion and concerns re on- and off-budget external funding[17]

On plan	Incorporated in planning documents. For the health sector, the MTEF serves as the annual plan, although this is not very satisfactory, not least as it gives no picture of the significant spending at the LGA level. No aggregation is undertaken of proposed spending at the council level which could be used to monitor against total planned sectoral planned activities.
On-budget	This is taken to refer to information captured within the official budget estimates (ie as submitted to the National Assembly). Ideally, there would be congruence between these and the MTEF. However, at present there is inconsistency in the presentation with some foreign spending included in the (recurrent) MTEF, other in the development MTEF and some not captured. Although the block grant and basket funding for councils is included in the central level budgets, there are other (notably external) resources which are included in the Comprehensive Council Health Plans and budgets which do not get reflected in the total sector budget. This situation may be improved with the further development and utilisation of PlanRep.
On Treasury	Funding passing through the Exchequer, and therefore channelled fully in harmony with GOT systems. Domestic resources and General budget support are "on-Treasury" resources.
On account	Funding which, regardless of whether it passes through the Treasury or not, is incorporated in financial reporting of the sector. Again, there is discord between central and LGA levels, with the Council TFIR in theory providing information on all sources of funding, rather than only those which are channelled through central line ministries and thus captured in the official budget estimates.
On report	Funding which, even if not captured in the official government accounts system, are reported on within the regular monitoring documents of the sector, ie through the Technical and Financial Implementation Reports at central and council level in the case of Tanzania.

Ideally, all external funds for the sector should be captured **on-plan** and **on-report**, even if not on-budget, on-Treasury or on-account. This would at least represent an improved starting point for ensuring that such resources are contributing to sector objectives, are considered when assessing funding gaps, and are monitored in terms of actual disbursements and expenditure as opposed to just budget.

During the attempted analysis of programmatic areas, it was clear that problems remain in the segment coding of activities, with the same codes duplicated in the recurrent and development sections of the MTEF, while reflecting different activities. This is confusing. One recommendation for strengthening the MTEF, ideally to be carried through to the External Finance database (which suffers from poor categorisation of projects[18]), would be to have a single, mutually exclusive list of segment codes per area. The source of funding is indicated elsewhere in the IFMS codes, and although the current distinction between recurrent and development is also unhelpful, being based largely on funding being external, this could provide the basis for inclusion in the recurrent or development section of the MTEF. At present, there is a mix of "on-budget and on-Treasury", and "on-budget but off-Treasury" or "on-budget but off-account" spending included in the MTEF. Even the IFMS appears to be complete only for GOT and JD, with other external funding sometimes reported and sometimes excluded as "direct to project".

[17] This section draws on definitions taken from E Pavignani, S Sjolander and D Aarnes (2002). *Moving on-budget in the health sector of Mozambique*. Unpublished report. December 2002.

[18] For example, on the original list obtained from MOF, activities related to forestry, the Primary Education Development Programme, and financial sector deepening, among others, were all included on the database under Health.

Annex E Complementary financing

Health Service Fund

The MOH Appropriation Accounts include information on the cost-sharing revenues collected and spent at public hospitals, known as the Health Service Fund. The data indicate the following total for FY2004/05, presented together with the figures from the previous year.

Table 12 Health Service Fund summary data

	Balance Brought Forward	Revenue	Expenditure	Closing balance 30th June 2005
2004/05	2,226,415,485.40	2,974,371,343.48	2,697,528,652.88	2,503,258,176.00
2003/04	1,788,475,204.59	3,082,288,980.37	2,725,582,151.76	2,145,182,033.20

The PER estimates for HSF in the coming year, in the absence of any projections from within the health sector, have been assumed equivalent to actual expenditure in the previous year. However, in FY2004/05, for the first time, both revenues and reported actual expenditure are actually less than in the previous year[19]. This may be due to incomplete information, or to better functioning of the exemption and waiver system in the light of recent attention, but in the absence of any additional information, it is impossible to state the cause. It does, however, indicate a need to better monitor cost-sharing revenues, as some explanation for a reduction is warranted.

Community Health Fund

As is generally the case, it has not been possible to obtain a full picture of revenues nor expenditures under the CHF. However, limited data was available on the value of membership funds received in a few councils, 12 in FY05 and 25 in the first half of FY06, proxied by their requests for matching grant funding provided through the Basket. This is shown in Table 4 below.

Table 13 Council requests for CHF matching grant funding

FY2004/05		FY2005/06 (to December)	
Council	**Matching grant paid**	**Council**	**Claims deemed complete**
Igunga	32,980,000	Igunga	22,685,000
Singida	39,374,000	Singida	22,350,000
Nzega	16,190,000	Iramba	30,860,000
Songea	56,772,000	Rombo	36,661,500
Hanang	9,400,000	Newala	5,060,000
Iringa	35,120,000	Sengerema	6,500,000
Mwanga	16,205,000	Geita	7,220,000
Masasi	80,000,000	Serengeti	14,965,000
Sumbawanga	19,255,000	Manyoni	14,615,000
Mbulu	16,782,000	Kasulu	11,554,500
Mufindi	7,910,000	Kigoma	8,405,000
Kigoma	13,390,000	Babati	7,520,000
		Shinyanga	23,140,000
		Mpwapwa	4,235,000
Total	**343,378,000**	**Total**	**215,771,000**

This is undoubtedly an underestimate of revenues raised, not least as the majority of funds generated in councils implementing the CHF tend to arise from user fees paid by non-members. No explanation has been obtained to date on why there is no equivalent data from all implementing councils which would be an improvement on the consistently poor reporting in this particular area.

[19] It is also of note that the Balance brought forward for FY2004/05 is higher than the closing balance from FY2003/04, which also merits further examination.

Annex F Estimation of resource envelope for FY08

Annex F Table 14 gives the composition of the summary estimates of the sector resource envelope for FY08.

Table 14 FY08 base projections - details

	FY06	FY07	FY08
Rec			
AGO	20,457	30,000	34,756
MOHSW	180,306	202,628	211,961
Regions	11,522	18,978	21,591
LGAs - GOT	75,325	119,414	138,281
Health basket	19,638	22,242	22,844
Devt			
MOHSW - total	90,863	85,841	50,164
PMORALG	19,838	41,633	25,081
Regions	5,049	4,238	3,567
LGAs - GOT	1,428	1,470	1,631
Total - on-budget	**424,425**	**526,444**	**509,876**
Off budget			
HSF	2,698	2,832	2,974
CHF	8,012	8,813	9,695
Off-budget external	94,483	95,000	95,000
Total - off-budget	**105,193**	**106,646**	**107,669**
TOTAL Projected RE	**529,619**	**633,090**	**617,544**

FY06 - figures are taken from the Master table reproduced in Annex B.

FY07 - by row

- The figure for the AGO allocation to NHIF are estimated at 3% of the wages and salaries figure for the entire budget, taken from Table 3a p 72 of the Budget guidelines for FY06.
- MOHSW recurrent is taken from the same source, Table 4a on p 75.
- Regional health allocations are taken from Vol III Estimates for FY07 as submitted to National Assembly, as is the GOT block grant allocation to the LGAs
- Health basket (LGAs) is taken from the LGA Budget guidelines, Table 4.1 p 33
- MOHSW development is taken from Budget Guidelines, Table 4b, p 80
- PMO-RALG development -
- Regional development, extrapolated from the FY06 share of the regional development budget and applied to the overall Regional total from the Budget Guidelines
- LGA development, estimated at 25% of the LGDP capital grant as no other source found. This results in a drop from the present level. LGDPCG is intended, as per LGA Budget guidelines to be channelled to activities in a limited number of sectors of which health is one. 25% chosen bearing in mind government commitment to expand infrastructure substantially
- HSF – 5% annual increase
- CHF – 10% annual increase
- Off-budget external – held constant at around the FY06 level, on assumption that more might be channelled through budget (though concerns around low FY08 projection need to be clarified)

FY08 – As for FY07 except where stated below

- Regions recurrent – based on health sector share of total in FY07
- PMO-RALG – (unchecked)

Some issues for clarification: When does the IDA support switch from sector to general budget support? There is a substantial drop in the FY08 foreign development funding to MOHSW in the Budget Guidelines, but if this is due to the reduction in IDA support, it should be compensated for in the recurrent budget. If not, is it just due to poor projections and/or the short-term nature of commitments?

Annex G Additional tables and figures

Table 15 Breakdown by category, FY03 – FY05 (TSh bn)

	FY03			FY04			FY05		
	PE	OC	Total	PE	OC	Total	PE	OC	Total
Administration									
MOH headquarters	3.79	7.95	11.75	4.63	11.59	16.22	5.34	14.93	20.27
NIMR	1.59	0.35	1.95	1.73	0.91	2.64	2.09	0.76	2.86
TFNC	0.66	0.22	0.88	0.72	0.48	1.20	0.69	0.53	1.22
Sub-total Administration	**6.05**	**8.52**	**14.57**	**7.07**	**12.99**	**20.06**	**8.13**	**16.22**	**24.35**
Hospitals									
Muhimbili National Hospital	5.36	1.75	7.11	5.41	6.92	12.33	7.02	5.27	12.28
Muhimbili Orthopaedic Institute	1.53	0.85	2.38	1.62	1.16	2.78	1.81	1.61	3.43
Ocean Road Cancer Institute	0.35	0.40	0.75	0.40	0.75	1.16	0.45	1.06	1.51
Bugando Medical Centre	0.94	1.09	2.04	1.14	1.44	2.59	1.34	1.62	2.96
Kilimanjaro Christian Medical Centre	1.48	0.63	2.11	1.70	1.29	2.99	2.10	1.22	3.32
Referral hospitals, MoH *	-	-	0.87		1.76	1.76		2.24	2.24
Regional hospitals	5.69	1.83	7.52	6.89	5.34	12.22	7.64	6.26	13.90
District hospitals	6.54	2.66	9.20	8.00	8.32	16.31	10.05	11.98	22.03
Designated District Hospitals	3.43	1.19	4.62	3.60	2.58	6.18	4.80	1.86	6.66
Voluntary Agencies - Hospital	2.32	-	2.32	2.37	0.20	2.56	4.52	0.62	5.14
TPDF and unspecified								3.84	3.84
Sub-total Hospitals	**27.65**	**10.41**	**38.06**	**31.13**	**29.76**	**60.88**	**39.72**	**37.59**	**77.31**
Preventive/Primary health care									
MoH preventive services	0.30	5.89	6.19	0.34	12.32	12.67	0.44	11.93	12.37
Regional preventive services	0.15	0.15	0.30	0.17	2.67	2.85	0.20	0.14	0.34
Council preventive	23.40	11.08	34.47	25.22	18.80	44.02	36.30	30.06	66.36
Sub-total Preventive/Primary	**23.85**	**17.12**	**40.97**	**25.74**	**33.79**	**59.53**	**36.93**	**42.14**	**79.07**
Total GOT Health recurrent			**93.60**			**140.48**			**180.72**

Table 16 Regional budget performance, FY05

	Approved Estimates FY05			Actual expenditure FY05		
	PE	OC	Total	PE	OC	Total
Curative	7,104,797,598	2,369,914,726	**9,501,589,988**	7,067,626,099	2,324,671,071	**9,418,985,957**
Preventive	167,504,564	403,468,023	**804,869,083**	163,968,419	122,648,901	**520,295,255**
Sub-total	**7,272,302,162**	**2,773,382,749**	**11,743,378,670**	**7,231,594,518**	**2,447,319,973**	**11,368,979,359**

Note. The totals are shaded as they are based on calculation from the individual (incomplete) regional figures given. They differ from the totals as provided by PMO-RALG.

Table 17 Hospital budget performance, FY05

	Approved estimates FY05	Expenditure FY05	Expd as % Bgt
Mbeya Referral Hospital	512,365,800	512,365,800	100%
Mirembe and Isanga Institution	378,708,800	378,708,800	100%
Kibongoto Hospital	330,750,000	330,750,000	100%
Muhimbili National Hospital	11,428,117,996	11,428,117,976	100%
Muhimbili Orthopaedic Institute	3,043,218,700	3,043,218,700	100%
Ocean Road Cancer Institute	1,125,661,380	1,125,661,380	100%
Kilimanjaro Christian Medical Centre	2,846,371,480	2,846,371,480	100%
Voluntary Agencies - Hospital	5,228,913,984	5,139,481,844	98%
Designated District Hospital	5,846,424,176	5,846,424,176	100%
Bugando Medical Centre	2,358,869,868	2,358,869,868	100%

Table 18 National Health Insurance Fund data, TSh

	FY03	FY04	FY05	FY06
Budget	6,915,980,248	6,616,450,152	10,116,000,000	20,456,910,000
AGO release	5,525,000,000	10,563,724,111	16,534,000,000	
Reimbursements	1,345,852,463	3,808,424,078	4,204,623,264	

Table 19 Incomplete Basket funding projections, FY07 – FY09

Funding organisation		FY06/07		FY07/08		FY08/09 *Indicative*	
		Donor currency (millions)	USD millions	Donor currency (millions)	USD millions	Donor currency (millions)	USD millions
CIDA		Can $3.0	2.69	Can $2.0	1.79	Can $ 2.0	1.79
Danida	centre	DKK 8.0	1.3	DKK 8.0	1.3	DKK 8.0	1.3
	district	DKK 47.9	7.6	DKK 49.3	7.8	DKK 50.8	8
	rehab	DKK 10.3	1.6	DKK 11.1	1.8	DKK 11.6	1.8
Ireland		Euro 5.85	7.45	Euro 5.85	7.45	TBD	
Netherlands		Euro 7.00	8.92	Euro 7.0	8.92	TBD	
SDC		CHF 6.0	4.6	CHF 5.4	4.2	TBD	
KFW		Euro 2.0	2.54	Euro 4.48	4.48	Euro 3.5	4.48
World Bank/GOT		USD 13.8	13.8			-	
UNFPA		USD 0.6	0.6	USD 0.6	0.6	TBD	
Total Pool			**51.1**		**38.34**		**17.37**

Table 20 Share of PEs in the sector recurrent budget, FY06

	PE	OC	Total
AGO		20,456,910,000	**20,456,910,000**
MOH HQ - GOT	6,406,945,700	173,898,908,200	**180,305,853,900**
Regional Administration - GOT	9,059,119,300	2,462,452,551	**11,521,571,851**
LGA - government	47,978,500,500	27,102,881,400	**75,081,381,900**
LGA - basket		20,074,739,000	**20,074,739,000**
Total recurrent	**63,444,565,500**	**243,995,891,151**	**307,440,456,651**
% split	*20.6%*	*79.4%*	