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Ministry of Health

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Health sector PER update FY 2003

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Acronyms

AIDS	acquired immuno-deficiency syndrome
AMMP	Adult Morbidity and Mortality Project
CMH	Commission on Macroeconomics and Health (WHO)
DANIDA	Danish International Development Agency
DFID	Department for International Development (UK)
DDH	Designated District Hospital
DPS	Department of Preventive Services (MOH)
DRE	Discretionary Recurrent Expenditure
ESRF	Economic and Social Research Foundation
FY	financial year (1 July to 30 June)
FY03	1 July 2002 to 30 June 2003
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
HIV	human immunodeficiency virus
HSD	Hospital Services Department
HSSP	health Sector Support Programme (DANIDA)
IFMS	Integrated Financial Management System
IMR	infant mortality rate
JD	joint disbursement (donor basket funds)
LG	local government
LGA	Local Government Authorities
LGRP	Local Government Reform Programme
MDA	ministries, departments, agencies (government)
MNH	Muhimbili National Hospital
MOH	Ministry of Health
MOF	Ministry of Finance
MSD	Medical Stores Department
NACP	National AIDS Control Programme
NIMR	National Institute for Medical Research
OC	other charges
PE	personnel emoluments
PER	Public Expenditure Review
PORALG	President's Office, Regional and Local Government
PRBS	Poverty Reduction Budget Support
PRS	Poverty Reduction Strategy
REPOA	Research into Poverty Alleviation
SDC	Swiss Agency for Development and Cooperation
TEHIP	Tanzania Essential Health Interventions Project
TFNC	Tanzania food and Nutrition Centre
TMAP	Tanzania Multi-country AIDS Project
TSh	Tanzanian shilling
TORs	terms of reference
U5MR	under-five mortality rate
VA	voluntary agency
WHO	World Health Organisation

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The health sector PER update for FY03 was undertaken by a Task team, supported by colleagues from the Ministries of Health, Finance, President's Office – Regional and Local Government, and President's Office – Planning and Privatisation Commission. An external consultant health economist, Ms Sally Lake, was contracted by the Swiss Agency for Development and Cooperation through Health and Life Sciences Partnership (UK) to support the process.

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In addition, we would like to recognise the useful input from the members of the Sector Working Group (also known as the Sub-committee on Plans, Budgets, Reviews, Monitoring and Evaluation) who provided comments on various drafts and made useful suggestions for further work.

Executive Summary

The Public Expenditure Review health sector update for the financial year 2002/03 (FY03) was undertaken by a Task Team from the Ministry of Health (MOH), with support from other colleagues in the Ministry, officials from the President's Office – Planning and Privatisation Commission, President's Office – Regional and Local Government (PORALG), and the Ministry of Finance. An external consultant provided additional support to the Task Team. Terms of Reference (TOR) were adapted from the generic TORs provided by the PER Working Group. The process was delayed due to various factors and data collection was split between December 2002 and January 2003. Unlike previous updates, no primary data collection was undertaken.

As was the case in 2002, the PER update for FY03 does not go into depth on the background related to the Poverty Reduction Strategy Paper (PRSP), the Medium Term Expenditure Framework (MTEF), the health sector reform process and sectoral strategy, and the interested reader is referred back to the comprehensive PER report for FY01 for details of this policy framework. Instead, the health sector PER update for FY03 concentrates on providing updated information on the following areas:

- An overview of the key trends in health sector income and expenditure, with breakdowns by source of funds (domestic, foreign), by type (on-, off-budget), by level (central, regional, local government), and by expenditure category (eg medical supplies and services, HIV/AIDS spending). It also includes some analysis of the Development budget;
- A brief exploration of spending at the Local Government Authority (LGA) level, both in terms of the level of health spending compared to total LGA budgets, and by geographical area, with local LGA subventions summarised by region and compared with population figures and poverty levels;
- A review of sectoral performance in relation to stated PRS objectives regarding pending on Primary Health, and in terms of the sector's own finance-related performance indicators;
- A summary of available information on future costs and revenues, in order to inform development of the budget and MTEF for FY04 onwards. This section does not include the detailed costing of priority programmes as was requested in the TORs due to the lack of time for such a sophisticated exercise, but it uses recent information prepared by selected priority programmes to indicate the potential order of magnitude of future resource requirements.
- Summary of key recommendations and possible next steps for strengthening the current budgetary/review process and for future work.

The main objectives of the PER update for FY03, as identified in the TOR, included the following:

- To strengthen government ownership and sector participation in the PER process;
- To improve quality and timing of PER outputs;
- To improve ex ante coverage of programme support and donor-funded projects in the Government budget;
- To provide support to the implementation and monitoring of the Tanzania Poverty Reduction Strategy;
- To undertake pieces of analytical work to inform fiscal policy dialogue on Tanzania's revenue effort, tracking expenditure and service delivery, coherence of the development budget with PRS priorities, and fiscal risks associated with the drive towards more budget support.

It was not possible to meet all these objectives, and in particular the others not mentioned here (for which see the TORs in Annex A) due to a number of constraints. Notable among these we would include:

- Delays in the arrival of the external consultant due to in-country procedural hurdles;
- Failure by the MOH Task Team to undertake any substantial data collection prior to the arrival of the external consultant;
- Delays in completion of, or subsequent revision to, MOH documents such as the Appropriation Accounts for FY02;
- Non-availability of most of the Task Team throughout the process due to leave, other priority activities, or lack of financial incentives such as extra duty allowance (even though this was included in the MTEF and budget);
- Timing which cut across several public holidays, including the Christmas/New Year period, and key meetings, such as the main Consultative Group meeting in December, thereby limiting the availability of key individuals;

and, as a result;

- Limited personnel and time with which to perform the necessary data collection, input, analysis and report writing.

The key findings below summarise what was feasible given the above constraints. It is hoped that they will contribute to the ongoing debate among MOH, Ministry of Finance, PORALG and development partners regarding past budgetary and expenditure performance, the extent to which resource allocation within the sector meets priorities, and assessment of the desired future direction.

Key findings

Overall trends

In terms of total public expenditure in the sector, there has been an disappointing increase in the share of the health budget over few years since the publication of the PRS, from 7.5% in FY00 to an estimated 8.7% in FY03 (Figure 1), only 0.2% of this occurring in the last two years. Expenditures continue to fall below budget estimates, but have also risen from 6.6% to 8.3% between FY00 and FY02. In addition to moving only slowly in the desired direction, these figures are still relatively low given the importance of the health sector in both human and economic development, and also relative to the target of 15% of government budget agreed in Abuja in 2001. In terms of adjusted Discretionary Recurrent Expenditure, the picture is slightly more encouraging, at a budgeted 12.5% in FY03 compared to 10.8% in FY02 (Figure 2).

There has been a continued downward trend, in both budget and expenditure, in the share of domestic funding in the on-budget total. This is largely due to the growth in the donor basket, to an estimated 24% of total planned on-budget spending and 28% of the recurrent budget in FY03 (Figure 4), which has enabled GOT to direct resources elsewhere. With the progressive move to general budget support, this lays the sector open to the risks of being unable to maintain expenditure at the current level without a shift from GOT/budget support resources back into the sector in the future.

In terms of spending by level, the trend of increasing financial subventions to Local Government Authorities (LGAs) for health spending from FY99 to FY01 has since been reversed, with a fall in budget estimates from 32.1% to 31% of total on-budget estimates between FY01 and FY03, and from 36% to 34.5% in actual expenditures between FY01 and FY02 (figures 6 and 7). This has benefited the central level, and suggested a reversal of the stated PRS objectives of getting a greater share of funds to the operational level. It should be noted however, that transfers in kind continue to grow.

The data on spending by type, ie the Preventive/Hospital/Admin split, is subject to some query. However, the preliminary analysis suggests that the largest increase over the past year was seen in Preventive spending last year, reaching 37.2%, and compared to growth of 29% in spending on central level administration and 1.9% on Hospital services (Table 3 and Figure 8). This is encouraging in terms of the intra-sectoral allocation of resources, given the long-standing calls for increased emphasis on preventive activities. Discussion on the usefulness of this Preventive/Hospital split continues.

The share of the recurrent budget has continued to rise as a percentage of the on-budget total, reaching 79% of the FY03 budget, and 83% of the FY02 expenditure (Table 4). This is largely due to the increasing share of the basket, and the fact that the majority of basket spending is accounted for through the recurrent budget. Useful analysis of the recurrent/development budget split requires a more systematic assessment of what type of activity development spending actually funds.

The share of on-budget spending has continued to rise, largely as a result of the concerted effort by MOH and MOF to improve information on external funding to the sector, and to capture a higher proportion of the total within budgetary estimates, and through improvements in the planning and budgeting process as the MTEF becomes a more familiar tool. On-budget estimates rose dramatically from 69.5% to 79.3% of the FY03 budget, while in terms of actual expenditure the figure rose from 57.3% to 62.4% between FY01 and FY02 (Figure 9).

Budget allocations, releases and expenditures continue to improve at the central level, both in terms of GOT funding and the basket, with 98% release of GOT funding and 83% of basket, excluding procurement in FY02 (Table 5). In terms of expenditure, over 99% of GOT releases were spent, while the figure of 86.6% of expenditure of basket funds represents a substantial improvement on the figure of 47% in FY01.

There has been a significant increase in spending on drugs and supplies (34%, Table 6), one of the areas targeted for expenditure in the text of the PRS. The increase has been slightly higher in terms of spending on drugs and supplies for the Local Government priority level (36%, Table 15). However, there was a significant difference between the increase in government spending (7.6%) and spending through the central basket (83%), which needs to be carefully considered during the budget preparation for FY04 given the uncertainties regarding the future of the central level basket. The majority of hospital drug allocations in FY02 (57%) went to facilities at the district level (Table 8). There are large per capita variations in hospital drug allocation by region which would benefit from further exploration (Figure 9).

Spending on HIV/AIDS occurs both through the MOH recurrent and development budgets, and through off-budget expenditure both within and outside the sector, and more analysis is required to adequately compile this. However, a preliminary analysis shows a substantial increase in spending from the central level basket, on both Preventive and Hospital Services. The allocation of GOT funds to the National AIDS Control Programme was only 3.7% in FY03 (Table 9). At local government level, all LGAs had assigned funds for HIV/AIDS plans in their budgets, although at a very low level of total LGA health OC spending, but there has been a substantial rise between FY02 and FY03 (Table 10).

A limited analysis of the MOF External Finance database indicated that less than half (46%) of external financing in FY03 was captured in the budget, and that over 75% of projects in the sector are implemented through the MOH. Basket funding accounted for 40% of the total external funding, while HIV/AIDS, TB and Malaria accounted for only 7.2% of the FY03 allocation. The locally-financed MOH Development budget covers a number of infrastructure rehabilitation projects, seen as a strategy for achieving PRS targets. Further analysis should

be undertaken of the Development budget, in order to reconcile spending figures both with the MOF database, and with PRS targets.

District/Local Government

There has been a very small increase in the level of health budgets at LGA level, with health rising only from 17.6% to 17.7% of total LGA budgets between FY01 and FY03, with very little difference between urban and rural councils. Looking only at OCs, the figure for FY03 is 24.4% of total LGA OCs, with district councils allocating a slightly higher share than urban councils (Figure 13). Comparison with FY02 was not feasible. These figures disguise wide variations between councils which it would be interesting to explore further.

In general, releases matched budgets for FY02, with only 8 of the 115 districts receiving a different amount. No justification could be found for this variation which again would benefit from further exploration.

The mean per capita allocation (PE and OC) for Tanzania mainland for health spending at LGA level was calculated at TSh 1,288 in FY03, up 19% from TSh 1,079 in FY02 (although these figures would be more usefully presented in US dollars). The range varies for FY03 from TSh786 in Kagera to TSh2,708 in Coast. There appears to be no correlation between regional poverty levels and LGA allocations, total or OC, and the picture appears to have worsened between FY02 and FY03 (Table 15).

Moves have been made in the sector to define a more objective, transparent resource allocation formula for allocating funds across the region and councils, and parallel activities have been undertaken under the Local Government Reform Programme. It remains to be seen what decisions will be taken in the future, but standard baseline figures should be developed in order to monitor progress over time towards a stated equity target.

Sector performance

Health sector performance in relation to stated PRS priorities was analysed for government spending only, and further analysis should be undertaken of basket and other foreign funding within the total in order to obtain a clearer picture of the whole sector. For government spending there was a mixed picture (Table 15). The absolute level of spending on Primary health has increased by 184% between FY00 (actual spending of TSh 11.69 bn) and FY03 (budget estimates of TSh 33.24 bn). However, as a share of government spending in the sector, the FY03 estimates represent a slight fall from 30.1% to 28.2% implying a change in implicit priorities. There has been a slight increase in the share of Primary Health within Discretionary Recurrent Expenditure (Figure 14).

In terms of finance-related performance indicators for the sector, there have been improvements in nominal per capita GOT allocations at the central, regional and district level, in total per capita health spend, and in per capita GOT recurrent spend by level, with the largest increase in per capita preventive spending at 37.6% (Table 16). A slight fall in % funds for LGA health activities is noted. It was impossible to calculate the indicator for cost-sharing performance.

Future costs and revenues

Information on future costs and revenues remains one of the weaker parts of the PER. No detailed costing has yet been undertaken, and this remains a subject for discussion among partners. The objective of such a costing must be clear prior to undertaking such a time-consuming and costly exercise, and the political will to accept and to act upon the findings thereof must be there. Estimates from four priority programmes indicate that if their

requirements were met, they would absorb almost 25% of the total sectoral resource envelope (on and off-budget) for FY03.

The picture regarding revenues is gradually improving, particularly with respect to foreign funding, as the database developed by the Mnistry of Finance improves in accuracy and completeness, but there is still some way to go. Concerns regarding the future level of basket funding for the central level, and the extent to which shortfalls will be offset by general budget support remain for the period beyond FY04.

Recommendations and next steps

A number of recommendations and next steps are outlined in Section 6 of the report. Key among them is the need to better institutionalise the process of the PER within the MOH in terms of actual commitment and involvement, and reduced dependence on external support. A clear articulation of the information needs, shared among parties within the sector (MOH, PORALG, MSD etc) and timetable for undertaking smaller pieces of analysis which would feed into the process could be developed quite simply.

Various improvements are required in terms of information, particularly relating to local government spending, cost-sharing income and expenditure, and arrears within the sector, particularly of larger institutions. More analysis is required of the development budget, and beyond that of the information contained within the MOF External Finance database in order to determine the type of expenditure supported by external finance, and the extent to which spending through the Development Budget meetings PRS objectives.

In order to better assess the realism of future estimates, and to be able to prioritise available resources between activities and levels of the system, some type of standard costing should be undertaken, based on agreement as to key interventions, and feasible levels of coverage. This would also enable better geographical targeting to under-resourced areas, or those with greater health need.

Various aspects of the Government budget structure and coding need to be reviewed, as has been pointed out in previous PER reviews. Agreement should be reached on the most appropriate split for analysis (eg preventive curative, or district, referral, central). Planned harmonisation of central and local government expenditure coding and financial years should assist. However, review of some sub-item codes is required (eg HIV/AIDS epidemics, the various categories of allowances), as is a better articulation of cost centres across the levels of the system, rather than heavy reliance on central level transfers to different institutions and geographical areas.

1 Introduction

1.1 Background and context

The Public Expenditure Review (PER) in Tanzania has become a vital component of the government planning and budgeting process. One of its key objectives is to ensure that the expenditure patterns of the government match the policy priorities as stipulated in the Poverty Reduction Strategy Paper (PRSP). In this case, all funds contributed from various sources including external development partners and utilized by the government in order to achieve PRSP targets are indicated under this review. It also gives a detailed picture of how the funds have been utilized in recent past by levels, functions and institutions and determine how the spending relate to stated strategic objectives.

The Health Sector PER update for the financial year 2002/03 (FY03[1])is the third consecutive PER undertaken as part of a broader exercise through the Government of Tanzania that focuses particularly on the priority sectors as identified in the Poverty Reduction Strategy (PRS). The 2003 update started in December 2002 and builds on the data collected for the 2002 update and other information collected in the course of this exercise. The 2003 update, unlike other studies, includes information on resources allocated to other ministries which have health related activities as will help in giving true picture of some indicators (such as health spending per capita) as to how much public funds are directed to health sector.

A Task Team and Consultant carried out the study prior to the preparation of the Medium Term Expenditure Framework (MTEF) for 2003/04 to 2005/06 for Ministry of Health. Members of the Task Team were:

- Mr Richard Mkumbo, Economist, Directorate of Policy and Planning, MOH (Coordinator)
- Mr Richard Shankango, Accountant, MOH
- Ms Mariam Ally, Economist, Directorate of Policy and Planning, MOH
- Ms Nainkwa Mnvaza, Economist, Directorate of Policy and Planning, MOH

Additional support was provided by Mrs Anna Matowo, Desk Officer, Health, Planning and Privatisation Commission, and by Mr M.W.F Maganga, PORALG.

Overall direction and support was provided by:

- Mr Max Mapunda, Coordinator of the Basket Fund, MOH
- Mrs Regina Kikuli, Economist, and Head, Planning and Budget Section, MOH
- Ms Jacqueline Mahon, Health and Poverty Advisor, SDC

1.2 Terms of Reference

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

The core expected outputs of the health sector PER 2003 included the following:

- A review of PER FY02 findings and actions taken by the sector in response to those findings, indicating unaccomplished/pending actions, and identifying follow-up actions for FY03;
- Analysis of recurrent and development budget performance for the past three years;

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

- Analysis of expenditure trends at sectoral and sub-sectoral level including the central-local government split, including an analysis of priority areas/items of expenditure highlighted in the Poverty Reduction Strategy;
- A review of existing plans and strategies for the sector, with a view to harmonising the PRS, sector policies/objective and the MTEF;
- A costing of priority interventions over the medium term, and comparison of the financial requirements for meeting PRS targets with the projected resource availability.

Due to changes in the timing of the consultancy which was commissioned to assist the MOH undertake the PER, TORs relating to outputs required to feed into the preparation of the MOH Budget Guidelines became irrelevant as the guidelines had already been submitted to the Ministry of Finance. In addition, due to constraints in terms of both time and MOH staff availability, several of the TORs could not be met.

1.3 Process

Unlike the previous PER update, the process of updating for FY03 was undertaken entirely in Dar es Salaam, through desk review, data collection from relevant ministry departments and other agencies. Following the experience of the PER update for FY02, the decision had been taken not to repeat the exercise to solicit information from local governments, as it was felt that the quality of the data obtained did not justify the time and expense.

Prior to the arrival of the consultant, initial work to gather some of the required data had taken place by MOH members of the Task Team.

The MOH Sub-committee serves also as the Sector Working Group overseeing the health sector PER update, and the initial intention was that progress would be reported on a weekly basis to this committee. However, the main working period covered several public holidays, including the Christmas and New Year break when several members were not available. Meetings therefore resumed on the 10th January.

The process was severely constrained through the non-availability of MOH officials during the designated time period, due to other conflicting claims on their time. The timing itself also contributed to the delays in production of the report, with various public holidays, the Christmas and New Year break, and the CG meeting falling within the first few weeks of the assigned period. Delays in obtaining information, particularly relating to expenditures on pharmaceuticals, presented another obstacle to timely completion of the PER update.

1.4 Structure and contents of the report

As with the previous PER update for FY02, the aim of the report, as per the TORs, is to concentrate on the key findings of the assessment, and the implications of these findings for the coming budget preparation cycle.

Section 2 summarises recent trends in overall public health spending, in relation to the overall Government of Tanzania (GOT) budget. Trends in the total public health budget and expenditures, and various sub-sectoral trends are then reviewed, with a more detailed analysis of particular recurrent expenditure items and of the development budget in the final sub-section.

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

relation to fiscal decentralisation and proposals for future allocations between geographical areas.

Section 4 reviews sectoral performance in relation to the PRS, analysing the extent to which budgets and expenditures have supported the priority items within the health sector. Stated sectoral priorities are revisited and compared with their allocations, and the performance of the sector in relation to its own defined financial performance indicators is assessed,

Section 5 attempts to assess potential future costs and revenues within the health sector, looking at the projected revenues from both domestic and foreign sources, and planned expenditures particularly by priority areas. It also touches briefly on the area of indebtedness.

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

2 Recent trends in health sector expenditure

2.1 Review of previous PER studies

This being the third consecutive PER exercise, it is useful to highlight key findings of the previous studies in order to set the context for the analysis presented here. The overall findings of the PER update undertaken for FY 2001/02 are therefore summarised below.

- Allocations to the health sector had grown consistently and substantially between FY00 and FY02, with increases coming from both Government and basket funds. This trend was evident in both budgets and expenditures.
- Off-budget expenditures still accounted for over 40% of the total, although the trend was downwards due to the sector-wide approach. Foreign funding more generally was up from 53% in FY00 to 56% in FY02.
- Recurrent spending dominated, at over 80% of the total, both in terms of budgets and actual expenditure. This was due in part to the fact that development expenditures are generally substantially below budget estimates.
- There was evidence of trend in expenditure away form secondary and tertiary hospitals, and towards district-based health services, from 50% to 60% over the review period. Similarly, spending on preventive activities also rose from just over a third in FY00 to an estimated 43% in FY02.
- Basket funding was underspent by 22% in FY01, largely due to delays in agreeing the actual budget. Almost 30% of the central basket was spent on employment allowances in FY01, more than on medical supplies and services (27%). Estimates for FY02 showed a substantial change with drugs and supplies accounting for 57%.

2.2 Total public health budget and expenditure

2.2.1 Health in relation to the total GOT budget

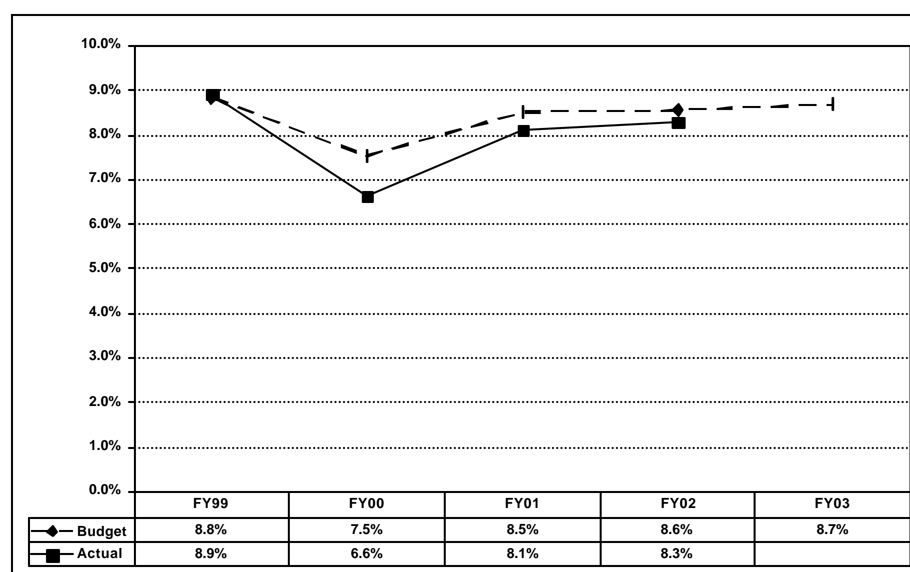
Health has been identified as a priority sector within the Poverty Reduction Strategy, and as such is expected to benefit from increases in both the absolute level of government funding, and in its share of the budget. Figure 1 below plots total on-budget spending on health as a

percentage of the total government budget, both for approved estimates and for actual expenditure over the past five years[2].

Figure 1 shows that there has been an increase of just 1.2% in the share of the health budget since FY00. Following a 1% increase in the year of publication of the PRS, the share has virtually stagnated since, with an increase of only 0.1% in FY02 and again in FY03. It should be noted that the trend shown in Figure 1 above differs from that shown in the equivalent graph in the FY02 PER update for the sector as no fall is seen in FY02. This is likely to be due to differences in the denominator[3].

The share of the health budget in FY03 is relatively small for a priority sector, at only 8.7% of the total, particularly given the important role of the sector in improving both human and economic development, as noted in the 2001 report from the WHO Commission on Macroeconomics and Health[4]. This figure also appears quite low compared to other countries in the region (for example, initial figures for Uganda for FY03 were 9.8%), and to the target of 15% which many countries signed up to in Abuja in 2001. The very small increase in the share of the sector in the total budget suggests that even in terms of budgetary intent, health is not performing particularly well overall, particularly when considering that it has failed to reach the share of the budget it held prior to the publication of the PRS and identification of health as a priority sector.

Figure 1 On-budget health spending as a proportion of the total GOT budget, FY99 – FY03



	FY99	FY00	FY01	FY02	FY03
Budget	8.8%	7.5%	8.5%	8.6%	8.7%
Actual	8.9%	6.6%	8.1%	8.3%	

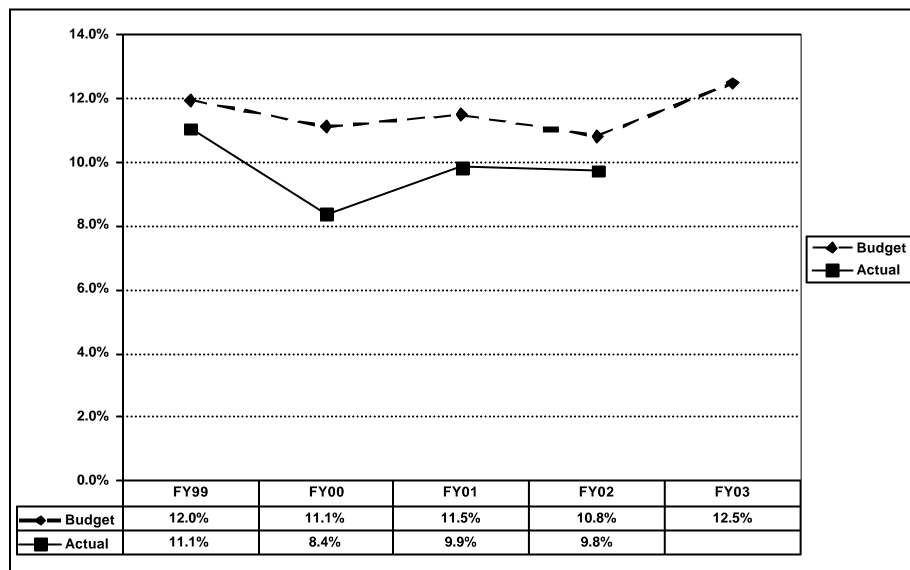
Figure 1 also shows that with the exception of FY99, actual spending on the sector has continued to fall short of the budget commitment, although the difference has narrowed in recent years. This difference may reflect changing priorities at the national level, delayed

[2] Note that the data throughout the document refer to spending by MOH, through PORALG to regions and councils, and by development partners. A small amount of public health expenditure takes place through other Ministries, Departments and Agencies (MDAs) and this is summarised in Annex D.
[3] As indicated in Annex B, the source for the denominator is successive years' documentation from the PER Macro Working Group as circulated at the annual Consultative PER meetings (Analytical Budget Frame FY99 to FY03) . There are some inconsistencies from year to year, even within these submissions, and it would be useful to have one single "official" source.
[4] WHO. *Macroeconomics and Health: Investing in health for economic development*. Report of the Commission on Macroeconomics and Health. Geneva: December 2001 (Tale A2.4 on p166).

releases, or absorption capacity constraints in actual spending within the sector. The sections below shed further light on this finding.

Given the importance of recurrent spending in improving health service quality, and the focus on recurrent spending within the Poverty Reduction Strategy Paper (PRSP), it is worth also examining the share of the sector in overall recurrent spending. This information is generally presented in terms of Discretionary Recurrent Expenditure (DRE), ie the recurrent budget available for allocation between different sectors or priority areas after the deduction of statutory expenditure requirements such as debt service. However, the MOH benefits from additional resources to support recurrent spending, through the donor basket or joint disbursement funds. These, although recorded as development spending following convention, are allocated to Departments of the MOH, or to Local Government Authorities (LGAs) to help meet day-to-day recurrent expenditure requirements. In order to ensure that the numerator and denominator are comparable, the figure for DRE has therefore been adjusted upwards to take account of the basket funding considered as "recurrent" throughout the analyses in this PER update[5]. Figure 2 below shows the share of on-budget recurrent health spending as a share of adjusted DRE. It should be noted that FY00 is the first in which basket funds were disbursed.

Figure 2 Recurrent health spending as a share of adjusted DRE



	FY99	FY00	FY01	FY02	FY03
Budget	12.0%	11.1%	11.5%	10.8%	12.5%
Actual	11.1%	8.4%	9.9%	9.8%	

Figure 2 shows a somewhat different picture to Figure 1, firstly indicating that health generally benefits from a higher share of DRE than it does of the total GOT budget, and secondly illustrating a different trend, with an initial reduction and stagnation in the budgeted share of the sector until FY03 when the share recovers to 12.5%, ie beyond its FY99 level, and an increase of 1.7% from FY02. This could be interpreted as showing that the basket funds have not only replaced government recurrent spending in the sector, but that a disproportionate reduction in the allocated share of domestic funds to the sector took place in the first years of the PRS. Basket funds are estimated to provide over 28% of recurrent spending in the sector in FY03 (See Figure 4 below).

Actual expenditures are again lower than budget shares, although the gap of 2.7% in FY00 was narrowed to 1.6% and then 1% in FY01 and FY02 respectively.

[5] Details of the adjustment are given in the explanatory notes for Figure 2 in Annex B.

2.2.2 Trends in overall public health expenditure

Table 1 Total public health expenditure in Tanzania (Billion shillings)

	1998/99		1999/2000		2000/2001		2001/2002		2002/2003
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Recurrent									
MOH	37.25	37.15	39.20	32.39	49.39	44.25	61.60	58.99	86.94
Region	9.25	8.68	9.36	9.01	6.21	5.61	7.06	6.58	7.60
Local Govt	15.72	16.34	18.69	17.95	36.35	35.67	46.26	46.28	57.66
Total rec.	**62.21**	**62.18**	**67.25**	**59.34**	**91.95**	**85.53**	**114.92**	**111.86**	**152.20**
Development									
MOH	21.21	17.27	17.75	10.19	20.47	14.84	32.07	21.12	33.78
Regions	5.00	0.67	2.57	0.79	4.62	1.39	2.35	1.28	4.75
Local Govt	0.62	-	1.18	1.06	1.73	1.52	1.70	-	2.04
Total devt	**26.83**	**17.94**	**21.50**	**12.03**	**26.81**	**17.74**	**36.12**	**22.40**	**40.57**
Total on budget	**89.04**	**80.11**	**88.75**	**71.38**	**118.76**	**103.27**	**151.04**	**134.26**	**192.77**
Off budget expenditure									
Cost sharing	-	1.09	-	1.49	-	1.86	-	1.37	1.20
Other foreign funds	35.55	42.76	52.33	60.04	59.41	75.00	66.14	79.37	49.25
Total off budget	**35.55**	**43.85**	**52.33**	**61.53**	**59.41**	**76.86**	**66.14**	**80.74**	**50.45**
Grand total	**124.58**	**123.96**	**141.08**	**132.91**	**178.18**	**180.13**	**217.18**	**215.01**	**243.23**

Note: basket funding included under recurrent or development as appropriate

Table 1 above shows that nominal spending on the health sector in Tanzania has been rising rapidly since FY00, with the estimates for FY03 showing an increase of almost 12% over the previous year in terms of total budget, and of over 27% for the on-budget portion. This is largely due to an increase in recurrent spending of 32%, a substantial share of which is likely to be due to the increase in the donor basket fund for the health which rose by over 80% between FY02 and FY03. The more detailed table on which this (and others) is based is given at Annex C, Table 24.

2.3 Sub-sectoral trends in budget and expenditure

2.3.1 Domestic and foreign spending

The level of foreign financing within a sector or country may be of concern in terms of financial sustainability in case of general donor fatigue or susceptibility to changing donor priorities. Although it is recognised that long-term commitments from donors are required in order to raise health service access and standards to a level able to ensure the requisite investment in human capabilities, the picture does vary from year to year, and it is therefore useful to monitor trends in the share of domestic and foreign spending over time, and to analyse the nature of resources of each type.

Table 2 below shows the magnitude of domestic and foreign funding of the sector since FY99, while Figure 3 shows the relative shares of domestic and foreign financing for both budget estimates and actual expenditures of on-budget sectoral funding (both recurrent and development).

Table 2 Public health spending, by funding type (Billion shillings)

	1998/99		1999/2000		2000/01		2001/02		2002/03
	Budget	Actual	Budget	actual	budget	actual	budget	actual	budget
Recurrent									
Govt funds	62.21	62.18	60.73	57.98	75.47	74.90	91.63	90.29	109.39
Foreign funds	-	-	6.52	1.36	16.48	10.63	23.29	21.57	42.81
Total	**62.21**	**62.18**	**67.25**	**59.34**	**91.95**	**85.53**	**114.92**	**111.86**	**152.20**
Development									
Govt funds	2.60	0.92	4.56	2.80	5.14	5.13	5.34	3.59	6.03
Foreign funds	24.23	17.01	16.94	9.24	21.67	12.61	30.79	18.82	34.54
Total	**26.83**	**17.94**	**21.50**	**12.03**	**26.81**	**17.74**	**36.12**	**22.40**	**40.57**
Total budget	**89.04**	**80.11**	**88.75**	**71.38**	**118.76**	**103.27**	**151.04**	**134.26**	**192.77**
Off budget									
Govt funds	-	1.09	-	1.49	-	1.86	-	1.37	1.20
Foreign funds	35.55	42.76	52.33	60.04	59.41	75.00	66.14	79.37	49.25
Total	**35.55**	**43.85**	**52.33**	**61.53**	**59.41**	**76.86**	**66.14**	**80.74**	**50.45**
Grand total	**124.58**	**123.96**	**141.08**	**132.91**	**178.18**	**180.13**	**217.18**	**215.01**	**243.23**

Table 2 shows the clear impact of the health basket funding, with an estimated TSh42.8m allocated to recurrent spending at central and local government levels in FY03, an increase of almost 84% on the FY02 budget. However, domestic resources remain the major source of recurrent funding, unlike the development budget where 85% of planned spending in FY03 is foreign. It is of note that while budgeted and actual foreign recurrent funding were much closer in FY02 than in previous years, possibly due to improved planning and a concerted effort to improve absorption within the sector, foreign funding through the development budget continues to consistently fall short of estimates.

It should be noted that caution should be exercised when interpreting figures on the foreign component of the development budget, and that figures may not necessarily be consistent between MOH and MOF. This is due to the practice by the MOF of "adjusting" estimates of foreign spending according to past disbursement performance by individual development partners. As a result, the estimates of the Basket, for example, are much lower in the official Development Budget (Kitabu cha Nne) than they are in the MOH's own MTEF and budget documents.

For the off-budget share of the sectoral budget, again the majority planned spending is foreign, due to off-budget project spending by donors. Domestic sources are expected to rise as the National Health Insurance Fund becomes more established, but cost-sharing to date has contributed relatively little to the overall sectoral resource envelope.

Figure 3 On-budget share of domestic and foreign funding, FY99 – FY03

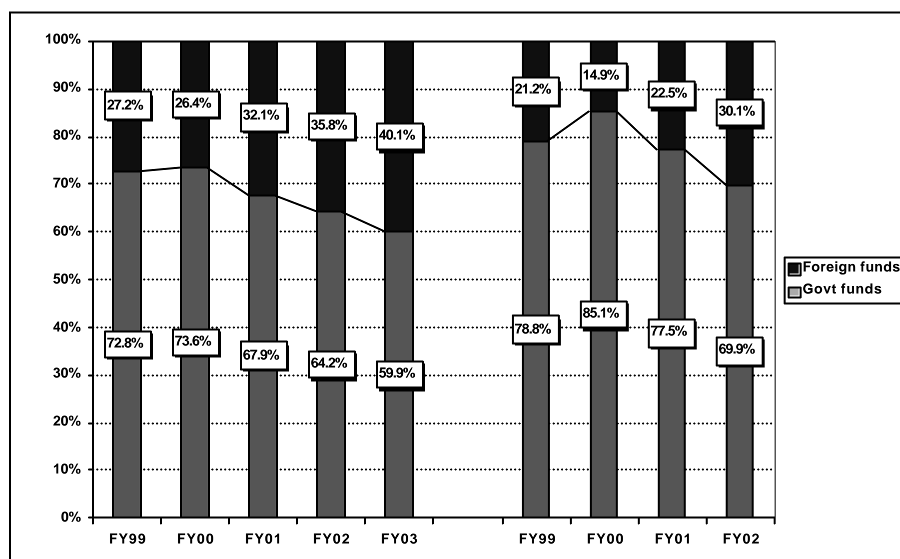
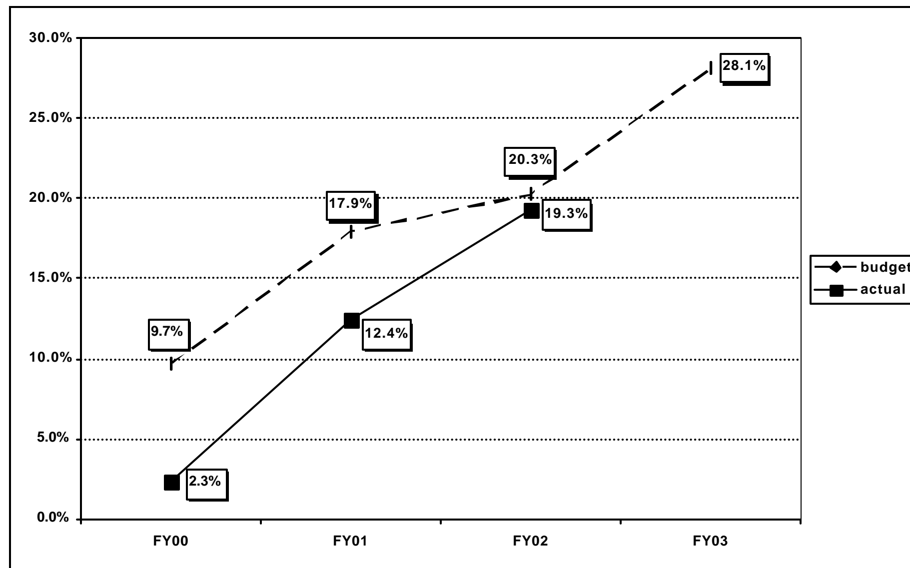


Figure 3 shows that there has been a steady increase in the share of foreign funding since FY00, reaching an estimated 40% in FY03. Although this pattern has been replicated in terms of actual expenditures over the past two years, the foreign share of expenditures has been consistently lower than the estimates, at only 30% in FY02. This is largely due to non-disbursement of project funding through the development budget, as shown in Table 2 above. Table 5, in Section 2.4, shows that the performance of the basket has also been somewhat poorer than that of government funding, at 87% of budget, compared with 98% for GOT funding. Figure 4 below shows the high rate of growth in basket funding as a proportion of recurrent funding in the four years since its introduction.

Figure 4 Basket funding as a share of recurrent health spending, FY00-FY03



The growth in the share of the basket in total on-budget funding is broadly similar, with the budgeted share reaching 24% in FY03, while the actual share was 19.5% in FY02. While it is encouraging to see the commitment of development partners in supporting the recurrent budget, in the absence of long term agreements to maintain this level of earmarked support, this arguably increases the risk of the sector being unable to maintain the absolute level of recurrent and total on-budget funding, and the implications of this should be fully explored.

Figure 5 below shows the rise in nominal on-budget spending over the past few years, broken down according to whether the source is GOT, basket funding, or other foreign resources.

Figure 5 Role of foreign funds in increased sectoral spending, FY99-FY03

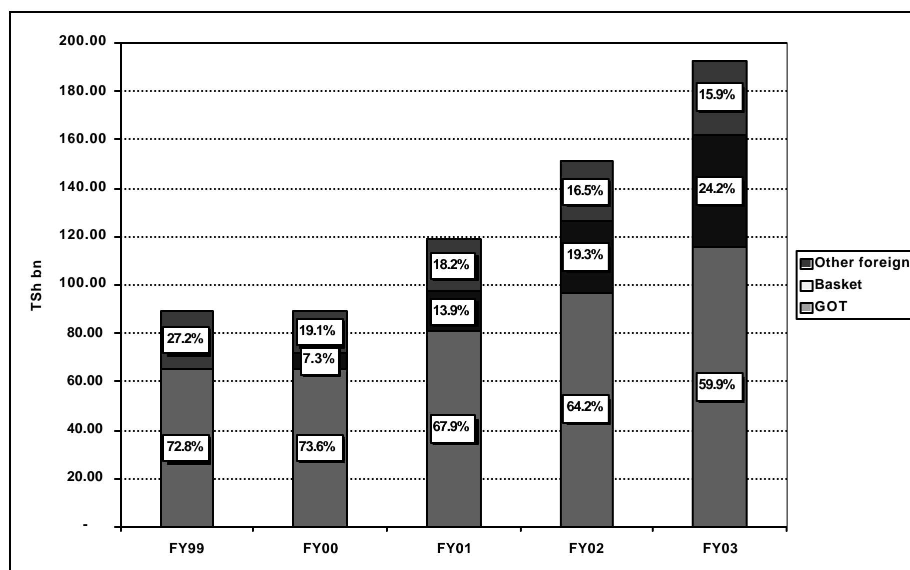


Figure 5 confirms that although there has been a steady rise in GOT funding to the sector in nominal terms, by far the largest contribution to the overall increase has been the basket funding which is directly earmarked to the sector. As seen in Figure 3 above and from the percentages given in Figure 5, the share of GOT funding has fallen over the same period, while there has been a clear shift from project support (ie other foreign) to basket funding of the sector. It will be interesting to see what happens with the progressive shift of development partners to general budget support rather than then earmarked basket in coming years.

2.3.2 Spending by level of the health system

The Government of Tanzania has a long-standing programme of decentralisation, which has received increased attention with the development of the PRS and the move to better meet the needs of the majority of the poor who reside in rural areas. The MOH, in line with the overall decentralisation programme, is therefore expected to increasingly allocate funds to the local government level, to enhance service delivery at the most accessible level for the majority of health service beneficiaries. Table 1 above shows the clear increase in nominal spending, both budget and actual, targeted at local government. Figures 6 and 7 below show the changing allocation of on-budget estimates and actual expenditures by level of the system. It should be noted that these figures are based on financial subventions only, and do not include transfers in kind (eg of drugs and supplies procured centrally). More details of the breakdown by level including in-kind transfers are given in Sections 2.3.3 and 2.5.1 below.

Figure 6 Proportion of estimated budget by level, FY99 – FY03

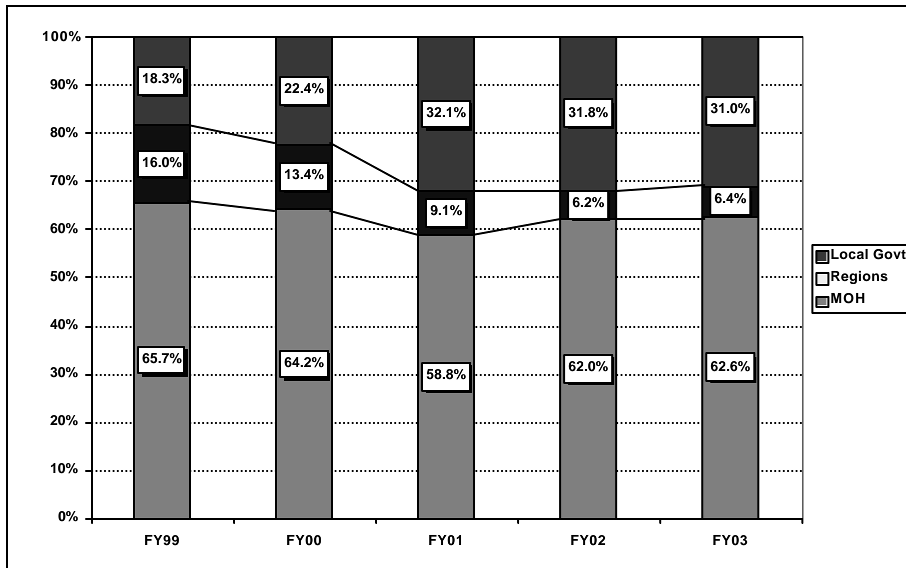
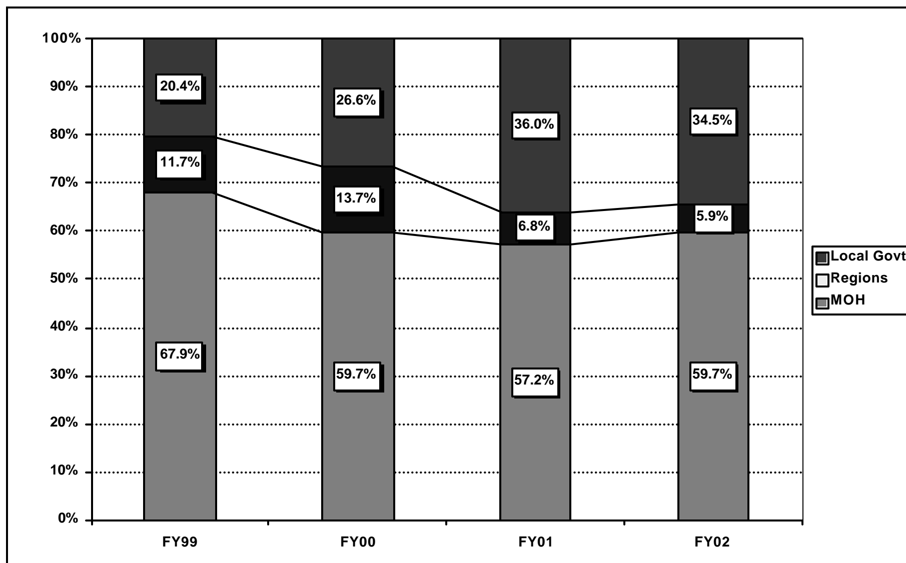


Figure 6 shows that, in terms of budgetary intent, there was a clear shift away from central level allocations between FY99 and FY01, and towards the LGAs where priority health services are delivered. This shift took place at the expense of both the central level and the regions, allocations to both falling by almost 7% in the three year period. However, although the regional level has continued to be squeezed, the central level has seen an increase in the last two years, up from 58.5% in FY01 to 62.6% in FY03. As a result, the share of the health budget allocated to LGAs has seen a slight fall from 31.2% to 31.0%. Although small, this fall still indicates a worrying reversal of policy intentions.

Figure 7 Proportion of actual expenditure by level, FY99 – FY02



In terms of actual spending the picture is similar, as seen in Figure 7, with an initial fall in the share of both central and regional levels, with the gain substantially increasing the share of the LGAs from 20.4% in FY99 to 36.0% in FY01. However, in FY02, the LGA share declined by 1.5%, due to an increase in the allocation to the central level. It should be noted that the LGA figures for FY02 are slightly understated as the figures for actual LGA development

spending at that level were not available at the time of writing. However, the level of such spending is low (only 1% of the health budget in FY02) and therefore unlikely to reverse the direction of the final figure.

On the one hand, this apparent reversal in the share of funding allocated to LGAs may not be too serious, given the substantial transfers in kind (see below), particularly in the context of a quite substantial increase in allocations for drugs and supplies. However, with the increasing absolute value of the basket allocations to LGAs, this does require some additional exploration. In addition, given that the ultimate aim is to enhance autonomy and fiscal responsibility at that level, ideally we would see a reduction in the share of funding withheld at central level for procurement, and a shift towards increasing financial allocations to the operational level, possibly with certain safeguards or through a more transparent system of "nominal" accounts held at Medical Stores Department which could in future be better incorporated into the calculation of LGA resources for health.

2.3.3 Spending by activity type

There was some debate during the process of the PER update as to the usefulness of the classification which has been made between preventive and hospital services in past PERs, and there appeared to be consensus that a more useful disaggregation is that by level of care, clearly identifying district level health services, including the district hospitals, as the priority level for service delivery. However, three of the agreed performance indicators for financing refer to spending on preventive services, as does the discussion of performance in relation to the PRS (see Sections 4.1 and 4.2 below), and Table 3 below therefore presents the data in a similar format to previous years.

Table 3 Summary of spending by level/category, TSh billion

	FY00			FY01			FY02		
	PE	OC	Total	PE	OC	Total	PE	OC	Total
MOH Admin, NIMR and TFNC	**2.59**	**1.26**	**3.86**	**2.90**	**3.69**	**6.58**	**3.25**	**5.24**	**8.50**
Hospitals									
Muhimbili Medical Centre	4.93	1.36	6.29	3.79	1.20	4.99	4.78	1.72	6.51
Muhimbili Orthopaedic Institute	0.44	0.26	0.69	0.54	0.30	0.85	0.56	0.38	0.94
Ocean Road Cancer Institute	0.26	0.15	0.42	0.28	0.23	0.51	0.29	0.43	0.72
Bugando Medical Centre	0.54	0.32	0.87	0.71	0.86	1.57	0.72	0.41	1.13
Kilimanjaro Christian Medical Centre	1.02	0.61	1.63	1.20	0.83	2.03	1.33	0.71	2.04
Referral hospitals, MoH *	2.82	2.49	5.32	1.74	4.06	5.81	2.03	0.32	2.35
Regional hospitals	8.10	1.78	9.88	4.43	2.07	6.50	5.14	2.40	7.54
District hospitals	2.87	2.75	5.62	3.53	5.06	8.59	5.22	4.39	9.62
Designated District Hospitals	1.91	0.89	2.79	3.07	1.27	4.33	2.94	2.23	5.16
Voluntary Agencies - Hospital	1.03	0.08	1.11	1.91	0.23	2.14	1.94	0.09	2.03
Total hospitals	**23.93**	**10.69**	**34.62**	**21.20**	**16.11**	**37.31**	**22.93**	**13.07**	**38.03**
Preventive/Primary health care									
MoH preventive services	0.25	1.53	1.78	0.27	3.55	3.82	0.27	6.01	6.28
Regional preventive services	0.25	0.09	0.34	0.13	0.08	0.21	0.25	0.05	0.30
Council preventive	11.39	6.00	17.39	14.11	12.86	26.97	18.50	17.45	35.95
Total Preventive/Primary	**11.89**	**7.62**	**19.51**	**14.51**	**16.49**	**31.00**	**19.02**	**23.51**	**42.53**
Total Health recurrent			**57.98**			**74.90**			**89.06**

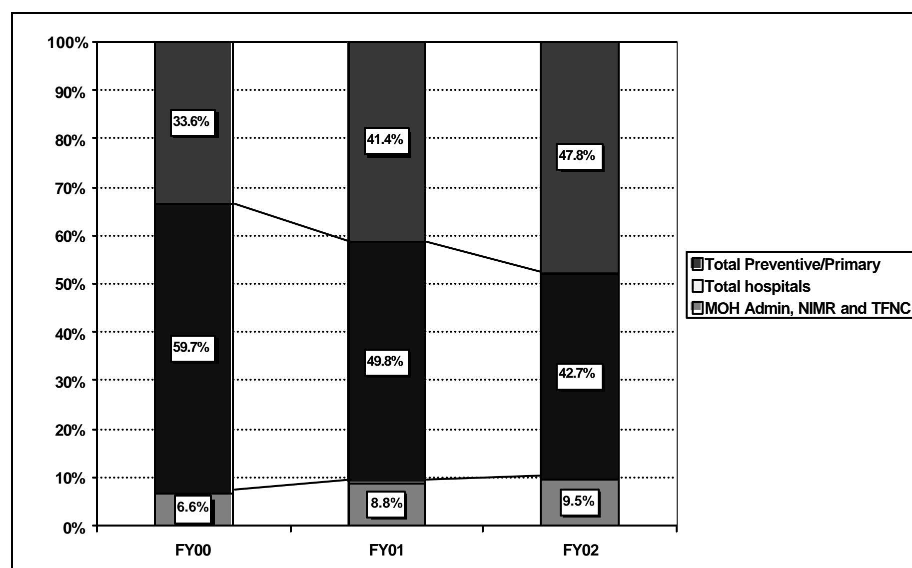
Table 3 should be treated with some caution, as some data is missing (non-drug OCs for the three referral hospitals), and the data on allocation of drugs and supplies by level is incomplete. In addition, FY02 data may include funds from non-GOT sources, which reduces the comparability with previous years[6]. Although the total recurrent expenditure figure for FY02 is only slightly lower that that given for GOT funding in Table 2, the missing data on Referral hospitals would be expected to result in a total figure greater than the GOT

[6] For example, the Danida-supported Health Sector Support Programme provides funds for essential drugs, including drug kits but is included within the Development Budget rather than the Recurrent Budget of the MOH. It also provides funds for vaccines but it is not clear whether these are included in this table.

total of TSh90.29bn, ie including some basket funds. Dependent on the future of the central basket, it would make more sense to combine analysis of GOT and basket funding in such a table. More detailed analysis of basket funding could, if required, be undertaken separately.

Although further work is required to finalise this table, the initial data suggest that the largest part of the overall increase of over 18% in the total is due to substantial growth in the share of Preventive services within the total. The data as they stand show an increase of 37%, compared with only 1.9% in the hospital share. While the hospital share is undoubtedly slightly understated due to the missing data, this picture is unlikely to be reversed, and shows a clear commitment to the Council preventive category in particular, in line with the PRS priorities, as shown in Figure 8 below (see also Sections 4.1 and 4.2).

Figure 8 The trend in allocation by category of spending, FY00 – FY03



2.3.4 Recurrent and development spending

In Tanzania, as in many other countries, the picture regarding recurrent and development spending is complicated by the manner in which external financing to the sector is recorded. Much donor-financed activity actually contributes to recurrent expenditures, yet convention requires that this be recorded as development spending. The exception in Tanzania is the case of the Joint Basket, the majority of whose funds directly supports the recurrent budget of the MOH and is recorded as such in the accounts of the MOH, despite inclusion to date of the total in the Government Estimates for the development budget. With the continued improvement of budgetary systems, this anomaly may be rectified for other externally financed recurrent spending in future years, but the analysis below is based on the conventional distinction.

Table 4 below shows the relative shares of recurrent and development spending within the on-budget total. In the light of the above point about recording of development expenditures, discussion of whether this is an appropriate split is rendered meaningless in the absence of more detailed analysis of what development expenditures actually comprise.

Table 4 Breakdown between recurrent and development spending, FY99 – FY03

	Budget					Actual			
	FY99	FY00	FY01	FY02	FY03	FY99	FY00	FY01	FY02
Recurrent	70%	76%	77%	76%	79%	78%	83%	83%	83%
Development	30%	24%	23%	24%	21%	22%	17%	17%	17%

Table 4 shows that the share of the recurrent budget in the total has been consistently rising over the past 5 years. This is most likely due to the introduction of the donor basket, and the subsequent reclassification of such spending from development to recurrent. After an initial rise in the share of the actual recurrent spending in FY00, there has been no change. The recurrent share in actual expenditure is higher than budget due to the relatively poor development budget performance, as seen in Figure 3 and the tables above.

2.3.5 On and off-budget spending

As in previous years, the major sources of domestic off-budget spending in the health sector come from established cost-sharing mechanisms:

- The Health Service Fund (HSF), which covers contributions and expenditures from user fees at government hospitals around the country;
- The Community Health Fund, which is a World Bank-supported, community-based prepayment scheme operating in a limited number of areas in 36 pilot councils; and
- National Health Insurance expenditures, which are made by the National Health Insurance Fund from deductions from civil servants' pay supplemented by a contribution from central government.

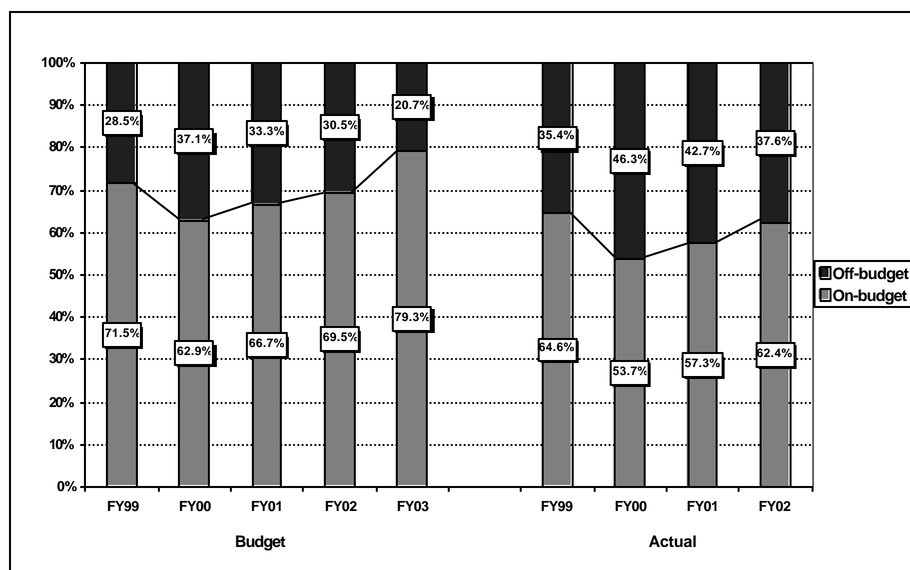
These sources still represent only a small proportion of total off-budget spend, and Table 24 in Annex C shows recent trends in spending from cost-sharing funds.

For FY02, the picture is somewhat mixed in relation to cost-sharing, with a slight increase in the reported revenue from the Health Service Fund (despite incomplete data, notably missing information from Muhimbili National Hospital, MNH) but a fall in Community Health Fund receipts. This has been attributed, anecdotally, to falling registration, partly due to people losing interest after paying and not seeming to benefit from the scheme, partly due to loss of confidence following financial management problems in some areas, and in part due to the increasing coverage of the National Health Insurance Fund, as some past members of the CHF were public servants who are automatically covered by the NHIF. It should be noted that the data on the HSF are incomplete, notably missing data form Muhimbili National Hospital.

Off-budget domestic contributions continue to be dwarfed by the foreign component of off-budget spending. The information in the External Finance database provides an estimate for FY03 and beyond, but unfortunately does not provide a historical perspective. The database provides an inventory of projects financed by a wide range of development partners, and which are planned or being implemented through government (MOH, PORALG etc), regions, local governments, NGOs and the private sector. More details of the database are given in Sectin 2.6, indicating whether such spending is occurring on or off budget and, as such, substantially increases the level and share of off-budget spending. Time during the PER process has not permitted a reconciliation of information held by the MOH and by MOF, and it is recommended that further work be undertaken in this area during the course of the year.

As seen in Figure 9 below, the share of off-budget funding within the health sector has been falling in recent years, both in terms of the budget and actual expenditure. Since FY00, the off-budget share of budget estimates has dropped by over 16%, while in actual terms the drop has been over 8%.

Figure 9 Trends in on- and off-budget shares of health spending, FY00 – FY03



This is most likely due to the concerted effort by MOH and MOF to strengthen information regarding the donor-funded share of the budget, through the development and annual updating of the database (see Section 2.6), and improved planning processes through the sectoral programme.

2.4 Analysis of recurrent spending

The inclusion of both government and basket funds in the Integrated Financial Management System (IFMS), and the availability of the Daily Itemised Balances in Excel has substantially simplified the task of analysing recurrent expenditure in the MOH level, although this has yet to be institutionalised as an activity within PER preparation. Table 5 below shows the breakdown of both government and basket funds by department in FY02, reflecting the approved estimates, releases to MOH, and the actual expenditure. It should be noted that procurement through the Basket funds has been assigned to the Policy and Planning Department and may therefore slightly overstate the share of that Department. Data for FY03, showing budget and first half release and expenditure, is presented in Table 25 in Annex C.

The budget allocations match closely with releases and expenditure for the MOH in FY02 in all departments. The overall releases against budget were over 95% with over 98% for government funding, and 83% for the basket. The anomalous figures showing expenditure exceeding release are due to the inclusion of the procurement figures in the expenditure, but not in the release which is taken from Platinum. Releases by departments vary quite widely, particularly for basket funds. The Administration and Personnel Department, and the Chief Government Chemist received less than half their total budget (44.9% and 31.4% respectively).

Table 5 Budget performance of recurrent funds, government and basket, FY02

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

In general, a high proportion of releases were spent, and it is notable that again the Administration and Personnel Department, and Chief Government Chemist were the poorest performers, spending less than two-thirds of the funds that were released to them. Reasons for this should be explored more fully, but may be due to poor planning, or possibly delays in releases. In total over 99% of government funding releases were spent. Although final expenditures using basket funds were 13.4% less than budgeted, performance of 86.6% represents a substantial improvement on previous years (6% in FY00 and 47% in FY01), suggesting that the system is maturing, and that improved planning processes are paying off.

2.5 Analysis of particular recurrent expenditure categories

This section first presents more detailed analysis of recurrent spending in FY02. As in previous years, this includes an analysis of spending on drugs and supplies to the extent possible with the data available. In addition, it presents a summary of recorded spending on the major priority programmes in FY02 and budget for FY03, going into more detail on HIV/AIDS spending within the sector. Finally, it presents a summary of the major OC items under each MOH department, for both government and basket funds, commenting on differences between budget, release and actual expenditure.

2.5.1 Drugs and supplies

Drugs and supplies are of course critical to the effective functioning of the health sector, and their availability is internationally recognised as perhaps the most important factor in people's perceptions of service quality. The MOH budget for drugs and supplies falls largely under the Department of Hospital Services, although the supplies meet preventive as well as curative needs. Funds are transferred to Medical Stores Department, either for purchase of drug kits for councils (for health centres and dispensaries), or for purchase of loose drugs for councils and hospitals. It was not possible to verify with MSD whether the formula previously used and reproduced in Annex 16 of the health sector PER for FY01 is still in use, but it is assumed so.

- **By central MOH department**

Table 6 below is based on the budget sub-items under **2604 Medical Supplies and Services**, for both government and basket funds, and are drawn from the IFMS Platinum file. A description of the sub-items is given in Annex E. These figures underestimate the total spending on drugs and supplies as they fail to include commodities procured directly by technical programmes and non-basket donor-funded projects. This information is available to some extent within the MTEF which includes other sources of funding to the sector, but personnel and time constraints precluded analysis of non-basket donor spending in this area. A more detailed analysis should be made of the extent of such procurement in order to assist in quantifying physical and financial gaps in relation to drugs and supplies in the future.

Table 6 below shows the absolute level of spending (GOT and basket) on drugs and supplies as reflected in the Detailed Cash Flow and the IFMS. FY02 data represents actual expenditure, while FY03 data shows budgeted estimates. A more detailed breakdown by sub-item is given in Annex E.

Table 6 Spending by MOH department on drugs and supplies, FY02 and FY03

		FY02		FY03	
		GOT	**Basket**	**GOT**	**Basket**
2001	Curative/Hospital services	11,270,002,202	2,905,668,252	11,000,000,000	8,208,070,000
2002	Chief Government Chemist	2,600,000	-	2,600,000	33,000,000
3001	Preventive services	1,614,111,333	4,038,815,780	2,800,654,600	4,492,385,000
4001	Tukuta	30,514,634	580,000	10,415,000	3,200,000
5001	Human Resource Devt	-	-	6,300,000	-
Total MOH Departments		**12,917,228,169**	**6,945,064,032**	**13,819,969,600**	**12,736,655,000**

The table above shows that the planned level of spending on medical supplies and services has increased by almost 34% in nominal terms between FY02 and FY03, largely as a result of the 83% increase in the level of basket funding spent on such items. Spending from domestic resources increased only 7.6%. The bulk of spending is undertaken through the Department of Hospital Services, at around 71% of the total. Preventive services accounts for approximately 27% of the total.

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

Table 7 below shows the breakdown of spending on drugs and supplies by level, indicating the allocation between hospital services and preventive services. However, this table should be treated with caution due to the incomplete and inconsistent data on which it is based. Unfortunately, time constraints prevented a fuller analysis in order to match sources of funding for medical supplies and services and their allocations. This should be undertaken during the course of the year. No information was obtained as to the planned breakdown for FY03.

Table 7 Drugs and supplies allocation by level and type

MoH spend on drugs (Tshs)	FY99	FY00	FY01	FY02
Muhimbili Medical Centre	237,784,073	291,727,000	277,960,000	340,000,000
MOI and ORCI	105,137,552	136,889,700	114,800,000	257,500,000
Bugando and KCMC	205,415,971	373,854,600	247,020,000	400,000,000
DDHs and other VAs (hospitals)	414,515,478	779,993,800	463,000,000	837,000,000
3 Referral hospitals	274,333,529	404,968,099	259,130,000	317,500,000
Regional hospitals	796,506,108	1,473,967,900	892,250,000	1,252,000,000
District hospitals	1,329,521,757	2,492,731,700	1,533,560,000	2,545,750,000
TPDF hospitals and JKT		109,710,000	101,810,000	141,250,000
Total hospitals	3,363,214,469	6,063,842,799	3,889,530,000	6,091,000,000
Primary health care kits		5,746,494,000	4,624,782,000	7,633,278,419
MoH preventive & HQ dispensary		88,294,000	254,800,000	43,064,000
MoH vertical programmes		284,567,000	220,260,000	79,986,623
MoH emergency / reserve accounts		177,607,000	103,410,000	109,041,177
Total preventive	5,061,070,881	6,296,962,000	5,203,252,000	7,865,370,219
Total MoH spend on drugs	**8,424,285,350**	**12,360,804,799**	**9,092,782,000**	**13,956,370,219**
Total MoH recurrent spend	**37,150,248,895**	**32,055,992,068**	**39,885,344,271**	**48,165,359,880**

This table is subject to the more general criticism that was raised regarding the artificial distinctions between preventive and curative/hospital spending, and in future it might be more useful to improve the data on allocation by level of the health care system. Table 8 shows a possible breakdown within the hospital category, but more information is required regarding the breakdown in allocation of drugs and supplies classified in Table 7 as "Preventive" in order to complete the picture.

Table 8 MOH hospital drug allocations by level/hospital type, FY02

	FY02	
	TSh	%
District hospitals, DDHs, and other VAs	3,382,750,000	57%
Regional hospitals	1,252,000,000	21%
National/referral/specialist hospitals	1,315,000,000	22%
Total	**5,949,750,000**	**100%**

It should be noted that many of the regional, referral and national hospitals also perform the role of district or first-level hospitals, and it would be interesting to analyse this further in order to obtain a truer picture of use of drugs and supplies by type of hospital activity.

- **By geographical area**

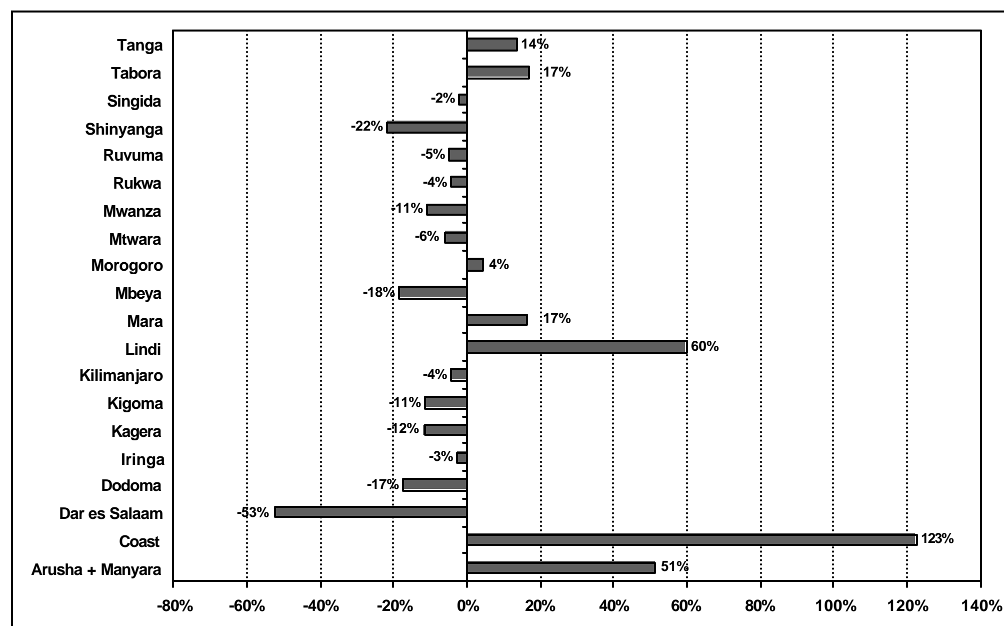
Data on the geographical distribution of drugs and supplies has been restricted for this PER update to the allocations to hospitals as it proved impossible to obtain a complete set of data on allocation of the drug kits and other supplies to councils from Medical Stores Department. This is a major shortcoming and effort must be made during the year to work with MSD in order to enable them to provide timely and accurate reports in a format which is useful to the MOH. Figure 10 below shows the variation in per capita allocations of hospital drugs for each region (ie district, DDH, VA and regional hospital allocations), shown as percentage difference from the national mean.

This diagram is included largely for illustrative purposes, to demonstrate the potential use of the method for assessing geographical variation. More information would be required to assess to what extent the over or under-allocations may be justified in terms of different health needs. For example, in Dar es Salaam, the graph indicates that per capita spending on hospital drugs is 52% below the national mean of TSh141. However, a substantial proportion of the population may seek first and second level referral care at Muhimbili National Hospital (MNH), which although inefficient, would mean that the appropriate per

capita consumption of drugs and supplies at MNH should be taken into account when assessing total per capita public expenditure on drugs in the Dar es Salaam region.

The diagram clearly shows, however, that there are wide variations in per capita spending on hospital drugs by region, which should be explored further to ensure that differences in infrastructure are not resulting in an inequitable distribution of drugs and medical supplies. A similar analysis could usefully be performed for spending on drug kits by LGA.

Figure 10 Variation in per capita hospital drug allocations by region, FY02



2.5.2 HIV/AIDS spending

The TORs for the FY03 PER update included an analysis of HIV/AIDS spending. As a similar exercise was being undertaken specifically for HIV/AIDS spending across sectors, this report provides only a brief examination of spending on HIV/AIDS-related activities. Further work is necessary to unravel spending throughout the sector, as will be seen below.

It should be noted that much spending on HIV/AIDS-related activities also takes place through the development budget, despite many such activities having a recurrent component. The sections below refer only to recurrent spending through GOT and basket resources. Table 26 in Annex C summarises details of the 9 projects identified in the MOF Health database as covering HIV/AIDS-related activities, although again this provides only partial information as HIV/AIDS is treated as a separate sector within the MOF database.

- **Central level**

Some recurrent spending on HIV/AIDS related activities in the MOH is summarised under a specific sub-item code **- 260409 HIV/AIDS Epidemics -** which was introduced in FY02. All expenditure under this item falls within the budget of the Department of Preventive Services (DPS), reflecting the activities of the National Aids Control Programme (NACP). However, it is necessary to look also at the MTEF and Detailed Cash Flow in order to identify HIV/AIDS related spending within the Hospital Services Department, where it is identified by activity and uses the traditional sub-item codes.

Table 9 below shows the pattern of spending on HIV/AIDS-related items and activities for FY02 and the first half of FY03. Data on curative spending in FY02 is missing, due to time

constraints preventing the extraction of the necessary information from the Physical and Financial Implementation Report for FY02.

Table 9 HIV/AIDS spending, Central MOH (TSh)

Year	Dept	Source	Budget	Funds Released	Total Expenditure
FY02	Preventive	Govt	1,511,962,600	1,511,962,600	1,511,962,600
		Basket	15,000,000	15,000,000	15,000,000
		Total	**1,526,962,600**	**1,526,962,600**	**1,526,962,600**
	Curative	Govt			
		Basket			
		Total			
FY03*	Preventive	Govt	1,567,676,000	898,313,412	674,431,740
		Basket	401,914,000	126,418,000	0
		Total	**1,969,590,000**	**1,024,731,412**	**674,431,740**
	Curative	Govt	0	0	0
		Basket	1,992,955,000	723,726,000	490,845,000
		Total	**1,992,955,000**	**723,726,000**	**490,845,000**

* To 31 December 2002

Items included within the analysis of Curative spending on HIV/AIDS related activities have been guided in part by the list of activities included within the draft Budget Guidelines for HIV/AIDS. However, as much activity within the Curative/Hospital sub-sector relates to appropriate diagnosis and case management, and cannot be easily extracted from more general spending, this is likely to substantially underestimate spending through this department, and is most likely the explanation for their being no identified government spending in FY03. The figures for FY03 include activities related to ensuring safe blood transfusion, Prevention of Mother to Child Transmission of HIV, Technical AIDS committee meetings, development of workplace interventions, and ensuring support to a continuum of care.

Table 9 is encouraging in that it shows that the full amount of government funding was both released and spent in FY02 for the sub-item "HIV/AIDS epidemics", representing 16% of the budget for the Preventive Services Department. Releases in the first half of FY03 have also been in line with budget, with over 50% having been made available to NACP, although the basket funds are lagging behind. Most of the 29% increase in Preventive spending on HIV/AIDS is due to the substantial increase in basket funding assigned to this area, with only a 3.7% increase in government funding.

- **Local government level**

At local government level, there has been a concerted effort to include HIV/AIDS activities within the budgets of all councils, as one of the PRS priorities. In line with the objective of raising to 75% the share of districts with active HIV/AIDS awareness campaigns, a new item code was created in FY02 within the Health vote, **1716 HIV/AIDS plans**. The expected level and share of LGA OC spending under this budget line is indicated in Table 10. No data is available on actual releases or expenditures against this item.

Table 10 HIV/AIDS spending, Local Government Authorities

	1716	Health OC	%
FY02	150,791,200	11,749,499,000	1.28%
FY03	297,447,700	13,739,092,700	2.16%

Table 10 shows that although the absolute level of spending on HIV/AIDS plans is relatively low, at only 2% of the LGA OC budget in FY03, there has been an increase of almost 100%

in the nominal budget, and a 68% increase in the share of OC spending, both of which indicate that this is being seen as a priority activity. Examination of the local government budget estimates for FY02 and FY03 indicates that there is no consistency as to whether HIV/AIDS plans are included under the 511 Curative or 512 Preventive sub-votes, and in one case, it appears under 514 Dispensaries.

2.6 Analysis of the sectoral Development Budget

The TORs specified that some analysis should be undertaken of development spending within the sector, in order to ascertain the extent to which such spending was in line with PRS priorities. An attempt has therefore been made to analyse some of the data from the MOF database of externally-financed projects in terms of various categories. This is relatively limited, and should be subjected to verification by MOH, MOF and bilateral and multilateral donors. In addition, a review of locally funded development projects has also been undertaken.

2.6.1 Projects within the MOF External Finance database

The MOF database includes information on 128 different projects within the health sector, at different stages of planning or implementation, and undertaken at different levels of the system and by a range of different implementing agencies. This was analysed in relation to a number of different aspects as illustrated below. Although the database aims to collect information on external funding over the period FY03 – FY06, analysis was restricted to FY03 as uncertainties remain regarding projected funding levels.

Figure 11 shows the breakdown between externally-financed projects which are captured in the regular budget, those which are not, and others which for some reason have not been classified. No attempt has yet been made to reconcile the subset of projects which are recorded here as on-budget with those itemised in the Development Budget of the MOH, but this should be done either before or as part of the next PER exercise.

Figure 11 Health sector external financing, by budget status, FY03

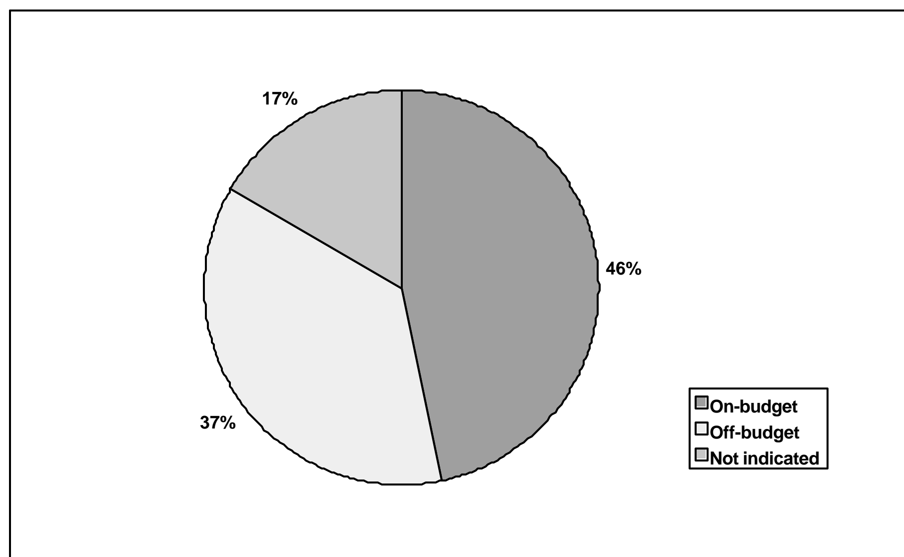
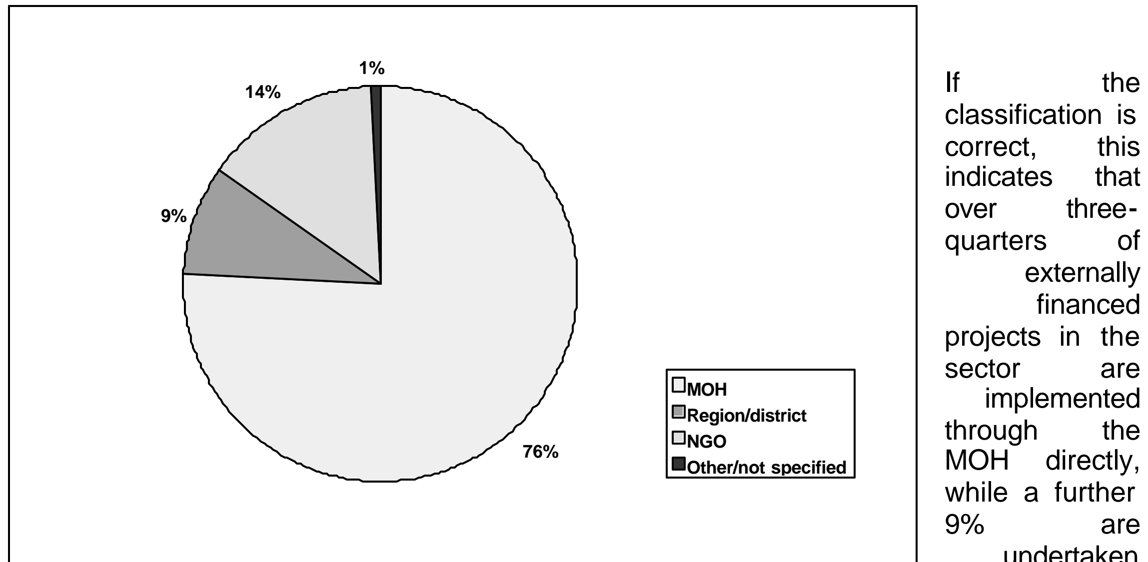


Figure 11 above shows that for the current financial year, over half the total reported external funding (54%) within the sector is flowing outside the budget. This represents a total value of TSh 49.25bn.

Figure 12 below shows the breakdown between projects implemented by the Ministry of Health, Regions or Districts, NGOs and others. Others include donor agencies (eg World Food Programme) and other MDAs, eg Water. It should be noted that some changes have been made to this classification, and further work should be undertaken by the MOH and partners to ensure that this breakdown is accurate.

Figure 12 Health sector external financing, by implementing agency, FY03



If the classification is correct, this indicates that over three-quarters of externally financed projects in the sector are implemented through the MOH directly, while a further 9% are undertaken through regional or district authorities. No projects in the database are currently being implemented by the private sector although the NGO share is quite substantial at 14%. It was not possible in many cases to see which NGOs were involved.

A cursory analysis was undertaken of the breakdown of projects between priority programmes and areas, as shown in Table 11 below. Again, this should be treated with some caution as projects may cover a broader range of activities than that suggested by the classification. All reform programmes fall under the category Health Systems, as do geographically-based health projects, while the category “Other” includes a diverse range such as other communicable diseases, health promotion, and good governance. This classification should be reviewed and further refined in the future, but the intention here was partly to illustrate the type of analysis which can be undertaken, and partly to highlight major areas of support in relation to discussion below on future costs and revenues (see Section 5).

Table 11 Crude classification of development projects within MOF database

Category	No	Allocation FY03	%
Basket funding	10	37,160,106,220	40.3%
Reproductive Health	19	12,897,610,213	14.0%
Other	25	12,808,581,565	13.9%
Health Systems	22	9,409,642,961	10.2%
Infrastructure	8	5,539,152,438	6.0%
Immunisation	6	4,849,614,756	5.3%
Child Health	7	2,745,857,500	3.0%
TB/Leprosy	5	2,413,339,701	2.6%
HIV/AIDS	9	2,337,414,937	2.5%
Malaria	11	1,968,845,930	2.1%
Training	6	131,875,000	0.1%
Total	**128**	**92,262,041,221**	

Not surprisingly, the Basket Funding category topped the list, accounting for just over 40% of external financing in the sector. This figure is lower than the estimated value of the basket contributions based on the side agreements in the March 2002 Joint Review report, and the discrepancy should be clarified, although it may relate to direct procurement. Reproductive health accounts for the second largest share of development funding at 14%, slightly ahead of the "Other" category. The share of HIV/AIDS projects is perhaps artificially small due to HIV/AIDS being considered a separate sector for the purposes of the MOH database, with projects being included elsewhere in the budget. This is something which should be explored further, ideally through the HIV/AIDS PER. Some HIV/AIDS-related activities may be included under projects classified here as Reproductive Health.

It should be noted that the MOF database does not yet include information on projected inflows from the Global Fund on AIDS, Tuberculosis and Malaria, the Gates Foundation, or from the World Bank Tanzania Multicountry AIDS Project (TMAP). These can be expected to substantially inflate both the total external funding within the sector, and also the allocations to these three priority programmes which between then currently only account for 7.2% of (vertical) external project funding.

It has not been possible to undertake the necessary reconciliation of the MOH development budget figures with those projects included as on-budget within the MOF database. This exercise should be undertaken during the coming months, in order to ensure that the budget for FY04 is fully consistent with the data held in both Ministries.

2.6.2 Projects within the sectoral Development Budget

As noted above, the listing of projects within the MOH Development Budget (Central, Regional and at Local Government level), is a sub-set of those captured within the MOF database. In addition, several projects within the sector receive local but no foreign funding. Table 27 in Annex C shows the development budget by type of funding for FY03.

The MOH prepared its development budget for FY02 and FY03 taking into consideration the PRS targets. The main aim of the health sector is to improve and provide quality health services and all the activities included in the development budget are geared to reduce morbidity and mortality rates with special focus on infants, elderly, disadvantaged groups and women of reproductive age. In order to provide quality services, this includes the rehabilitation of health facilities at different levels, construction of new infrastructure where necessary, provision of hospital and diagnostic equipment, and counterpart funds for donor-funded projects.

Funds allocated under the Health Sector Planning and Management project were used in FY02 to develop a rehabilitation proposal for different health institutions, particularly primary health facilities at local government level. At the same time, funds have been used to fund the purchase of computers and their installation in all districts in order to improve the Health Management Information System. Other funds under this project were used for supervision and monitoring purposes, with staff from central level providing on the job training during supervisory visits.

The Health Sector Programme Support funds include basket funds which are allocated under the recurrent estimates for implementation of priority programmes including TB/Leprosy, EPI etc. Non-basket funds from DANIDA are used for the purchase of drugs for PHC facilities (kits) and for monitoring and supervision at district and lower level facilities. As such, these provide a clear example of how funding identified within the Development Budget is actually supporting recurrent expenditures.

Funds allocated to the Strengthening of National Hospitals, Chief Government Chemist, National Institute for Medical Research, Tanzania Food and Nutrition Centre, and Ocean Road Cancer Institute were geared towards improving quality services through rehabilitation of facilities, which as mentioned above, is one of the strategies for achieving the PRS targets.

Funds allocated for the Control of Communicable Diseases were aimed at contributing towards the reduction of HIV incidence, and tuberculosis cases, as funds were used for clearance and distribution of condoms, IEC materials, and drugs for sexually transmitted infections at different levels. Some funds were also allocated towards the clearance and distribution of vaccines through EPI, whose aim is it increase immunisation coverage and therefore to reduce infant and under-five mortality.

Counterpart funds were provided for the Strengthening of X-ray services, whereby x-rays were distributed and installed in most of the district hospitals in order to improve diagnostic services. Counterpart funds for Muhimbili Rehabilitation Project were for major work on MNH to improve national hospitals services, and also construction and extension of facilities in rural Dar es Salaam to improve maternal and child health services.

3 Local government budgets, allocations and spending

According to the PRS, spending in priority areas at the local government level in priority sectors represents a substantial component of the allocation towards pro-poor activities. In the health sector, the local government level comprises four sub-votes, all of which are included in the PRS priority level:

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

As discussed above, there are difficulties in clearly distinguishing between preventive and curative spending at any level, and this is perhaps particularly the case at the point of entry into the formal public health system. Together with the fact that there is some inconsistency in the manner in which different cost items are assigned across these four levels, this indicates that there is little to be gained by analysing LGA data at the sub-vote level at present.

3.1 Local government health sector spending

This section analyses in a little more detail the nature of government subventions to the Local Government Authorities, given the strategic importance of the LGA level in meeting PRS objectives, and the continued focus on decentralisation within the country. The analysis is incomplete as it does not include a complete breakdown of centrally procured drugs and supplies, not does it include the basket funds allocated to LGAs. The reason for the former is lack of up to date, accurate data, in part due to limitations in the information systems, and for the latter, is the fact that to date basket funds have been allocated only to those districts which have qualified as reforming districts in Phase 1 or 2.

3.1.1 Overall level and share of government subventions to LGAs

As seen in Figures 6 and 7, government subventions to councils for spending on health have fallen slightly as a share of total on-budget spending on health. However, the absolute level has risen as shown in Table 12 below. Twenty-three of the 115 Tanzanian LGAs are described as urban. In the sections below, local government subventions have been analysed separately for urban and district councils.

Table 12 Government subventions to LGAs, FY01-FY03 (Billion shillings)

	FY01 Approved estimates			FY02 Approved estimates			FY03 estimates		
	PE	OC	Total	PE	OC	Total	PE	OC	Total
Urban	4.47	1.57	6.04	4.90	2.16	7.06	6.34	25.22	8.86
District	16.58	6.47	23.05	18.83	9.59	28.42	23.60	11.22	34.81
Total	**21.05**	**8.04**	**29.09**	**23.73**	**11.75**	**35.48**	**29.94**	**13.74**	**43.68**

Figure 13 below shows the proportion of LG spending allocated to health, for urban, district and all councils. Both the numerator and the denominator for FY02 are taken from the net approved estimates. Data was not available to enable a comparison with OC allocations for FY02.

Figure 13 LG health budgets as a proportion of total LG budgets

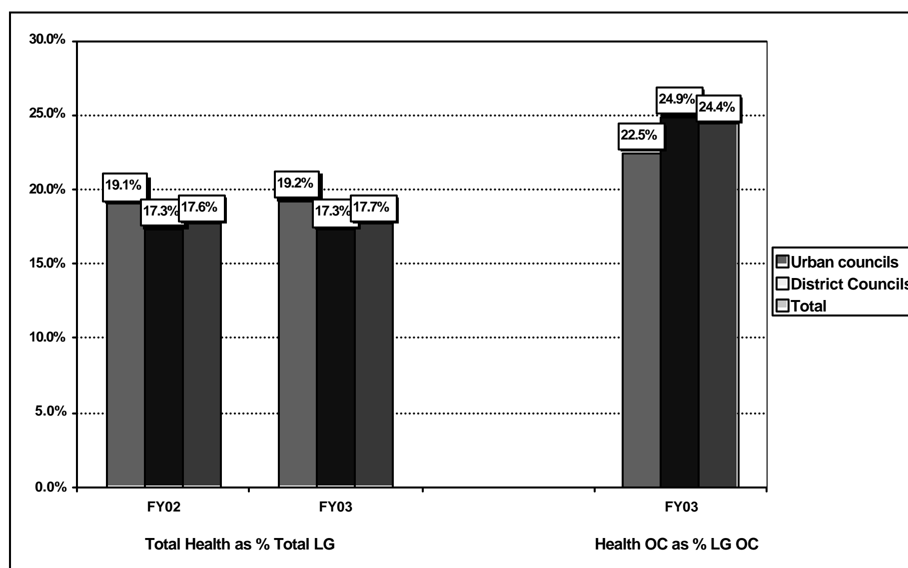


Figure 13 shows that, on average, LGAs allocate about 18% of their budget to the health sector, with little difference between urban and rural district councils. The share is slightly higher for OCs, with the FY03 estimate indicating that almost 26% of the OC budget has

been assigned to health. In FY03, district councils have assigned slightly more OCs than urban councils, at 24.9% and 22.5% respectively.

These figures disguise a wide variation between councils. For example, 3 LGAs (Dar es Salaam City Council (CC), Bukoba and Muleba District Councils (DC)) have allocated less than 10% of their total budget to health, while 4 have allocated more than 30% (Rufiji and Mafia DCs, and Kibaha and Bukoba Town Councils (TC) in FY03. When it comes to the share of OCs, the range is even greater, with Dar CC and Bukoba DC allocating less than 5%, while 6 councils have allocated more than 35% to health, the highest being Bukoba TC at 40%.

The manner in which the LGA budget is recorded, with inconsistency between items placed in each sub-vote[7], means that it is probably not helpful to analyse the distribution between these four levels within the council. However, the PE: OC split gives some idea of the availability of key staff and of complementary funds for district health services. Ideally, a more full analysis would also include an assessment of the funding to regional, referral and Designated District Hospitals which perform the role of the first level referral facility in those LGAs without a government district hospital.

Figure 14 PE:OC split at LG level

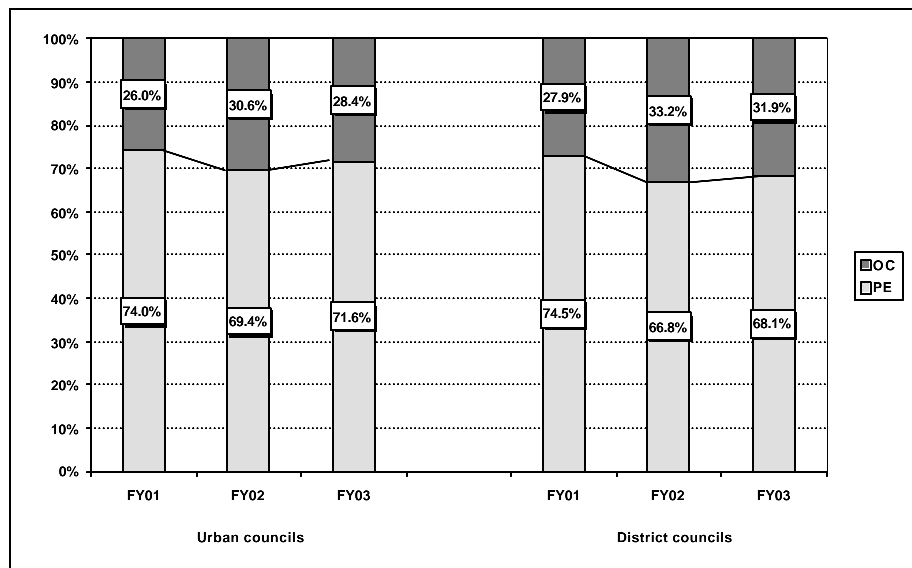


Figure 14 shows that over the past three years, the share of PEs in total district subventions for health has fallen slightly from almost 75% to around 71%. If the value of drugs and supplies, included within the central MOH budget and distributed through MSD, were added, the share of OCs would not seem as low, but this has not been undertaken due to time constraints, and in any case would be possible only for hospital drugs and supplies. However, it is of note that in FY03 even within the cash subventions the share of PEs has started to rise again slightly.

This national average again disguises a wide variation among LGAs, and it would be useful in the future to analyse this further to explore the source of such variation.

[7] For example, the item HIV/AIDS plans fell in some districts under Curative, others under Preventive, and one under Dispensaries.

3.1.2 Releases as % of budget

Analysis of LG spending on health (and other sectors) is seriously hampered by the lack of timely and reliable reports on actual expenditures. For that reason, in this PER update as in previous ones, the record of OC releases by sector to each LGA are used as a proxy for actual spending. Spending on Personal Emoluments is assumed the same as approved budget. This is recognised as a weakness in the analysis, particularly given the evidence from past tracking studies that there are no guarantees that funds released for health (and education) are in fact used for those purposes. A tracking study undertaken in FY01 found that actual receipts as a % of actual sectoral disbursements over a three month period in a selection of LGAs varied between 16.8% and 100%[8].

The MOH does in fact receive a quarterly report from those councils which are receiving basket funds, and these reports are expected to contain information on all funds received, by source, and also to report on spending by level and category. However, it appears that to date no systematic collation of these reports has taken place, and therefore no analysis of the data provided, although ad hoc activities have made use of the reports[9]. This is a serious shortcoming, not least as it places an additional reporting requirement on councils without the data provided being fully used at the higher level. It is understood that the quality of many of these reports is weak, and that there are inconsistencies with the eventual appropriation accounts submitted through PORALG, but this is arguably an area where additional effort would be justified not only to improve information, but also to raise capacity at that level. Extension of the IFMS system to LGAs should eventually remove this constraint to analysis, but it may be worth strengthening existing monitoring in the interim.

Releases of LG funds for health have generally been satisfactory, with 107/115 councils (93%) receiving 100% of their net approved estimated budget. Variations are shown in Table 13 below.

Table 13 Variation between LG budget and release for OCs, FY02

Region	Council	Approved OC budget	% variation
Dodoma	Dodoma	111,615,800	+ 26.9%
Mbeya	Rungwe DC	131,993,200	+ 30.3%
Mwanza	Magu DC	85,080,900	+ 47.0%
Shinyanga	Shinyanga MC	63,191,300	- 6.8%
Tanga	Korogwe DC	136,012,400	- 0.4%
	Pangani DC	108,770,600	- 38.0%
Kagera	Bukoba TC	113,463,100	- 39.3%
	Bukoba DC	68,883,900	+ 64.7%
All LGAs		**11,749,499,000**	**+ 0.6%**

No information was available as to why the variation between approved OC budgets and releases as shown in Table 13, and this is something which might be followed up later.

3.1.3 Geographical variation

As mentioned in Section 3.1.1 above, there is substantial variation in the share of the LG budget allocated to health around the country, whether for OC only or the total figure. Table 14 presents the per capita LG allocations by Region, as official data for the population at the regional level exist[10].

[8] REPOA and ESRF. *Pro Poor Expenditure Tracking.* Draft report submitted to the PER Working Group. Dar es Salaam: March 2001 (Table 7).
[9] For example, previous PER reports, and the draft MOH Performance Profile.
[10] Insert website reference

Table 14 Regional variations in per capita government LG allocations, FY01 – FY03

Region	FY01			FY02			FY03		
	PE	OC	Total	PE	OC	Total	PE	OC	Total
Arusha	673	267	941	675	469	1,143	883	577	1,460
Coast	1,088	530	1,618	1,560	729	2,288	1,741	968	2,708
Dar es Salaam	649	146	796	719	168	887	1,028	271	1,299
Dodoma	669	269	938	727	339	1,066	839	349	1,188
Iringa	654	218	872	701	341	1,042	901	381	1,282
Kagera	390	177	566	457	261	718	492	295	786
Kigoma	683	317	1,001	696	479	1,176	873	412	1,285
Kilimanjaro	550	257	807	888	302	1,190	983	422	1,405
Lindi	946	386	1,332	909	574	1,484	1,248	656	1,904
Mara	630	313	943	590	385	974	754	352	1,107
Mbeya	606	246	851	612	304	916	786	398	1,184
Morogoro	693	215	908	642	343	985	886	335	1,221
Mtwara	788	239	1,027	723	377	1,100	846	417	1,264
Mwanza	653	144	798	697	192	889	872	273	1,145
Rukwa	749	216	965	894	308	1,202	989	490	1,479
Ruvuma	746	325	1,072	765	656	1,422	949	450	1,399
Shinyanga	425	171	595	540	271	810	596	333	929
Singida	703	426	1,129	707	480	1,186	871	427	1,299
Tabora	697	313	1,010	725	422	1,148	790	521	1,311
Tanga	868	321	1,189	897	428	1,325	1,091	382	1,472
Tanzania mainland	660	252	912	722	357	1,079	883	405	1,288

Such analysis at the regional level can only serve to illustrate the nature of variations, as the LGAs within a region are likely to vary substantially in terms of demographic, topographic and epidemiological factors contributing to both health and health service need.

However, with the availability of detailed regional figures on poverty from the 2000/01 Household Budget Survey, it is possible to do a cursory analysis of the relationship between per capita allocations to health at the local government level, and the regional poverty level. Table 15 below summarises the Pearson correlation coefficients for per capita local government allocations (total = LGA, and OC) for the past two years, compared with the headcount ratios for both the Basic Needs Poverty Line (BNPL) and the Food Poverty Line (FPL).

Table 15 Correlation between per capita LG allocations and poverty levels, FY02-FY03

	LGA-BNPL		LGA-FPL		OC-BNPL		OC-FPL	
	FY02	FY03	FY02	FY03	FY02	FY03	FY02	FY03
Values	0.40	0.31	0.28	0.22	0.52	0.35	0.47	0.29
Rankings	0.36	0.14	0.17	-0.06	0.51	0.31	0.44	0.19

Correlation coefficients were calculated for both the actual values of the per capita allocations and the Headcount ratios, and also for a ranking of the regions for both sets of data. Table 15 shows that the relationship between allocations and poverty levels is very weak in both years, and for both definitions of poverty. It also shows that even at the low levels of correlation, the picture has worsened for each combination between FY02 and FY03. Clearly, although a very crude analysis, this indicates a need for a more focused mechanism for targeting spending towards poorer geographical areas, as is being proposed through the MOH and the Local Government Reform Programme activities outlined below. The proposed allocation for FY04 could usefully be analysed in the same way prior to finalisation.

3.2 Fiscal decentralisation and allocation formulae

Recurrent funding to LGAs for the health sector has come from two main sources in recent years, the government subventions and, for those councils designated as “reforming” under

the Local Government Reform Programme (LGRP), additional grants through the donor basket. Allocations to Phase I councils began in FY00, with Phase II councils receiving funds from January 2001. The final group of LGAs, the Phase III reforming councils, have started receiving funds with effect from January 2003.

The local government financial year currently runs concurrently with the calendar year, and is therefore not synchronised with the central government planning and budgeting system, and this causes some problems in analysis as well as in planning. However, this anomaly is expected to be rectified with effect from the start of FY05.

The basis for the geographical allocation of government subventions in general has long been recognised not to be transparent, and to be relatively insensitive to policy changes such as those articulated in the PRSP. This is also the case within the health sector, with the rationale for allocations to LGAs unclear and not transparent. Basket funds to councils are allocated on a simple per capita basis, at $0.50 per capita. This, while objective and simple, undoubtedly results in an allocation which reflects health and health service need less than might be the case with an alternative formula, and which cannot really be considered pro-poor.

The MOH has been working over the last year to develop a more needs-based formula for the allocation of financial resources to LGAs. The most recent proposal identifies a list of ten potential factors to be considered, but suggests that allocations to councils initially be based on four factors:

- Age and sex-weighted population (50%);
- Poverty levels, based on the Poverty Welfare Index of the geographical area under question (15%);
- An index of mileage, to and within the LGA (15%); and
- Burden of disease, to incorporate under-five and adult mortality rates plus any others available (20%)[11].

In the past few months, work has also been commissioned through the LGRP to review existing mechanisms and to propose an objective, equitable and transparent system of intergovernmental grants. The draft report proposes options for both vertical and horizontal resource allocation, and includes proposals and simulations for the health sector[12]. Three options are presented:

- 100% population, as with the current basket fund. This is both simple, objective, and transparent, and recognises the size of the LGA population as the primary determinant of demand for health care;
- Population (80%), land area (15%) and poverty count (5%), recognising the greater needs of rural, poor LGAs. Weights were determined based on implicit policy priorities;
- Population (70%), poverty count (regional) (10%), vehicle route mileage (10%), and infant or under-five mortality (10%), most closely reflecting the MOH proposed formula, but with an increased weighting for population[13].

Issues of data availability, reliability and the relative incentive effects of different factors will need to be taken into account in whichever formula is selected, as will the need to minimise the effect of any changes in LGA allocations, up or down, through phasing of implementation

[11] MOH Health Sector Reform Secretariat and Department of Health Policy and Planning. *Proposed criteria for allocation of resources in the health sector*. November 2002

[12] Andrew Young School of Policy Studies, Georgia State University. *Developing a system of intergovernmental grants in Tanzania*. Study prepared for the Local Government Reform Programme. Draft of 11 December 2002

[13] Op cit. (pp 4-44 to 4-45)

of the formula. In addition, close monitoring will be required to ensure that releases based on the formula actually reach the intended beneficiary sector, and that funds are spent in accordance with national and local priorities.

The intention of the LGRP is to introduce the new transfer system for FY04. It is therefore expected that further modelling of the impact of the different options will take place over the coming months, and it would be useful to clearly document the baseline allocations, and to monitor progress towards a stated equity objective in coming years.

4 Sectoral performance

4.1 Health sector performance in relation to the PRS

As in previous PERs, one key objective of this update was to review the performance of the health sector in terms of its stated policy objectives. The PER FY01 and the update for FY02 provide more detailed background information on the development of the Tanzanian Poverty Reduction Strategy. To recap briefly, the national health goal of the PRS is firstly to arrest the decline in life expectancy and then to raise it to 52 years by the year 2010. Policies are intended to achieve the following objectives by 2003:

- Lower the IMR from 99 to 85 per 1000 live births
- Reduce U5MR from 158 to 127 per 1000 live births
- lower maternal mortality from 529 to 450 per 100,000 births
- reduce malaria-related fatality for under-fives from 12.8% to 10%
- raise the proportion of the rural population with access to safe and clean water from 48.5% to 55%.

Strategies to achieve these objectives include strengthening immunisation services, improvement in the availability of drugs and supplies, provision of quality health services through delivery of the essential health package, and strengthening and reorienting the delivery of secondary and tertiary health services, to ensure more effective support of primary health care.

It is not possible to report here on the success or otherwise of the sector in terms of meeting these objectives, and delivering on the strategies. However, it is possible to broadly show the extent to which stated priorities, as articulated in successive budgets, have been met with actual expenditures.

Health was identified as one of the original priority sectors within the PRS, and although there is some debate regarding the unilateral decision by GOT to expand the definition of such priority sectors in subsequent progress reports, the data in Figure 1 in Section 2 indicate that the sector as a whole has received an increase both in the nominal level and the share of the budget since publication of the PRS.

The picture with regard to the priority items/areas within the sector is less clear. Table 16 below attempts to show the performance of the budget lines which comprise “primary health” since publication of the PRS. It should be noted that the figure for LA drugs allocation in FY03 overstates the allocation for drug kits as it includes also drugs for district hospitals, but was used as we were unable to obtain the figure for drug kits.

Table 16 Spending on PRS priority items, FY00 to FY03 (TSh bn)

Priority Items - Primary Health	Vote	Subvote	Item	FY 00 Actual	FY01 Actual	FY02 Actual	FY03 Estimates
OC Subvention to LA	*70-89 + 95*	*1001*	*all*	2.63	8.04	11.75	13.74
LA drugs allocation budgeted under MoH	*52*	*2001*	*260402*	5.75	4.62	7.63	10.40
MoH Preventive Subvote OC	*52*	*3001*	*all*	3.22	5.40	8.82	8.99
Regions Preventive Subvote OC	*70-89 + 95*	*3002*	*all*	0.09	0.08	0.05	0.12
Total: Primary Health				**11.69**	**18.14**	**28.26**	**33.24**
Total health spending - Govt				60.78	80.03	93.88	115.42
Primary health as % of Govt health				***19.2%***	***22.7%***	***30.1%***	***28.8%***

Table 16 shows that the nominal level of spending on PRS identified priority items (OC and government funds only) within the health sector has grown substantially since publication of the PRS, almost tripling in total. However, when this is compared with total on-budget government spending, although there was rather a rise of almost 11% in the share of primary health between FY00 and FY02, there has actually been a slight fall in the budgeted figures for FY03, from 30.1% to 28.2%. This needs further exploration as it implies that there has been a change in the implicit priorities within the sector away from those articulated in the PRS.

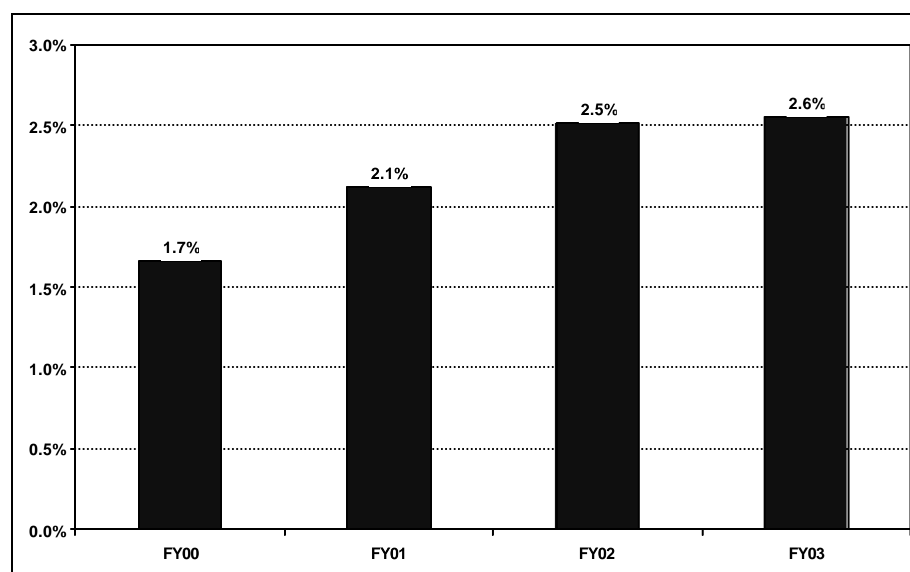
Figure 15 below demonstrates that the priority items within the health sector have absorbed an increasing share of overall (unadjusted) DRE, albeit at a very low level. Because of the relatively large increase in the share of health as a % of adjusted DRE (see Figure 2), the drop in the share of primary health within the sector is not seen in this graph, but the increase between FY02 and FY03 is very small at 0.1%.

It should be noted that there are various question marks regarding this table and the way in which it is calculated. For example, should it include government funding only, or also basket funds (presumably the latter, in which case presumably a similar adjustment needs to be made to the recurrent budget denominator as in Section 2.1)? Does MOH Preventive OC include the transfers to institutions such as NIMR and TFNC or not? And if it does, is that only the OC component or the total? Precisely which allocations for drugs are included: kits + councils loose drugs + DDH + district hospitals + VAs? Should MOH Preventive OC exclude the drugs and supplies which are included under the separate line for such allocations to LGAs, in which case where do these figures come from?

The PRSP is itself confusing as it indicates that only the OC component is to be included, yet reports PE figures in its own tables[14].

[14] See for example Table 3 on p35 of the October 2000 version of the PRSP.

Figure 15 Primary health spending as % of DRE, FY00 to FY03



4.2 Health sector financing performance indicators

The MOH has developed a performance profile in order to assess its progress towards meeting the objectives of reform and improved service delivery within the sector. Five of these indicators relate to aspects of health financing, and based on the analysis in the sections above new values of these indicators are provided in Table 17 below. The population figure for Tanzania mainland used to calculate the 2002 per capita values – 33,584,078 - is taken from the preliminary Census estimate, and the 2003 estimate is based on the estimated annual growth rate of 2.9%, ie 34,558,016[15].

Table 17 Finance-related health sector performance indicators

Indicator		Level	Baseline	FY02		FY03
				Budget	Actual	Budget
1	Total GOT public allocation to health per capita (central, regional, and district)	Central Regional District	TSh 1,245 TSh 172 TSh 848	1,558 222 1,107	1,529 208 1,058	1,785 233 1,323
2	GOT and donor allocation (budget and off-budget) to health per capita	National average	TSh 5,100	6,467	6,361	7,003
3	Per capita GOT recurrent expenditure broken down by level (central, hospital services, preventive services)	Central Hospital Preventive	TSh 190 TSh 1,077 TSh 894		246 1,100 1,231	
7	% of GOT funds available for budgeted and actual district health activities against the total overall funds available for district activities	Budget Actual	18% 15%	17.6%	n/a	17.7%
12	Cost-sharing fees collected by public health facilities in year x as a proportion of the 1998 targets	National average	0.46			

As mentioned in Section 2.3.3 above, there was discussion during the FY03 PER update process regarding the usefulness of the preventive/curative or hospital distinction as reflected in Indicator 3, given the inter-relationship between the two types of services, and the multiple purpose of different types of health facility. Although values of this indicator have been estimated as part of the PER process, a decision should perhaps be taken regarding future inclusion of this particular indicator. This would ideally be based on the broader discussion of the budgetary format and its appropriateness for intra-sectoral resource allocation.

[15] Taken from Draft Budget Guidelines, p19

The 2001 draft Performance Profile questions the usefulness of Indicator 12 which records cost-sharing performance, given the failure of many institutions to set targets. The incompleteness of the data is commented on in Section 2.3.5 above, and also detracts from the usefulness of this particular indicator, which has been left blank.

Table 17 shows an encouraging picture in terms of Indicators 1, 2, and 3, all of which have seen an increase in the per capita Tanzania shilling value. Increases are seen particularly in the per capita values of district-level GOT public spending which has increased by 56%, and in the per capita value of GOT recurrent spending on preventive services which has risen by almost 38%. Both these figures indicate that spending is increasing at the priority level. However, presentation of these figures in US dollar terms, or using a price deflator, would undoubtedly show a less optimistic picture.

The data on health spending as a proportion of local government subventions shows stagnation since the baseline year, although as seen in Section 3.1.1, there has been an increase in the overall level of the subventions.

5 Future costs and revenues

As in past years one of the requirements of the PER Macro Working Group for the sector PER studies, was that a costing of priority expenditure programmes and activities should be undertaken (See the TOR in Annex A). However, the nature of such a costing requires a separate study, as was undertaken for the new HIV/AIDS strategy, rather than being included within the TORs for the PER which is a relatively time-limited exercise. Although the recommendation to undertake such a separate costing has been reiterated in the PERs for FY01 and FY02, progress to date has been limited to an incomplete attempt to develop TORs for the exercise.

In the absence of a detailed costing of priority programmes as part of the PER update for FY03, the section below compares some of the cost information within the documents obtained from technical programmes, and also discusses the priorities identified by the MOH in their submission to the MOF for inclusion in the FY04 draft Budget Guidelines.

Data on expected revenues over the coming three year period are drawn from the MOF external financing database, together with additional information obtained during the course of the PER update process, and refer to both government and foreign funding, whether through the basket or other channels.

5.1 Future costs

In January 2000, the MOH produced a National Package of Essential Health Interventions in Tanzania, which outlines an *"integrated collection of cost-effective interventions that address the main diseases, injuries and risk factors, plus diagnostic and health care services to satisfy the demand for common symptoms and illnesses of the population to be served."*[16] However, the document includes no costing, and makes explicit the fact that *"(t)he number of interventions included in the package depends on the health expenditure per capita available.."*[17]. A preliminary costing undertaken in 1998, based on the 1993 World Development Report (WDR) framework of 1993, estimated the requirements for Tanzania to

[16] MOH. *National Package of Essential Health Interventions in Tanzania*, Dar es Salaam: January 2000 (page 2)
[17] Op cit.

be approximately US$9 per capita[18]. More recent work by the WHO Commission on Macroeconomics and Health (CMH), estimates the costs of scaling up a relatively limited set of priority interventions at between US34 and US41 for a very low income country[19]. There is clearly a wide discrepancy between these two, and the current relevance of the earlier estimates is therefore thrown into doubt.

Basic information requirements for a costing include technical (and political) decisions on what the critical, cost-effective intervention set should include, on existing and target coverage, on average unit costs of such interventions but also more geographically specific information on what the costs of scaling up coverage might be. Much of this is not yet available in Tanzania, although now would be an opportune time to initiate activity to better define these parameters. The recent exercise undertaken for HIV/AIDS could be usefully repeated, where the information does not exist, within other key technical programmes. Much could also be extracted from programme documents such as the *National Malaria Medium Term Strategic Plan 2002-2007*, and the recent financial sustainability analysis of EPI activities.

Additional sources of information on the future costs of scaling up essential interventions would be the IDRC-funded Tanzania Essential Health Interventions Project (TEHIP), and the DFID-funded Adult Morbidity and Mortality Project (AMMP). Both these projects have benefited from substantial investment for both health systems and services in their limited geographical areas, and presumably now have some useful lessons for the rest of the country.

There is an ongoing debate regarding the usefulness of such a costing exercise, given that experience from other countries has tended to illustrate the non-affordability of any such defined Essential Packages[20]. It is therefore important to be clear at the outset on the purpose of any such costing. A recent publication on costing PRSs highlights the confusion that exists *"..over whether the role of costing is to work within financial constraints imposed by the available resource envelope (as in the MTEF) or to estimate the full extent of the fiscal gap between a country's poverty reduction needs set out in the PRS and available resources."*[21] Clarification should be sought from the overall PER Working Group on this issue.

Table 18 below presents information from selected priority programmes regarding their estimated future costs. The source documents do not in all cases provided details of how the costs have been obtained, and it is not clear to what extent there has been discussion and approval of the contents therein. One advantage of a sectoral costing would be to ensure a standardised methodology across programmes, ensuring that shared costs are adequately represented. The malaria, HIV/AIDS and immunisation source documents were all drafts at the time of writing, and caution is urged in use of these figures. However, they provide an illustration of the potential costs of scaling up some key interventions, demonstrating that the high cost scenarios of these four programmes alone could potentially absorb almost a quarter of the total (ie on- and off-budget) resources available to the sector in FY03 (TSh 56.73bn / TSh 243.23bn).

[18] E Pavignani. *Recurrent costs in the Tanzanian health sector 1998-2009: An exploratory analysis.* November 1998
[19] WHO CMH report (op cit, footnote 7), Table a2.4 on p166.
[20] Examples include Malawi and Uganda.
[21] PRS Monitoring & Synthesis Project. *Costing Poverty Reduction Strategies – early experience.* Briefing Note 4. May 2002 (page 1)

Table 18 Estimated costs of selected priority programmes

	Scenario	FY03	FY04	FY05
TB+Leprosy		4,576,409,370	4,801,193,122	-
HIV/AIDS	high cost	17,621,902,375	25,357,087,095	48,378,361,694
	low cost	8,058,952,057	22,556,901,945	42,772,321,544
Malaria		13,697,803,500	18,168,941,700	19,878,011,100
EPI	high cost	20,830,447,500	20,889,998,500	30,943,566,000
	low cost	20,830,447,500	20,889,998,500	22,104,523,500
Total	**high cost**	**56,726,562,745**	**112,664,120,861**	**164,076,783,837**
	low cost	**47,163,612,427**	**66,417,035,267**	**84,754,856,144**

As part of the preparation of annual budget guidelines, MOH submitted a list of priority areas for funding to the MOF in December 2002. This list is reproduced below in Table 19, as an indication of estimated future costs of sectoral activities. It would be useful if the basis for these estimates were made more explicit in the submission to MOF, in part because the figures prepared this year for FY03 show an increase of 4.4% over the same estimates prepared last year (cf Table 33 in the PER update for FY02).

In addition, the list is quite exhaustive, and it would be useful to see what activities or expenditures have actually been excluded, particularly given that the total for FY04 is less than the actual resource envelope in FY03 (TSh 243.23 bn). While it is appreciated that a substantial proportion of this figure is foreign-financed, and may not be targeted at MOH priorities, it is imperative that donor spending be progressively streamlined to meet (jointly-agreed) priority needs.

Table 19 MOH financing requirements of priority activities (TSh bn)

	FY04	FY05	FY06
Central MOH, admin and reforms	**16.4**	**16.8**	**18.0**
Running costs	6.5	6.5	7.6
Priority activities, of which:			
Undertake health sector reforms	2.6	2.0	1.5
Payment of utilities and arrears	1.3	1.3	0.9
Strengthening of M&E through HMIS and research	1.5	2.0	2.5
Capacity building (training institutions)	4.5	5.0	5.5
National, referral, regional hospitals	**45.5**	**51.1**	**58.9**
Running costs	13.8	15.9	18.3
Priority activities of which:			
Drug procurement	9.7	11.2	12.9
Purchase of medical supplies and equipment	5.2	7.8	11.7
Strengthening of diagnostic services	2.9	3.7	4.7
Payment of utilities and arrears	1.3	1.3	1.3
Undertake hospital reforms	0.6	0.4	0.3
Rehabilitation of health facilities	12.0	10.8	9.7
District, primary & preventive services	**93.8**	**100.2**	**108.6**
Running costs, including arrears	48.3	48.3	48.9
Priority actvities, of which:			
Purchase of drugs (district hospital, HC and dispensaries)	23.0	26.5	30.5
Purchase of medical supplies and equipment	5.5	5.8	6.1
Grants and subventions to Vas and DDHs	6.0	6.0	6.0
Undertake District health sector reforms	1.5	1.3	1.2
Rehabilitation of health facilities	9.5	12.3	15.9
Implement public health programmes including:	**57.2**	**59.6**	**63.6**
Immunisations	12.6	13.9	15.3
Reproductive and child health including IMCI	12.6	11.7	10.9
TB and leprosy control	6.3	7.3	8.5
Malaria prevention and control	5.2	5.4	5.6
Sector response to HIV/AIDS and awareness campaign	9.1	9.1	10.0
Nutrition	3.0	3.3	3.3
Support community initiatives	3.0	3.5	4.2
Other preventive	5.4	5.4	5.8
Total resources to priority activities (Tsh bn)	**212.9**	**227.7**	**249.1**

5.2 Future revenues

5.2.1 GOT and basket funding

Discussion about the level of GOT and basket funding for coming years has been dominated in recent months by the increasing trend towards general budget support among development partners, in particular the Poverty Reduction Budget Support (PRBS) which is supported by the European Community and a number of bilateral donors. For the health sector, this has taken on particular importance in FY03 with the decision by DFID to withdraw from the MOH basket fund and to channel their support through the PRBS instead from FY04. This has profound implications for the level of future basket funding, and is likely to result in a dramatic change in the nature of the basket structure[22].

This PER update cannot go into detail on the arguments for and against budget support compared with basket funding. However, it should be noted that, although the principles of budget support are clear in favour of PRS-identified priorities, including the health sector and Primary Health, through a mechanism which aims to enhance overall budget performance, transparency, and to reduce transaction costs, experience to date with safeguarding priority expenditures is mixed.

The overall level and share of basket funding, as discussed in Section 2.3.1, has increased steadily between FY00 and FY03. However, the figure is set to fall in the future not only due to DFID's withdrawal, but also due to reduction in the contribution from the World Bank as a result of the ending of the current IDA credit which provides their basket funds. Table 20 presents very tentative estimates of future basket funding, based on existing agreements and additional input from some development partners during the PER update process.

Table 20 Possible basket estimates, FY04

		2003/04			
Partner	**Own currency**	**Amount (M)**	**R of Ex**	**USD (M)**	**TSh (M)**
DANIDA - central	DKK	15.9		1.9	2,168
DANIDA - district	DKK	50.0		5.9	6,732
Germany - KfW	Euro	3.0	0.82	2.5	2,818
Ireland	Euro	4.1	0.82	3.4	3,851
Netherlands	Euro	2.0	0.82	1.6	1,879
SDC	CHF	4.9	0.66	3.2	3,690
World Bank	USD	4.6	1.00	4.6	5,249
Total				**23.13**	**26,386**

The figures in Table 20 represent a drastic fall in the absolute level of funding through the basket, and have necessitated discussion regarding the shifting of focus to the LGA allocations as the basket is no longer large enough to support both central and council levels. In theory, the DFID contribution for FY04 has been implicitly earmarked for the MOH budget in order to replace central level basket funding, but this will not necessarily be the case in future years. Also, future PERs will need to monitor the extent to which the allocation of the central level budget meets the same priorities as have been targeted by the basket funds (eg drugs and supplies, as seen in type of expenditure at central level mirrors and it will be interesting to see the extent to which this occurs in practice.

[22] in particular the extent to which a central basket will exist in the future given the dramatic fall in the total resources available. Given the increasing importance of the basket in central level recurrent spending, as seen in Figure 4, the implications of this must be given careful consideration.

At the time of writing, the budget guidelines for FY04 had not been circulated generally. The figures in Table 21 below on the projected resource envelope are therefore drawn from the submission by the MOH to MOF in December 2002. However, these estimates predate the change in basket funding, and should therefore be treated with extreme caution. Errors have been assumed to fall in the addition, and have been corrected on that basis.

Table 21 Projected resource envelope (TSh bn)

	FY04	FY05	FY06
Ministry of Health			
Recurrent	72.30	83.70	96.90
Development	4.70	5.20	5.70
Central basket	34.50	44.30	56.70
Central Government	**111.50**	**133.20**	**159.30**
PORALG			
Recurrent	62.20	71.50	82.20
Development	1.70	1.90	2.10
Council basket	1.00	1.50	2.25
Local Government	54.70	31.90	36.20
Total Region/LGA	119.60	106.80	122.75
Total on-budget	**231.10**	**240.00**	**282.05**
Off budget			
Other foreign assistance	62.00	28.50	20.10
Cost-sharing - hospitals	1.70	1.90	2.10
Community Health Fund	1.00	1.50	2.25
National Health Insurance Fund			
Off-budget revenues	**64.70**	**31.90**	**24.45**
Total	**407.30**	**405.10**	**465.80**

5.2.2 External project funding

The database prepared by the External Finance Department of the Ministry of Finance includes estimates of future inflows through donor project and basket funding. Estimates for the coming years are given in Table 22 below. It should be noted that the database was developed prior to the withdrawal of DFID from the basket, and subsequent information that both World Bank and funding from the German government would also be reduced.

Table 22 Expected donor inflows, FY04 – FY06

	FY04	FY05	FY06
On-budget	56.17	53.12	21.42
Off-budget	34.34	30.04	32.87
Not indicated	15.93	16.32	4.84
Total	106.44	99.48	59.13

The drop off in the figures over the years is to be expected given that it is often difficult for development partners to forecast several years ahead, and it will remain important to update these figures as new data become available through MOF.

These figures raise another question with respect to Table 21 as the level of projected on-budget development funding appears rather low. Again, as with the figures for the current financial year, this prospective view of external financing could benefit from a reconciliation exercise between now and the next PER.

5.3 Indebtedness of the sector

The TORs required analysis to be undertaken of the scope and nature of arrears within the health sector, over the past three years, together with an assessment of liabilities. Due in part to non-availability of the relevant staff from the Accounts and Finance Unit, it has not been possible to go into detail in this area. The recommendation therefore remains that a

more detailed study of arrears and indebtedness be undertaken prior to the next update, if this is deemed to be a priority. The reference in the Draft Budget Guidelines to a debt of TSh3.7bn at Muhimbili National Hospital, as justification in part of a large increase in the allocation to this institution, suggests that further investigation is necessary. Given the scant information from LGAs and hospitals throughout this report, the magnitude of this task should not be underestimated.

The MOH Appropriation Accounts for FY02 report that total liabilities of the Ministry of Health itself totalled almost TSh2.6bn, ie 1.7% of the budget (on-budget share). Over TSh 1.5bn, or almost 60% of these liabilities, were "commitment expenditure transfers", ie monies committed but not yet paid out, as in the case, for example, of incomplete infrastructure contracts. The remaining TSh1.1bn represented 0.7% of the FY02 budget. Some limited analysis of the nature of the other liabilities within the sector is presented in Table 23 below.

Table 23 Scale and categorisation of major liabilities, FY02

Personal emoluments and benefits	410,463,870
Bi/Multilateral organisations	116,383,097
Basket Fund	57,474,324
Technical programmes and projects	35,290,093
Other	437,017,190
Total	**1,056,628,574**

Table 23 shows that the largest category of liabilities for the last financial year was related to pay and benefits of health sector employees. The bulk of this was due to delayed payment under the Selective Accelerated Salary Enhancement (SASE) (TSh354m), while a further TSh56m was due to unclaimed salaries. In a context where inadequate numbers of skilled staff, low pay and poor staff motivation hamper sectoral performance, the scale of these liabilities is worrying.

Attempts were made to obtain more information on the category of "madeni ya ndani" (internal debts) which are included under "Other" in the table above, but to no avail. Anecdotal evidence from the Accounts and Finance Unit indicated that most of the arrears and liabilities from FY02 had been paid off at the start of the new financial year, but we were unable to verify this.

6 Discussion, recommendations and next steps

6.1 Mixed sectoral performance

In the light of the low and only slowly increasing share of the government budget allocated to Health over the past two years, there is a case to be made for lobbying for more funding, in both absolute and relative terms, as part of the budget process for FY04 and beyond. Absorption capacity is clearly increasing, and the list of unfunded priorities remains substantial, and it would not be unreasonable to expect a shift towards 10% of total spending, and 15% of DRE for the sector.

Local government allocations are low and bear no resemblance to poverty, taken as a proxy for health/health service need. More work should be done to strengthen capacity at this level to ensure expenditures in line with allocations, and to improve the level of the financial allocations accordingly.

6.2 Implications of the progression from project funding through the basket to budget support

The clear move over the past years from project support to direct support to the recurrent budget at both central and local government levels has been very encouraging, and the systems show clear signs of maturing in terms of absorption. However, much work remains in terms of reconciling the information on the MOF database with that held by MOH, and in inclusion of such funding within the government budget, with the important proviso that such development/external spending is in line with PRS objectives.

In addition, the increasing share of central government expenditures on drugs and supplies and on HIV/AIDS related activities which has come from the basket raises concerns regarding the sustainability of such spending with the progressive move towards budget support. The withdrawal of DFIF from the basket in FY04, and potentially of the World Bank, will leave a shortfall in the projected level of earmarked funding for the sector, and the MOH should ensure that the earmarked funds from DFID for FY04 (and/or domestic funds from GOT) are used to pick up such priority spending at the central level in order to avoid a shortfall.

Close monitoring through future PERs will be necessary in this area.

6.3 Institutionalisation of the PER process

This is the third consecutive PER update for the health sector, and the exercise had also been undertaken in previous years. However, there appears to be little internalisation of the process, with continued heavy dependence on external consultancy to undertake the necessary analysis and produce a report according to the timetable. This is most likely due to inadequate capacity in terms of staff numbers, and to conflicting priorities, as the MOH has several sufficiently qualified, capable staff who should be able to handle the PER process. Financial incentive should not be an issue, given that the PER features in the MTEF as a specific activity, indicating the assignment of 8 staff over two months and a budget of TSh3.7m.

There was wide variation in the willingness of technical programme staff to meet with the PER Task Team, and the incentives for programmes to reveal their full resource envelopes. It is hoped that the continued improvement in the External Finance database will strengthen information in this area.

MSD has recently changed their management and accounting software, from Navision to Orion. This, together with a changeover in key staff, meant that it was not possible to easily retrieve essential data to feed into the PER sub-sectoral analysis of budgets and expenditures on drugs and supplies. Simple formats were provided by the Task Team in order to assist MSD staff in extracting from their manual records, and these were subsequently used by the Information Technology section to generate a computerised report. However, the dataset was incomplete, both in terms of geographical coverage and of the type of drugs and supplies distributed to councils (ie kits and loose supplies). These formats were not discussed within the MOH, and if the PER is to be institutionalised, it is important that staff from the MOH and MSD meet to discuss relevant information needs and reporting requirements, in order for the data to be provided in a complete, timely and user-friendly manner at the end of each financial year (or other selected reporting period).

6.4 Areas where more and/or better information is required

6.4.1 Better definition and monitoring of local level spending

The MOH, as other ministries, puts a great deal of emphasis on the development of the MTEF and the annual plan and budget, as reflected in the voluminous Detailed Cash Flow. PRS objectives, however, require that increasingly funds should flow to the local government level. It is therefore unfortunate that the technical programmes which appear to be both implementing various activities at local level, and providing support to the relevant councils, are not able to separate their various activities by level in order to provide a more accurate estimate of what is flowing to the different levels.

The PER also continues to rely on official figures on releases of OCs to LGAs rather than being able to access timely, accurate information on actual expenditures. Evidence from other sources suggests that substantial mis-spending occurs at the local level (REPOA)…. It is appreciated that once the IFMS has been extended to LGAs, the process of monitoring expenditures should be somewhat simplified, but given that the health sector at LGA level incurs expenditure under a relatively small number of budget lines, the failure to maximise the opportunities under the District Health Services section is regrettable.

6.4.2 Improved information on allocation of centrally procured drugs and supplies by level and by geographical area

Drugs and supplies are one of the major areas of expenditure in the health sector, yet the information regarding their distribution around the country is quite poor. This is due in part to changing systems and individuals at Medical Stores Department, and to competing demands upon the relevant personnel at the MOH headquarters. However, given the substantial investment in these items, and their importance in terms of perceived quality at first line health facilities by beneficiaries, more emphasis on strengthening drug and supply logistic information systems would be worthwhile.

The PER has traditionally attempted to obtain a geographical breakdown of the distribution of drug kits and drugs and supplies for hospitals. However, substantial quantities of drugs and supplies, including contraceptives, are brought in under donor-funded projects, and there appears to be little systematic documentation of their distribution. This will become increasingly important as implementation of activities under the Tanzania Multi-country Aids Project, and GFATM begins.

In addition, data on the allocation of drugs and supplies by level of care are required for some of the PER analysis to be meaningful, and for health sector performance indicators.

6.4.3 Off-budget external spending

The picture regarding foreign spending has been much improved with the development of a more comprehensive database on external financing by the Ministry of Finance. However, no reconciliation has been undertaken of the funding considered on-budget as per the MOH Development Budget (See Table 27 in Annex C) and that contained within the MOF database. In order to reconcile these figures, it is proposed that the figures from the MOF database are circulated to each bilateral and multilateral development partner for checking, and that updated information be provided at the time of the next Joint Review meeting in early 2003 or as soon as possible thereafter.

6.4.4 Cost-sharing income and expenditures

Resources generated through cost-sharing, although a small proportion of the total, and currently considered as off-budget spending, could potentially represent a more substantial contribution in the future, depending on future policy direction. However, the quality of information regarding their collection and use is currently very weak. For the NHIF, this may

well be rectified as the scheme becomes more established, although it would be good to see concrete progress in this area by the time of the next PER update.

For the Community Health Fund, and for the Health Service Fund, there appears to be little such excuse. The CHF is an externally-funded project, with sufficient resources to generate the necessary data on a timely basis in order to feed into the PER process, while the regulations governing the HSF, although not being followed, are very clear as indicated below:

> *"4.5.2 Monthly Progress Report: Medical Superintendent of Referral hospitals, Regional/District Medical Officers and Medical Officer in charge of the District Designated Hospital shall submit to the Principal Secretary Ministry of Health the Monthly Progress Reports not later than 12th of the following month (Annex E1 and E2). The Principal Secretary Ministry of Health shall consolidate the report and submit to the Treasury copy to the Controller and Auditor General."* [23](MOH 1997, p 7).

This information is required in order to be able to calculate Performance Indicator number 12, yet there are large gaps in the information provided to the MOH, as noted in Section 2.3.5. As these funds represent out-of-pocket expenditures by individuals, it is arguably more important that there should be complete transparency regarding their use, not only at the facility level but through central level reporting. As one of the expenditure categories relates to purchases of essential drugs, improved reporting in this area would also help to complete the picture regarding availability of drugs and supplies around the country, and enable useful statistics such as cost-recovery ratios to be calculated. Annex G gives details of the format of monthly reporting, and the income and expenditure categories as presented in the 1997 Guidelines.

6.4.5 HIV/AIDS spending

The sub-item 260409 which is used as a catch-all for Preventive Services Dept spending on HIV/AIDS (through NACP) falls under the Item code 2604 Medical supplies and services. This is a somewhat misleading code for HIV/AIDS-related activities within the MOH as all other sub-items relate to actual drugs or supplies whereas review of the relevant activities within the MOH Detailed Cash Flow reveals that they include workshops, short courses, printing, computers, drugs etc, all of which have their own sub-item codes. These leads to a) inconsistency in the manner in which HIV/AIDS related spending is budgeted and reported in two different departments of the same ministry, and b) lack of clarity in exactly how the funds identified as sub-item 260409 have been spent, ie the extent to which they have gone on essential direct inputs such as drugs and supplies compared with, for example, staff allowances and travel.

For this reason, it may be more appropriate to highlight HIV/AIDS-related activities through identification of a new sub-vote, to be included in each MDA rather than as a catch-all sub-item. At the same time, for the health sector this runs the risk of increasing the vertical nature of activities undertaken by NACP. This will need further thought, and is being considered also in the PER for HIV/AIDS.

6.5 Budget coding and structure

The issue raised in Section 6.4.5 above is symptomatic of a more general problem in the structuring of the MOH budget, and has been raised in successive PERs. The major problem comes in the coding by cost centre, ie inclusion of substantial expenditures under

[23] MOH. *Ministry of Health Accounting Circular Number 2 of 1997 of Health Services Fund for cost sharing (User fees)*. Cost Sharing Implementation Team, MOH, December 1997 (page 7).

MOH headquarters departments which would more appropriately be assigned by level of the system, and ideally to individual cost centres (LGAs or hospitals). This would greatly simplify some of the analysis undertaken through the PER in terms of type of spending, or spending by level.

In addition, various item or sub-item codes are duplicative, particularly in the areas of employment allowances and fees for consultancy services, which enables the total expenditure in this area to be understated. The continued reliance on employment allowances as a means of enhancing salaries, rather than through a more appropriate wage policy, lies beyond the remit of the MOH, but the Ministry and partners should continue to lobby for action on this front.

The Development Budget is another area where budgetary structure confounds analysis, as much spending through so-called development projects is actually in support of recurrent expenditure. The inclusion of the basket funding in the Platinum reports provided by IFMS is a welcome step, but further analysis should be undertaken during the course of the eyar to unpack the existing projects both from the MOH and local government Development Budgets, and others contained in the MOF database, in order to identify type of spending, geographical areas, level of the health care system etc. This would facilitate a more complete analysis of public expenditure in the sector in the future.

6.6 Costing priority activities

Finally, the debate within the MOH regarding the need or otherwise to undertake a full costing of priority activities must be concluded one way or another. In any case, such an activity cannot be properly performed as part of the PER exercise, but requires substantial time and resources in its own right. As outlined in Section 5.1, a number of decisions need to be taken if this is to go ahead:

- The objective for such a costing must be clear;
- Agreement must be reached on a more limited and therefore feasible list of priority interventions;
- A standard methodology must be adopted, across programmes, based on either a full costing or an incremental costing;
- Assessment must be made of whether the methodology is appropriate given existing data constraints, and if not, how these constraints can be progressively lifted;
- There must be commitment to use of the findings in terms of reassigning expenditures in line with priorities in the future.

7 Annexes

Annex A: Terms of Reference for the Health Sector PER update

Purpose and Key Objectives

Since FY98, the Government of Tanzania working in partnership with development partners/donors and local stakeholders, has undertaken Public Expenditure Reviews, which have greatly influenced pertinent public policy formulation and budget management. PER FY03 will consolidate and build on the achievements realized so far. The main objectives of PER FY03 are to:

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

In achieving these objectives, all priority sectors are required to undertake PER update work to (a) immediately feed into the preparation of the Budget Guidelines before December 2002 and (b) inform the PER FY03 consultative meeting in May 2003.

Background for the Health PER

The role of the PER in the health sector is to provide the Ministry of Health and other key stakeholders in the sector) with a medium term view of budgetary allocations across the sector, and to review how they match with the stated strategic objectives. The purpose is to ensure efficient and effective use of scarce resources by strengthening the planning, budgeting and allocation across the sector. In addition, the PER should also provide information on: the anticipated resource envelope for the medium term, the cost of fully-financing all priority items within the budget, and the scope for progressively shifting resources to priority items within the sector over the MTEF period.

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

In Tanzania, health sector priorities are identified in the MTEF for the MOH, the Tanzania PRSP, and in the health plans of local councils and regional administrations. A new Medium

Term Strategy for the Health Sector is presently under preparation. This will articulate how PRS targets for the health sector will be addressed over the medium and longer term. The MOH, Regional Administrations and Local Councils are responsible jointly for the development of operational plans and budgets on a year-to-year.

Outputs of the Health Sector PER

The PER must provide key outputs in time to feed in to the budget guidelines 2nd December described under section 1 below. A full draft report should then be prepared, including outputs under section 2. The final draft of the report must be completed not later than 18th December.

Section 1: Outputs to feed into the preparation of MOF's Budget Guidelines, deadline 2nd December

- Describe health sector strategic objectives, priority areas for financing in the medium term and implications for budget allocation
- Provide estimates to feed in to budget guidelines including:
- Estimated resource envelope (all sources of financing on/off-budget, including revenues collected & retained in the health sector), high and medium scenarios
- Undertake/refine costing of priority interventions[24] over the medium term and their impact on PRS targets. Compare the financial requirements for meeting PRS targets to projected resource availability for the sector (see b(i) above) and present options for restructuring expenditure to meet the targets. This should also take account of the "residual" required to cover normal running costs. Spell out the implications of these options and recommendations (e.g. scaling back targets, improving efficiency, mobilization of additional resources etc).
- Profile of outstanding arrears for MOH (central), National/Referral hospitals, and principal expenditure items on which arrears occur. Identification of portion of arrears to be settled in FY03/04.
- Magnitude of implicit and explicit contingent liabilities (MOH, National and Referral Hospitals)

Section 2: Complete Sector PER Report, deadline 18th December

Specific Tasks

Review PER FY02 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 FY03.

Analyze the recurrent and development budget performance for the past three years (aggregate actuals vs budgets).

Show clearly the trends in expenditures at sectoral and sub-sectoral level including central-local government split. This should include doing an analysis of priority areas/items of expenditure highlighted in the PRS.

- Assess whether and how far these trends reflect policy objectives.

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

- Review deviations in overall budget performance (budgeted vs. actual expenditure) indicating clear justifications for such deviations and factors constraining the allocation of resources and supervision/control of expenditure.

- Assess planned versus actual resource allocation in FY01/02 at sectoral and sub-sectoral levels highlighting any notable new developments and their relationship with the FY02/03 budget.

- Analyze non wage expenditures (OC) by major expenditure items over the past three years and assess the relationship between budgeted and actual expenditures for at least five largest budget items. Also assess the appropriateness of the current composition of OC expenditures with respect to achieving the objectives of the sector. This analysis should use the same (re-) classification of expenditures used in the previous Health Sector PER (FY 01, 02).

- Document which expenditure items have benefited most from increased budget allocations and actual expenditures of the sector, indicating amounts (percent) that went to OC and to PE, and if there was prioritization to specific expenditure items, e.g. maintenance, transport, training, etc.)

- Provide a profile of arrears over the past three years, identify principal expenditure items on which arrears occur, and discuss underlying causes for arrears and measures taken to contain the accumulation of arrears

- Identify explicit and implicit contingent liabilities and indicate magnitude of these liabilities.

- Analyze revenue collection by the sector/Ministry, including a description of the tariff structure and base, the appropriateness of the administrative set-up, and rules for the use of such revenue.

- Undertake a detailed review of the health sector/MOH project portfolio, including project name/purpose, start and expected completion dates of the projects, status of implementation, coherence with PRS objectives and targets as well as the overall expenditure program of the ministry, recurrent expenditure implications.

- Analyze (a) the profile of MOH payroll (established posts, and staff in post, and unfilled positions by grade) and a discussion of the adequacy of the staffing profile; and (b) staff assignment i.e. ministry HQ, branch, region, district).

Discuss in detail how the decentralization affects the Ministry's expenditure program including transfers of staff that affect the wage bill, changes in expenditure responsibilities

Review the latest report of the Controller and Auditor General on MOH and the External Audit of the Central Basket, actions taken by the sector to address the major queries raised on systemic fiscal issues, and assess adequacy of the actions taken.

Review existing plans and strategies for the sector (including prioritization), with a view to harmonize the PRS, sector policies/objectives and MTEF. This will include, among others, re-aligning the sector priorities and articulating the links between the inputs and outputs identified in the MTEF and sector /PRS objectives.

Undertake/refine costing of priority interventions[25] over the medium term and their impact on PRS targets. Compare the financial requirements for meeting PRS targets to projected resource availability for the sector and present options for restructuring expenditure to meet the targets. This should also take account of the "residual" required to cover normal running costs. Spell out the implications of these options and recommendations (e.g. scaling back targets, improving efficiency, mobilization of additional resources etc).

Identify the key performance indicators that will be used to monitor progress, with reference to the PRS indicators, the PRS Progress Report and the Health Sector Performance Profile. These should include annual indicators and more medium term impact measures. These should relate to the PRS and information being collected through the poverty monitoring process. Also use these indicators to review sector performance and progress toward meeting PRS targets and MDGs.

Identify HIV-related activities and costing to be included in the 2003/04 Budget and MTEF FY04-06, drawing upon the preliminary costing of the Draft Health Sector Strategy for HIV/AIDS. Also assess status of HIV/AIDS budget execution for FY02 and FY03 and identify any major impediments.

Reporting Requirements

Outputs to feed in to the budget guidelines must be made available by <date>.

A full draft PER report, including annexes, tables and figures should be submitted by <date> in electronic form (MS-Word and MS-Excel)

The finalized report, taking account of comments/recommended amendments should be submitted in electronic form (as above) by <date>

The report will have a maximum of 40 pages, excluding appendices. It must include an accessible summary on the principal conclusions, policy implications and recommendations for wider distribution to the public (maximum 5 pages).

Programme of Work

Health Sector PER TaskTeam

In order to undertake the Health Sector PER, 2003, a task team is required, with members from all parts of the health sector, as well as those responsible for collecting and assimilating financial data for the sector. The PER task team for 2003, consist of the following members (t.b.c):

Mr Richard Mkumbo	Economist, Directorate of Policy & Planning, MoH (Co-ordinator)
Mrs Regina Kikuli	Economist, Head, Planning and Budget Section, MoH
Ms Mariam Ali	Economist, Directorate of Policy & Planning, MoH
Ms Nainkwa Mnzava	Economist, Directorate of Policy & Planning, MoH
Mr Mganga	Directorate of Local Government, PoRALG
Mr Richard Shankango	Accountant, Ministry of Health
Mr Charles Kibaya	Budget Officer, Ministry of Finance

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

Mrs Valeria Mamkwe Budget Officer, Ministry of Finance

In addition, an external consultant will provide technical assistance to the sector, involving two visits to Tanzania, firstly to support the PER task team to undertake the PER 2003. The consultant will bear sole responsibility for the completion of the PER draft and final report.

Health Sector PER Working Group

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

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

Timetable of activities

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

Activity	Dates	Responsibility
Formal Agreement on TOR	5 Nov.	PER Working Group
Collect core data:		
MoH, MoF, PORALG, local councils, development partners	4-15 Nov	PER task team
Collect additional data:		
Councils, MSD, MoH, MoF, BFC, CHF, parastatals	11-25 Nov	Consultant and PER task team
Preparation of draft report:		
Input data onto computer	11-25 Nov	Consultant and PER task team
Data analysis training and compilation of draft report	25–29 Nov	Consultant and PER task team
Presentation of data/outputs required for Budget Guidelines	2 Dec	Consultant and PER task team
Compile draft report	2-9 Dec	Consultant and PER task team
Feedback and final report:		
Present PER results	10 Dec	Consultant and PER task team
Amend draft report	10–13 Dec	Consultant
Disseminate final report	16–18 Dec	Ministry of Health

Annex B: Sources of information, key assumptions and other notes

Data for all tables and figures are included in a single accompanying file, **\PER tables 2003**, and the various "tabs" within this worksheet are, it is hoped, self-explanatory. However, much of the data in this file has been copied in from other working files, and has been copied as values rather than showing the various formulae or more detailed source data. The description of sources below therefore refers to the original source documents and working files, rather than the relevant tabs within \PER tables 2003, although these also generally specify the source data.

Figures

Figure 1: On-budget health spending as a proportion of the total GOT budget, FY99-FY03
Data on health spending is based on the figures in Table 1, **file \PER tables, tab Table 1,** which is itself drawn from Annex Table C1 (see below). The figures for the denominator, ie total GOT budget estimates and budget outturns, were taken from documentation circulated on behalf of the PER Macro Working Group to participants at the annual PER Consultative Meetings. The data is located in file **\PER tables, tab F1+F2 data**. ***<<add in the precise titles, add in the table of figures to Annex C>>***

Figure 2: Recurrent health spending as a share of adjusted DRE
Data for Figure 2 is drawn from largely the same sources as for Figure 1. Adjusted DRE is defined as DRE plus recurrent basket funding (to both MOH and councils), in order to ensure consistency between the numerator and the denominator in calculation of these figures. Data for the basket funding is taken from Annex Table C1 (see below).

Figure 3: On-budget share of domestic and foreign funding, FY99-FY03
Data for Figure 3 is taken from Table 2 (see below). Foreign funding includes both basket funding (recurrent and development, central and local government) and other project funding from the development budget identified as health sector spending. All original sources are as given in Annex Table C1 below.

Figure 4: Basket funding as a share of recurrent health spending, FY00-FY03
Data on the share of the basket is taken from Annex Table C1 below.

Figure 5: Proportion of estimated budget by level, FY99-FY03
Figure 6: Proportion of actual expenditure by level, FY99-FY03
Data on the breakdown of budgeted and actual on-budget spending in the sector by level (central, regional and local government) is taken from Annex Table C1 below.

Figure 7: The trend in allocation by category of spending, FY00-FY03
The data in Figure 7 are taken from Table 3 (see below). Some data gaps mean that this breakdown should be treated with some caution, and ideally the analysis repeated once all outstanding gaps have been filled.

Figure 8: Trends in on-and off-budget shares of health spending, FY00-FY03
Data on on-and off-budget shares are drawn from Annex Table C1 (see below).

Figure 9: Variation in per capita hospital drug allocations by region, FY02
Data on per capita hospital drug allocations and the regional variation from the mean value are taken from file **\Hospital drug allocations FY02**. This file collates data on the value of

quarterly allocations to each hospital (district, district designated, and regional, indicating who the account holder is. The data <u>do not</u> include the referral, specialist or national hospitals. This data was originally provided in separate quarterly files by the Chief Pharmacist which can also be found in the folder \Drugs. Population data was taken from the official website (www.tanzania.go.tz/fpopulation.htm ***<<check>>***)

Figure 10: Health sector external financing by budget status, FY03
Figure 11: Health sector external financing by implementing agency, FY03
Data on the breakdown of external financing to the sector in Figures 10 and 11 is taken from the database compiled by the External Finance Department of the Ministry of Finance which is contained in file **\External finance projections 2003-2006**. The various calculations can be found in **\Ext Fin manipulations**. The data itself is based on information solicited by MOF from development partners on their various contributions to the health sector, and internal knowledge as to whether the various projects are currently captured within the Got budget. A substantial proportion of projects have gaps in the information, resulting in the relatively large share of "not indicated" in Figure 10.

Figure 12: Health LG budgets as a proportion of total LG budgets
This figure compares estimates for government subventions to health (OC and PE) at LGA level to the LGA total allocation, by type of council, ie district or urban. Approved estimates are used for FY02, and estimates for FY03, from *Volume III Estimates (Regional) Urban and District Councils*. Data are presented in **\Local Government 2003, tab "sectoral %"**.

The graph also plots OC allocations to the health sector as a percentage of total OC allocations for FY03. Data were not available for a comparison with FY02.

Figure 13: PE:OC split at LG level, FY01-FY03
Data on the breakdown at local government level between PEs and OCs are taken from **\Local government 2003, tab "sectoral estimates"**. Data for FY01 and FY02 are approved estimates, while data for FY03 are original estimates.

Figure 14: Primary health spending as % of DRE, FY00-FY03
Figure 14 measures spending on "primary health", defined as the designated priority items within the health sector in the PRS, as a share of DRE. The data include government spending only, and so unadjusted DRE is used, taken from **\PER tables 2003, tab "F1+F2 data"** (see above).

<u>Tables</u>

Table 1: Total public health expenditure in Tanzania (TSh billion)
Table 1 shows the same data as Annex Table C1, shown in billion Tanzania shillings rather than units. Sources are given below under Annex Table C1.

Table 2: Public health spending, by funding type (TSh billion)
Table 2 is also drawn from Annex Table C1, summarising data on government and foreign funding for both on- and off-budget components of total spending. The foreign funding included under Recurrent includes donor basket funding to the MOH and to LGAs (and includes procurement, at least for FY02 and FY03 in the MOH total). The small proportion of the basket funds which pass through the Development Budget are included with other foreign funding under Development.

Table 3: Summary of spending by level/category, FY99 – FY03
Table 3 is an updated table based on previous PERs. FOR MOH Central/Admin, PEs and OCs are taken from the relevant departments, based on figures in previous tables, and the

Platinum report for FY02 (copied into **\Ministry of Health 2003, tab recurrent detail**). Data for NIMR and TFNC represent the transfers from the Department of Preventive Services, with the split between PE and OC identified from the MTEF/Detailed Cash Flow.

For most hospitals, the PEs are taken from the relevant transfers identified in the Detailed Cash Flow or Platinum files, supplemented where necessary with information from Release Warrants from the Department of Hospital Services. The OC allocation combines OCs where given in the details of the transfers or in the Detailed Cash Flow, together with information on actual allocations by hospital (see **\Hospital drug allocations FY02**). Caution should be excised in interpretation of this table, given the incomplete and inconsistent data on drugs and supplies provided for the PER FY03 update, as totals do not tally with earlier tables.

Regional hospitals are assumed equivalent to the Curative subvote at Regional level (**\Regional data 2003**) and District Hospitals are assumed equivalent to the Curative subvote at Local Government level (**\Local Govt 2003, tab …..**).

MOH Preventive represents the balance of the departmental allocation after deduction of the transfers to NIMR and TFNC. It is not clear to what extent the Medical supplies and services listed in the estimates and appropriation accounts are allocated by level, and this requires further analysis. Regional preventive is self-explanatory and is taken from an electronic version of the regional Appropriation Accounts for FY02, provided by PORALG.

Table 4: Breakdown between recurrent and development spending, FY00 – FY03
Table 4 is also drawn from Table 1, summarising total recurrent and total development on-budget estimates and actual expenditure.

Table 5: Budget performance of recurrent funds, government and basket, FY02
Table 5 summarises the Platinum report for the month of June 2002, which represents the end of the financial year. This was obtained in Excel format from the Account Department of the MOH. The data have been manipulated by Department and sub-item, and are reproduced in summary form in **\FY02 MOH IFMS**.

Data for the procurement component of basket funding has been taken from a printout from Charles Kendall, the company which acts on behalf of the basket donors in matters of direct procurement. The figures are given in sterling, and an approximate exchange rate of £1: TSh1,300 has been used which needs verifying (the Bank of Tanzania website had figures for US dollar figures only). One shipment of vehicles was incomplete, and the decision was taken to include 14/15 of the value of a similar order (for 15 twin-cab pickups) based on interpretation of the notes to the Charles Kendall table. All procurement was included under the Department of Policy and Planning, which probably overstates the allocation to this Department.

Table 6: Spending by MOH department on drugs and supplies, FY02 and FY03
Table 6 is drawn from the IFMS Platinum files for FY02 and FY03, and summarises expenditure by MOH department on sub-items 260401 through to 260408. The HIV/AIDS epidemics sub-item (260409) was excluded as it refers to all activities of NACP rather than to Medical supplies and services. The relevant data can be found in the various departmental tabs in **\FY02 MOH IFMS** and **\FY03 MOH IFMS**

Table 7: Drugs and supplies allocation by level and type
This table is based on data provided by the Chief Pharmacist for releases to hospitals in all four quarters of FY02 (**tab "by hospital" in file \Hospital drug allocations 2001-02**).

Queries remain as to whether there was additional spending on MOH Preventive as in previous PERs the table has referred to Preventive and Dispensary, whereas the data provided only mentions Dispensary. Similarly, in previous PERs, the table has referred to Emergency/Reserves, whereas the data provided make reference only to emergency supplies. The figure for vertical programmes is also rather low compared to previous years.

The figure for drug kits is taken from different data provided by the Chief Pharmacist, and is believed to include a contribution from the HSPS project (approximately equal to drug kits for one quarter). This failure to separate out sources and allocations reduces the usefulness of the current practice of measuring drug spend as a % of MOH recurrent only (ie GOT funding, excluding basket and project spending on recurrent items). This could perhaps be reviewed in the future.

Table 8: MOH hospital drug allocations by level/hospital type, FY02
Table 8 is also drawn from the data provided by the Chief Pharmacist and located in **\hospital drug allocations FY02, tab "by level"**. It excludes hospitals falling under the army (TPDF) and national service (JKT).

Table 9: HIV/AIDS spending, Central MOH (TSh)
Table 9 shows identifiable spending on HIV/AIDS related activities by the Preventive and Curative (Hospital Services) Departments at MOH headquarters, and is drawn from the Platinum files. For Preventive Services HIV/AIDs related activities are identified, as mentioned in the text, through a specific sub-item code relating to NACP. For the Hospital Services Department, HIV/AIDS related activities were identified using the Detailed Cash Flow volume of the MTEF. The relevant activity codes were then extracted from the IFMS file and summed. The original data for the HSD for FY03 can be found in **\FY03 MOH IFMS, tab "HIV-AIDS 2001 JD".** It was not possible to include data for government curative spending HIV/AIDS on FY02 due to lack of sufficiently detailed documents, although a similar exercise as for FY03 could be undertaken given access to the Detailed Cash Flow volume of the MTEF for FY02. For Preventive Services, the data is in **\FY02 MOH IFMS** and **\FY03 MH IFMS, tabs "3001 GOT" and "3001 JD".**

Table 10: HIV/AIDS spending by Local Government Authorities, FY02-FY03
Data in this table are drawn from Volume III Estimates **<<check title of LG volume>>**, and can be found in **\Local Government 2003, tab "HIV-AIDS spending"**. Figures for FY02 reflect approved estimates, while for FY03 the estimates were used. The numerator for calculation of the percentage share is the total OC allocation to LGAs in FY02 and FY03, drawn from the same file, **tab "sectoral %"**.

Table 11: Crude classification of development projects within MOF database
This breakdown in external spending (on- and off-budget) is taken from the MOF database referred to in the text and in the notes for Figures 10 and 11. More details of the selected categories are given in Annex **x**, and the classification given to each of the 128 projects is located in **\Ext Fin manipulations**. This classification is unashamedly crude, and further work should be undertaken to refine it during the course of the year, in order to better identify the extent to which externally financed projects and programmes are contributing to PRS objectives.

Table 12: Government subventions to LGAs, FY01-FY03 (Billion shillings)
Table 12 shows the absolute level of Government subventions to LGAs for health, as represented by the four sub-votes (Curative, Preventive, Health Centre, Dispensary/Clinic). It is drawn from United Republic of Tanzania, *Volume III Estimates of Public Expenditure Supply Votes (Regional), Details on Urban and District Council Grants and Subventions for the year from 1st July, 2002 to 30th June, 2003 as submitted to the National Assembly*.

Table 13: Variation between LG budget and release for OCs, FY02
Table 13 shows the difference between the Approved Budget for each LGA in FY02, and the subsequent sum of periodic releases, and the data are located in \Local Government 2003, tabs "sectoral estimates" and "Release FY02". The Approved Budget is taken from *Volume III Estimates (Regional), Urban and District Councils*, while the releases are taken from the quarterly newspaper listings of sectoral OC releases.

Table 14: Regional variations in per capita government LG allocations
The variation in regional per capita allocations, for both OC and for PEs, is taken from **\Local Government 2003, tab "per capita by region"**. The original data come from previous PER tables (for FY01), and from *Volume III Estimates (Regional), Urban and District Councils* for FY02 and FY03. Population data are taken from the official website (www.tanzania.go.tz/fpopulation.htm)

Table 15:
The data for correlations summarised in Table 15 can be found in \Local Government 2003, tab "cf poverty". The poverty data is drawn from the 2000/01 Household Budget Survey (electronic version), regional estimates of the Headcount ratios for the Basic Needs and Food Poverty Lines. The per capita estimates of LG spending are as in Table 14 above.

Table 16: Spending on PRS priority items, FY00 to FY03
The information on which are the relevant PRS priority items is drawn from the original PRSP of October 2000, page xx. The data are located in **\PRSP tab "PER table 15"**, and include OC allocations only as per the original PRSP. Original sources include: \Local Government 2002, tabs "urban recurrent" and "district recurrent"; \Local government 2003, tab "sectoral estimates" (based on *Volume III Estimates (Regional), Urban and District Councils)*; \Final tables 2003, tab "drugs" (from previous working PER tables, and the information for FY02 provided by the Chief Pharmacist); \Regional estimates 2003, tab "recurrent regions" (from previous PER working tables and Volume x, **……add……**); and \Ministry of Health 2003, tab "recurrent detail" (from the Platinum report).

The figures on government on-budget spending on health are actual expenditure figures for FY00 to FY02, and estimates for FY03, and are taken from Annex Table C1.

Table 17: Finance-related health sector performance indicators
Details of the indicators themselves are taken from MOH (2001). *Health sector performance profile 2001*, draft. The calculations are based on earlier tables within the PER. No figure could be calculated for Indicator 12 due to lack of information on the "target" for cost-sharing.

Table 18: Estimated costs of selected priority programmes
Data in this table is largely drawn from documents from the four programmes represented, apart from data on TB/Leprosy, which has been reproduced from the PER update for FY02. Where figures were given for calendar years rather than for financial years, the mean of the two years has been used. US dollar exchange rates were taken from the MOF external finance database.

Figures for HIV/AIDS are drawn from the Dec 2002 *Costing of HIV/AIDS Strategic Plan 2003-2007*, 2nd draft, with the exception of the low cost scenario for FY03 which is taken from the PER update FY02, Table 31 NACP budget requirements, and the FY03 high scenario is equivalent to the 2003 high estimates in the draft strategy costing as no figures were given for 2002. These figures may be slightly on the high side as some interventions may be implemented through other ministries but as the majority of the interventions listed in the draft costing are for care and support, the assumption has been made that they would be implemented through the NACP.

Figures for Malaria are taken from the *National Malaria Medium Term Strategic Plan 2002-2007*, draft 1.8 of September 2002.

Table 19: MOH financing requirements of priority activities (TSh bn)
This table is taken from the submission by the MOH to the Ministry of Finance for compilation of the Budget Guidelines for FY04. The basis for the calculations, and the source of the estimates is not known, and should be indicated in future such submissions.

Table 20: Possible basket estimates, FY04
The figures in Table 20 on possible basket estimates are taken from responses by individual development partners to an email circulated during the PER process, as noted in the relevant Tab in \PER tables, with the exception of DANIDA and World Bank which are taken from Annex 7, the Donor Side Agreements, of the report from the *Tanzania Joint Health Review of 11-13 March 2002* (final report dated 22 March 2002). As such, it may overstate the potential resources available as World Bank funding in particular is not certain.

The exchange rates are taken from the External Finance database of the MOF, and the Euro: US dollar one has been extrapolated from the Tanzanian shillings rates therein for FY04. This should be checked.

Table 21: Projected resource envelope (Tsh bn)
The projected resource envelope in this table is also taken directly from the submission by the MOH to the MOF for preparation of the Budget Guidelines for FY04. There are various queries regarding this table as the sources and bases for calculations were not clear, and there were various errors in addition, particularly for PORALG. The original table has been interpreted as well as possible, and noticeable errors in the addition corrected, but the data should be checked. The figures show a dramatically lower figure for the council basket, which is partly due to the practice by the Ministry of Finance to reduce projected estimates of foreign spending according to past experience with disbursement by individual development partners. It is assumed that Regional spending is included under PORALG, but clarification of this would be welcome.

Table 22: Expected donor inflows
The figures on expected donor inflows for the coming three year period are taken from the MOF database, and include both on and off-budget projections of expenditure. They are therefore subject to the various caveats mentioned throughout the text in relation to this database.

Table 23: Scale and categorisation of major liabilities, FY02
The information on major liabilities was taken from the Appropriation Accounts of the MOH (electronic version of late December), and subjected to a crude categorisation.

Annex C Table 24: Total expenditure on the health sector in Tanzania (TSh)
This is the base table from which several others are drawn. MOH recurrent budget data is drawn from *Volume II Estimates of Public Expenditure (Consolidated Funds Services (Section 1) and Supply Votes (Ministerial) for the year 1 July 2002 to 30 June 2003 as submitted to the National Assembly*, while recurrent expenditure data for FY02 is drawn from the latest version of the *MOH Appropriation Accounts* (electronic version received 27 December 2002).

Regional recurrent budget data is taken from *Volume III estimates of public expenditure Supply Votes (Regional) for the year 1 July 2002 to 30 June 2003 as submitted to the National Assembly*, and recurrent expenditure data is taken from an electronic version of the *Regional Appropriation Accounts* summary provided by PORALG. These can be found in **file \Regional data 2003**.

Estimates and Approved Estimates for local government recurrent budget figures are taken from *Volume III Estimates of Public Expenditure Supply Votes (Regional), Details on Urban and District Council Grants and Subventions for the year from 1st July, 2002 to 30th June, 2003 as submitted to the National Assembly* for FY03 and FY02 respectively. Data on actual expenditure lags by two years, and is taken for FY01 from the same volume.

Estimated and actual Basket funding figures for MOH headquarters for FY02 and FY03 are taken from IFMS, more specifically from an electronic (Excel) version of the relevant Platinum reports. Source data is located in **\FY02 MOH IFMS** and **\ FY03 MOH IFMS**.

Basket data for councils is drawn from audit reports (add in FY), and from minutes of the Basket Steering Committee ***<<check with Jacky>>***. Source data is contained in **\Local government 2003, tabs "LG basket 00 to 03"**.

Development spending from the basket is taken from Kitabu cha Nne, and the Appropriation Accounts of the MOH.

Annex C Table 25: Budget, release and expenditure by MOH Department, FY03
Data for this table are drawn directly from the Platinum report for 31st December 2001, and are located in **\FY03 MOH IFMS, tab "summary"**. Budget data represents approved estimates for the financial year, while release and expenditure refer to the first two quarters (July to December 2002)

Annex C Table 26: HIV/AIDS projects listed in MOF External Finance database, FY03
Data in this table is taken from the MOF External Finance database, and includes selected information regarding the 9 projects classified during the crude categorisation as relating to HIV/AIDS. The source data can be found in **\Ext Fin Manipulations, tab "categories"**.

Annex C Table 27: MOH Development budget by funding type, FY03 (TSh)
Data in this table come directly from the Government estimates as contained in the *Kitabu cha Nne (Ministerial)* for the financial year 1 July 2002 to 30 June 2003. The data is reproduced in **\MOH 2003, tab "development"**.

Annex C Miscellaneous additional tables and figures

Table 24 Total expenditure on the health sector in Tanzania, FY99-FY03

	1998/99		1999/2000		2000/2001		2001/2002		2002/2003
	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
Recurrent									
Ministry of Health									
Government funds	37,247,835,300	37,150,248,895	33,771,197,537	32,055,992,068	40,146,725,500	39,885,344,271	49,087,814,200	48,165,359,880	58,116,336,180
Donor basket fund			5,424,913,671	334,588,662	9,245,017,030	4,364,216,238	12,509,980,444	10,827,344,789	28,823,030,000
Regional Administration									
Government funds	9,246,035,600	8,684,574,173	9,363,412,405	9,008,206,554	6,206,326,511	5,614,804,137	7,062,588,748	6,584,825,460	7,602,297,700
Urban councils									
Government funds	4,933,571,831	3,571,224,855	5,045,401,204	4,489,209,418	6,038,363,000	6,067,256,194	7,215,534,300	7,166,663,655	8,860,711,200
Donor basket fund			452,823,200	418,196,000	2,060,190,187	1,635,792,491	2,476,963,415	2,472,793,397	2,763,096,113
District councils									
Government funds	10,781,499,300	12,769,240,818	12,548,841,000	12,429,340,225	23,073,974,900	23,333,303,942	28,262,447,400	28,377,319,802	34,814,714,100
Donor basket fund			640,605,300	608,943,000	5,178,497,029	4,632,995,861	8,301,693,509	8,266,416,055	11,222,194,068
Total recurrent	**62,208,942,031**	**62,175,288,742**	**67,247,194,317**	**59,344,475,926**	**91,949,094,157**	**85,533,713,134**	**114,917,022,015**	**111,860,723,038**	**152,202,379,360**
Development									
Ministry of Health									
Government funds	1,722,000,000	654,158,016	3,177,000,000	1,912,000,000	3,245,000,000	3,253,939,506	3,245,000,000	3,197,327,926	3,552,448,200
Donor basket fund							5,856,811,717	4,615,471,717	3,841,820,500
Foreign (non-basket)	19,487,694,000	16,615,973,076	14,575,086,329	8,281,183,077	17,226,052,570	11,583,576,639	22,966,181,000	13,309,109,927	26,383,612,500
Regional Administration									
Government funds	257,430,000	269,871,821	400,487,000	28,987,586	372,312,000	361,419,503	389,332,000	389,169,060	434,986,500
Foreign (non-basket)	4,741,851,000	397,959,488	2,166,066,000	757,095,717	4,242,770,000	1,024,583,643	1,962,380,000	892,908,611	4,312,535,100
Urban councils									
Government funds	140,083,000		215,662,000	181,046,000	349,898,000	355,028,000	359,669,000		406,394,700
Foreign (non-basket)			200,000,000	200,000,000	200,000,000	0			
District councils									
Government funds	479,237,000		765,578,000	673,975,000	1,176,751,000	1,160,314,000	1,344,211,000		1,636,502,000
Total development	**26,828,295,000**	**17,937,962,400**	**21,499,879,329**	**12,034,287,380**	**26,812,783,570**	**17,738,861,291**	**36,123,584,717**	**22,403,987,241**	**40,568,299,500**
Total on budget	**89,037,237,031**	**80,113,251,141**	**88,747,073,646**	**71,378,763,307**	**118,761,877,727**	**103,272,574,426**	**151,040,606,732**	**134,264,710,279**	**192,770,678,860**
Off budget expenditure									
Cost sharing									
Health Services Fund – Hospital		1,026,646,146		1,404,865,561		1,421,254,371		1,082,642,718	
Community Health Fund – PHC		61,100,334		87,146,973		438,258,582		155,262,177	
National Health Insurance								132,000,000	1,200,000,000
Other foreign funds	35,545,514,498	42,761,126,934	52,332,895,965	60,035,769,500	59,414,377,872	75,000,000,000	66,142,394,763	79,370,873,716	49,254,970,437
Total off budget	**35,545,514,498**	**43,848,873,414**	**52,332,895,965**	**61,527,782,034**	**59,414,377,872**	**76,859,512,952**	**66,142,394,763**	**80,740,778,610**	**50,454,970,437**
Grand total	**124,582,751,529**	**123,962,124,555**	**141,079,969,611**	**132,906,545,340**	**178,176,255,599**	**180,132,087,378**	**217,183,001,495**	**215,005,488,889**	**243,225,649,297**

Table 25 Budget, release and expenditure by MOH Department, FY03

Department	Source	Budget	Release	Expd	Release/ budget	Expd/ release	Expd/ budget
1001 Admin & General	Govt	1,808,978,500	735,024,806	399,296,573	40.6%	54.3%	22.1%
	Basket	777,530,000	177,808,000	76,270,570	22.9%	42.9%	9.8%
	Total	**2,586,508,500**	**912,832,806**	**475,567,143**	**35.3%**	**52.1%**	**18.4%**
1002 Finance & Accts	Govt	232,216,000	87,912,738	69,079,780	37.9%	78.6%	29.7%
	Basket	105,017,000	20,844,000	6,430,000	19.8%	30.8%	6.1%
	Total	**337,233,000**	**108,756,738**	**75,509,780**	**32.2%**	**69.4%**	**22.4%**
1003 Policy & Planning	Govt	600,000	300,000	-	50.0%	0.0%	0.0%
	Basket	253,081,000	75,786,000	43,345,420	29.9%	57.2%	17.1%
	Total	**253,681,000**	**76,086,000**	**43,345,420**	**30.0%**	**57.0%**	**17.1%**
2001 Curative (Hospital)	Govt	42,124,825,400	18,325,801,005	17,856,081,979	43.5%	97.4%	42.4%
	Basket	15,814,549,000	5,967,254,000	2,353,491,031	37.7%	39.4%	14.9%
	Total	**57,939,374,400**	**24,293,055,005**	**20,209,573,009**	**41.9%**	**83.2%**	**34.9%**
2002 Chief Govt Chemist	Govt	597,737,100	245,872,024	245,872,024	41.1%	100.0%	41.1%
	Basket	149,161,000	122,207,000	13,857,000	81.9%	11.3%	9.3%
	Total	**746,898,100**	**368,079,024**	**259,729,024**	**49.3%**	**70.6%**	**34.8%**
2003 Chief Medical Officer	Govt	243,950,100	59,420,463	53,512,547	24.4%	90.1%	21.9%
	Basket	40,283,000	0	0	0.0%	#DIV/0!	0.0%
	Total	**284,233,100**	**59,420,463**	**53,512,547**	**20.9%**	**90.1%**	**18.8%**
3001 Preventive	Govt	9,294,833,100	4,162,179,161	2,736,111,848	44.8%	65.7%	29.4%
	Basket	10,926,217,000	3,413,787,000	2,528,053,748	31.2%	74.1%	23.1%
	Total	**20,221,050,100**	**7,575,966,161**	**5,264,165,596**	**37.5%**	**69.5%**	**26.0%**
4001 Tukuta	Govt	223,219,300	98,336,265	40,317,638	44.1%	41.0%	18.1%
	Basket	71,031,000	35,845,000	1,306,000	50.5%	3.6%	1.8%
	Total	**294,250,300**	**134,181,265**	**41,623,638**	**45.6%**	**31.0%**	**14.1%**
5001 Human Res Devt	Govt	3,108,369,200	1,384,773,203	1,304,678,763	44.5%	94.2%	42.0%
	Basket	686,161,000	416,415,000	305,563,324	60.7%	73.4%	44.5%
	Total	**3,794,530,200**	**1,801,188,203**	**1,610,242,088**	**47.5%**	**89.4%**	**42.4%**
Sub-total	**Govt**	57,634,728,700	25,099,619,665	22,704,951,152	43.5%	90.5%	39.4%
	Basket	28,823,030,000	10,229,946,000	5,328,317,093	35.5%	52.1%	18.5%
TOTAL		**86,457,758,700**	**35,329,565,665**	**28,033,268,245**	**40.9%**	**79.3%**	**32.4%**

Table 26 HIV/AIDS projects listed in MOF External Finance database, FY03

Donor	Project title	On/off budget	FY03 allocation
Australia	World Vision Australia HIV/HTA	No	-
Australia	World Vision Australia Comm Mob HIV/AIDS	No	-
Australia	SAT – Kwetu Women and AIDS	No	-
Italy	Food Aid for AIDS affected people	?	-
Netherlands	TANESA 1	?	162,542,185
Netherlands	Social marketing condoms	?	1,625,422,752
UNICEF	ECD: improving access to basic services – PMTCT (district)	Yes	384,615,000
UNICEF	ECD: improving access to basic services – PMTCT (national)	No	109,890,000
UNICEF	ECD: improving access to basic services – PMTCT (private)	No	54,945,000

Table 27 MOH Development budget by funding type, FY03 (TSh billion)

	FY03 estimates			
	Local	Foreign (basket)	Foreign (non-basket)	Total
1003 Policy and Planning				
6200 Administration				
6271 Health Sector Plan and Management Project		239,448,600	909,079,200	1,148,527,800
6272 Essential Health Interventions				0
6273 Health Sector Programme Support		17,318,789,800	1,909,600,000	19,228,389,800
Total	**0**	**17,558,238,400**	**2,818,679,200**	**20,376,917,600**
2001 Curative services				
5400 Health				
5406 Strengthening National Hospitals	38,340,000	328,680,000		367,020,000
5412 Bohari ze Kanda				0
5467 Strengthening X-ray services				0
5494 Chief Government Chemists	216,988,800	373,600,000		590,588,800
5402 Muhimbili Rehabilitation Project	350,000,000		4,190,042,000	4,540,042,000
5486 Paediatric Ward Complex / Muhimbili Medical Centre		720,000,000		720,000,000
5487 Muhimbili Orthopaedic Institute	850,000,000		241,280,000	1,091,280,000
6200 Administration				
6274 Ocean Road Hospital	900,000,000			900,000,000
Total	**2,355,328,800**	**1,422,280,000**	**4,431,322,000**	**8,208,930,800**
3001 Preventive services				
5400 Health				
5407 Control of communicable diseases	740,500,000	1,007,411,400	7,227,625,900	8,975,537,300
5415 National Institute for Medical Research	136,500,000	250,910,000		387,410,000
5485 Health Sector Development Programme	200,000,000	236,036,000	7,445,512,600	7,881,548,600
5492 Aids control programme			4,460,472,800	4,460,472,800
5496 Tanzania Food and Nutrition Centre	75,000,000			75,000,000
Total	**1,152,000,000**	**1,494,357,400**	**19,133,611,300**	**21,779,968,700**
4001 Food security and control				
5400 Health				
5493 National Food Control Commission				0
Total	**0**	**0**	**0**	**0**
5001 Human resource development				
4300 Education				
4368 Strengthening of training institutes	45,119,400	685,734,500		730,853,900
Total	**45,119,400**	**685,734,500**	**0**	**730,853,900**
Grand Total	**3,552,448,200**	**21,160,610,300**	**26,383,612,500**	**51,096,671,000**

It should be noted that the figure for the basket has been adjusted according to the MOF's own formula which takes into account past disbursement performance by individual development partners, and therefore does not tally with estimates referred to elsewhere.

Annex D: Health spending in other ministries and government agencies

In addition to analysis of spending on health through the primary MDAs, ie MOH, PORALG and local government agencies, the PER update for FY03 also included a brief assessment of the extent of recurrent health spending in other government agencies at the central and regional level as these may also be considered as contributing to public expenditure on health. The findings of this analysis are presented below[26].

Table 28 Health spending in other MDAs

	2000/01 Actual	2001/02 Approved	2002/03 Estimates
PEs	206,421,839	210,047,800	228,049,500
Medical supplies and services	1,247,028,504	1,722,297,830	1,987,426,350
Other OCs	1,061,631	5,110,800	13,510,800
Total spending by other MDAs	**1,454,511,974**	**1,937,456,430**	**2,228,986,650**

Of the total of TSh2.2bn budgeted within other MDAs at the central and regional level for FY03, over two-thirds falls within the defence and police forces. The PEs in Table 23 come from the Police Medical College in Moshi. Table 24 below shows the major contributors to this figure, which is fairly typical of the region, as can be seen National Health Accounts data from other countries.

Table 29 Major contributors to health spending in other MDAs, FY03

	2002/03 estimates	
	TSh	%
Defence	750,000,000	33.6%
National Service	454,060,300	20.4%
Home Affairs - Police Force	298,000,000	13.4%
Sub-total	**1,502,060,300**	**67.4%**

Comparison with the data on which Figure 1 is based indicates that addition of the total budgeted amount for health-related spending in other MDAs at central and regional level would increase the overall ceiling for health very slightly from 9.4% to 9.5% of the budget for FY03.

[26] Figures for Police Dogs and Horses (within Home Affairs – Police), and for Water and Livestock Development have been excluded on the grounds that their supplies are more likely to be for veterinary than human use.

Annex E: Off-budget external spending in the health sector

The issue of donor project funding and its progressive incorporation into MTEFs and budgets is receiving increasing attention throughout the region, and Tanzania is no exception. With the publication of the PRSP and subsequent progress reports, it is important that all public finance for the sector can be clearly attributed to priority areas and items within the national budgetary framework. However, accurate information on donor project spending has typically been very difficult to obtain, particularly when much of it is channelled not through government agencies but through the non-governmental or even private sector.

The External Finance Department of the MOF has made a concerted effort over the last year to solicit updated information from bilateral and multilateral development partners on the level and nature of their support to each sector. Findings are incorporated into a database which records various facts about the project funding, as shown in Table 30 below.

Table 30 Fields in the MOF external financing database

Field	**Content and options**
Donor	Name of DP or NGO
M/B	Multilateral or bilateral
Name of project	
On-budget FY 02/03?	Yes, if included in Development budget
C/I/A/P	**C**losed, being **i**mplemented, **a**pproved, **p**lanned
Sector	
Sub-sector	
Scope	National, regional or geographic; field gives details if particular districts
Source of finance	Government, private, NGO
Implementing level of Govt	Ministry, Region, District
L/G	Loan or grant
Type	Cash assistance or direct to project
Donor code	From their accounting system
FY 2002/03 commitment	Gives funding provided
FY 2003/04 projections etc	Columns for next 3 years

As mentioned in the text in Section 2.6.1, it has not been possible to undertake a consistency check on the "on-budget" projects listed in Kitabu cha Nne and those included in the MOF database in order to determine where the discrepancies lie. This exercise could be undertaken before next year's PER.

Annex F: Medical supplies and services – item 2604

Item 2604 in the GOT budget has nine sub-items:

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

It should be noted, as discussed in Section 2. that the sub-item 260409, HIV/AIDS epidemics, covers the whole range of sub-items used in HIV/AIDS-related activities by the National AIDS Control Programme, eg allowances, stationery, travel, computers etc.

Supplies of the injectable contraceptive, Depo Provera, are included under 260408. Other items falling under this code include drugs for Intermittent Presumptive Treatment of malaria in pregnant women, and inputs for malaria treatment efficacy testing.

For GOT and basket funds, the breakdown between these items is shows in Table 31 below.

Table 31 Spending on Item 2604 Medical Supplies and Services

	FY02		FY03	
	GOT	Basket	GOT	Basket
2001 Curative services				
260402 Drugs and Medicines	10,589,007,100	1,600,000,000	10,397,900,000	4,000,000,000
260403 Special foods (diet food)	169,160,000			
260404 Dental supplies	22,437,001	137,563,000	70,245,000	500,000,000
260405 Hospital Supplies	237,398,100	1,168,105,252	381,855,000	1,000,000,000
260406 Post Mortem Expenses	2,000,001			
260407 Laboratory Supplies	250,000,000		150,000,000	540,000,000
260408 Specialised supplies				2,168,070,000
Sub-total Curative	**11,270,002,202**	**2,905,668,252**	**11,000,000,000**	**8,208,070,000**
2002 Chief Govt Chemist				
260406 Post Mortem Expenses	2,600,000		2,600,000	
260408 Specialised supplies				33,000,000
Sub-total Chief Govt Chemist	**2,600,000**	**-**	**2,600,000**	**33,000,000**
3001 Preventive services				
260401 Vaccines	749,804,939		1,670,324,000	
260402 Drugs and Medicines	84,103,500		2,800,000	2,071,225,000
260405 Hospital Supplies			19,435,200	
160407 Laboratory Supplies				1,564,000
260408 Specialised supplies	780,202,894	4,038,815,780	1,108,095,400	12,419,596,000
Sub-total Preventive	**1,614,111,333**	**4,038,815,780**	**2,800,654,600**	**14,492,385,000**
4001 Tukuta				
260407 Laboratory supplies	30,514,634	580,000	10,415,000	3,200,000
Sub-total Tukuta	**30,514,634**	**580,000**	**10,415,000**	**3,200,000**
5001 Human Resource Devt				
260407 Laboratory Supplies			6,300,000	
Sub-total Human Resource Devt	**-**	**-**	**6,300,000**	**-**
Total MOH				
260401 Vaccines	749,804,939	-	1,670,324,000	-
260402 Drugs and Medicines	10,673,110,600	1,600,000,000	10,400,700,000	6,071,225,000
260403 Special foods (diet food)	169,160,000	-	-	-
260404 Dental supplies	22,437,001	137,563,000	70,245,000	500,000,000
260405 Hospital Supplies	237,398,100	1,168,105,252	401,290,200	1,000,000,000
260406 Post Mortem Expenses	4,600,001	-	2,600,000	-
260407 Laboratory Supplies	280,514,634	580,000	166,715,000	543,200,000
260408 Specialised supplies	780,202,894	4,038,815,780	1,108,095,400	14,620,666,000
Total MOH	**12,917,228,169**	**6,945,064,032**	**13,819,969,600**	**22,735,091,000**

Annex G Monthly Progress Reports for the Health Services Fund

Station/hospital………………

Monthly statement of collection for the month ended ……………..

Item no	Particulars	Approved estimates	Expenditure for previous month	Expenditure for this month	Total 4 + 5
1	2	3	4	5	6
1001					
1002 etc					

Whereby categories of income collection are:

1001 Registration fee
1002 Drugs fee
1003 Hospitalisation (admission fees)
1004 Medical examination fees
1005 Dental services fees
1006 Eye services fees
1007 ENT services fees
1008 Orthopaedic/trauma services fees
1009 Neurosurgery services fees
1010 Urosurgery fees
1011 General surgery services fees
1012 Normal delivery services fees
1013 Gynae and Caesarian services fees
1014 Diagnostic services fees
1015 Gate toll
1016 Foreigners services fees
1017 Miscellaneous services fees

Station/hospital …………….

Monthly statement of expenditure for the month ended ………………

Item no	Particulars	Collection for previous month	Collection for this month	Total
1	2	3	4	5
2001				
2002 etc				

Whereby categories of expenditure are:

2001 Purchases of essential drugs
2002 Purchases of new essential hospital supplies and rehabilitation of existing hospital equipments
2003 Minor rehabilitation of buildings which are used for health services for not more than TSh 500,000/= per item per annum. Any work costing more than TSh 500,000/= prior approval shall be authorised by the Principal Secretary, MOH
2004 Purchase of office stationeries like registers used for record keeping as to facilitate the implementation of user fees in the country
2005 Payments of postage and communication charges for submission of Health Service Fund reports
2006 Payments of drugs bills from MSD, zonal depots, fuel and subsistence allowances
2007 Payments of ERVs and Fixed Fee Receipts

Source: Annexes A, C, E1 and E2 of *Ministry of Health Accounting Circular Number 2 of 1997 of Health Services Fund for cost sharing (User Fees)*.