

Summary of Health Expenditure

This section presents amount of financing in the Tanzania health sector and how the funds flow through the health sector. All funds are presented in 1999/2000 Tanzanian Shillings. Health expenditure is presented from three perspectives:

1. sources of health funds
2. health financing agents; the entities which pay for or purchase health care services
3. direct providers of health care services

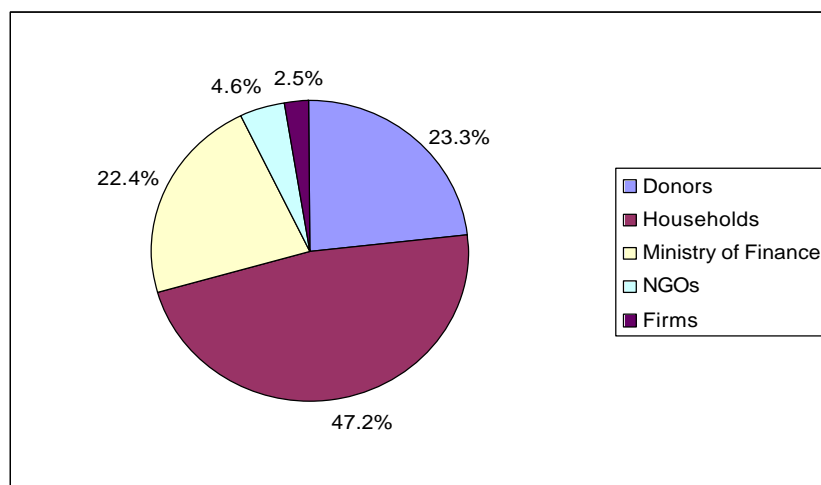
There are seven sources of funding for health in Tanzania. These include:

- Government of Tanzania / Ministry of Finance
- Households
- Donors
- NGOs
- Private firms

Tanzania households provide the greatest proportion of health care financing (47%). The Government of Tanzania and donors provide equal proportions of funds at 22% and 23% respectively.

Table 9.1: Annual financial contribution to the health sector 1999/00

Financing Agents	Total (Tshs 1999/00)
Households	130,081,376,585
Districts	53,980,491,652
Ministry of Health	51,480,115,525
NGOs	18,784,468,337
Regions	11,258,855,062
Private insurance	6,968,486,246
Other Ministries	2,976,412,368
Total	275,530,205,775



Funds provided from the sources of financing go to various health financing agents. These include:

- Ministry of Health
- Regions
- Districts
- Other Ministries

- NGOs
- Households
- Private insurance

1.1 Finance sources to financing agents

The table below shows the annual amount of money that is flowed from the sources of finance to the various financing agents. (Note that households are both sources of finance and financing agents). The total expenditure in the health sector in Tanzania in the FY 1999/00 was Tshs 175.5 billion. Among financing agents, households provide the greatest amount of funds to the health sector (Tshs 130 billion). The Ministry of Health and the District each spent approximately Tshs 50 billion on health.

Table 9.2: Annual funds provided from finance sources to financing agents (Tshs 1999/00)

Sources \ Financing Agents	Donors	Households	Ministry of Finance	NGOs	Firms	Total
Districts	36,131,419,577		17,849,072,075			53,980,491,652
Households		130,081,376,585				130,081,376,585
Ministry of Health	17,512,123,457		33,967,992,068			51,480,115,525
NGOs	6,065,766,967			12,718,701,370		18,784,468,337
Other Ministries	2,132,076,000		844,336,368			2,976,412,368
Private insurance					6,968,486,245	6,968,486,245
Regions	2,221,660,922		9,037,194,140			11,258,855,062
Total	64,063,046,923	130,081,376,585	61,698,594,651	12,718,701,370	6,968,486,245	275,530,205,775

Households contributes almost half of the health expenditure on Tanzania. Among the other health financing agents, funds from the districts contribute 19.6%, the Ministry of health contributes 18.7%, and the regions 4.1%. In total, the Government of Tanzania (with donor assistance) provides 42.4% of health financing. NGOs, including church dioceses, contribute almost 7% of health expenditure.

In United States dollars the total expenditure in the Tanzanian health sector is US\$361 million.

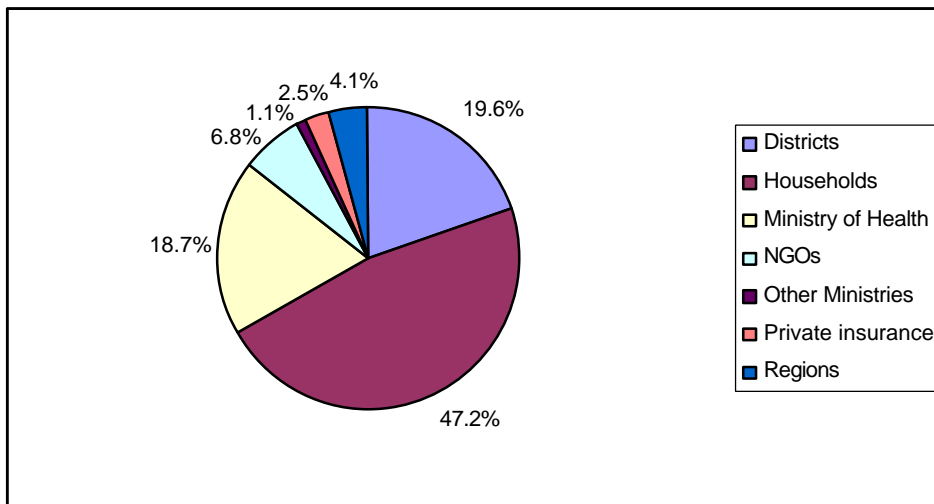


Table 9.3: Annual funds provided from finance sources to financing agents (US\$ 1999/00)

Sources to Financing Agents	Donors	Households	Ministry of Finance	NGOs	Firms	Total
Districts	47,354,416		23,393,279			70,747,695
Households		170,486,732				170,486,732
Ministry of Health	22,951,669		4,518,994			67,470,663
NGOs	7,949,891			16,669,333		24,619,225
Other Ministries	2,794,333		1,106,601			3,900,934
Private insurance					9,133,009	9,133,009
Regions	2,911,744		11,844,291			14,756,035
Total	83,962,054	170,486,732	80,863,165	16,669,333	9,133,009	361,114,293

Annual health expenditure in Tanzania averages US\$11.34 per capita. An average of \$5.35 per capita is spent annually by households. An annual average of US\$2.22 per capita is spent by the districts and US \$2.12 by the Ministry of Health.

Table 9.4: Annual per capita health expenditure by financing agents (US\$ 1999/00)

Financing Agents	Total	Per capita
Districts	\$ 70,747,695	\$ 2.22
Households	\$ 170,486,732	\$ 5.35
Ministry of Health	\$ 67,470,663	\$ 2.12
NGOs	\$ 24,619,225	\$ 0.77
Other Ministries	\$ 3,900,934	\$ 0.12
Private insurance	\$ 9,133,009	\$ 0.29
Regions	\$ 14,756,035	\$ 0.46
Total	\$ 361,114,293	\$ 11.34

Fifty-five percent of expenditure on health in Tanzania comes from private sources; 45% comes from public sources (government and donors combined). On average, in 1999/00 private sources contributed US \$6.41 per capita to the health sector. The public sector allocated US \$4.92 to health.

Figure 9.1: Percentage of health expenditure by the public and private sectors (US\$ 1999/00)

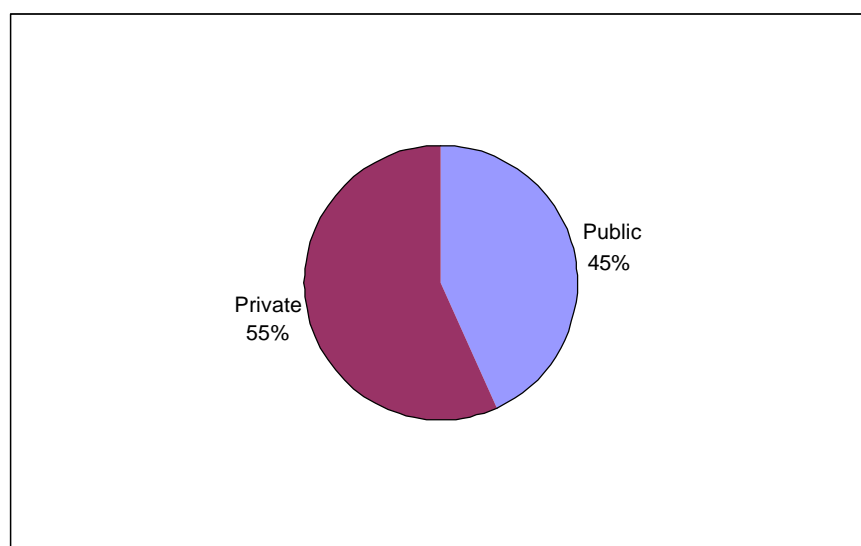


Table 9.5: Annual per capita health expenditure by the public and private sectors (US\$ 1999/00)

Financing Agents	Per Capita
Public	\$ 4.92
Private	\$ 6.41
Total	\$ 11.34

1.2 Financing agents to health providers

Eight classification of health providers are used for the purposes of this expenditure review. These providers include:

- Administration by health authorities
- Government dispensaries and health centres
- Government district, regional and referral hospitals
- Non profit dispensaries and health centres
- Non profit hospitals
- Private dispensaries and health centres
- Private hospitals
- Vertical programmes

On an annual basis, Tshs 32.8 billion is spent on administration in the health sector. The government, donors and households contribute Tshs 86 billion to government hospitals and Tshs 34.5 billion to government run health centres and dispensaries. A total of 34.2 billion is spent on non profit hospitals annually and Tshs 26.5 billion is spent at private hospitals. A total of Tshs 44.9 billion is spent on vertical programmes such as HIV, malaria, tuberculosis and polio.

Table 9.6: Annual funds provided from financing agents to health providers (Tshs 1999/00)

Financing Agents / Providers	Districts	Regions	Ministry of Health	Households	NGOs	Other Ministries	Private insurance	Total
Administration	6,244,554,422	1,034,410,005	25,507,355,048					32,786,319,475
Dispensaries / Health Centres	17,387,962,922			17,086,886,746				34,474,849,668
District/Regional/Referral Hosp	5,621,503,318	9,884,048,762	15,210,829,715	55,257,256,890				85,973,638,685
Non profit Dispensaries / Health Centres				4,796,319,087	2,646,960,814			7,443,279,901
Non profit hospitals			3,898,802,432	24,126,785,744	6,176,241,899			34,201,830,075
Private Dispensaries / Health Centres				8,093,788,459			1,155,584,222	9,249,372,681
Private Hospitals				20,720,339,659			5,812,902,024	26,533,241,683
Vertical Programmes	24,726,470,990	340,396,295	6,863,128,330		9,961,265,624	2,976,412,368		44,867,673,607
Total	53,980,491,652	11,258,855,062	51,480,115,525	130,081,376,585	18,784,468,337	2,976,412,368	6,968,486,246	275,530,205,775

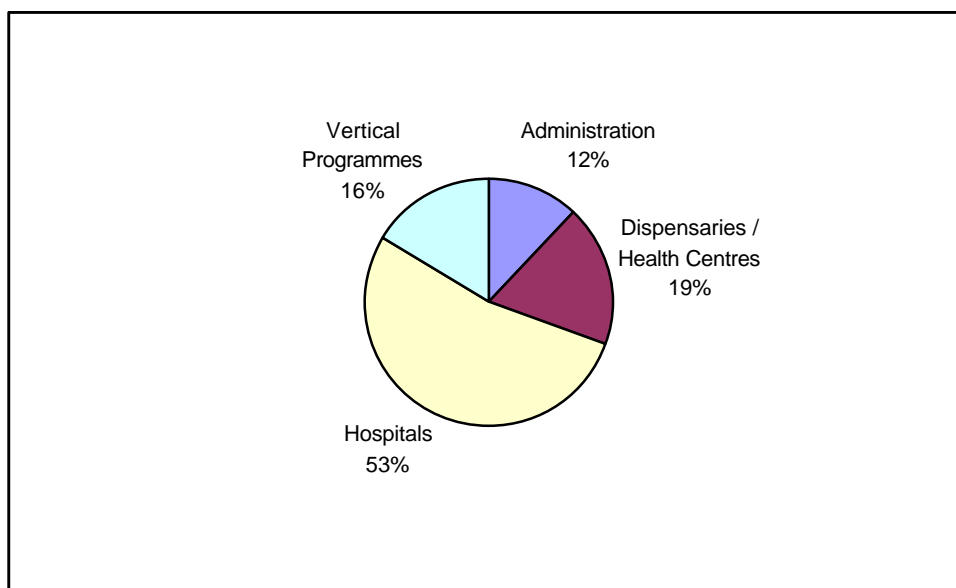
Thirty-one percent of the annual health expenditure in Tanzania is allocated toward government hospitals. Overall, 53% of total annual health expenditure is spent on hospitals. Nineteen percent is allocated to health centres and dispensaries, with two-thirds of this expenditure in the public sector. Vertical programmes account of 16% of annual health expenditure. Public administration accounts of 12%.

Table 9.7: Percentage of total health expenditure by health provider (Tshs 1999/00)

Health Provider	Total
Administration	11.9%
Dispensaries / Health Centres	12.5%
District/Regional/Referral Hosp	31.2%
Non profit Dispensaries / Health Centres	2.7%

Non profit hospitals	12.4%
Private Dispensaries and Health Centres	3.4%
Private Hospitals	9.6%
Vertical Programmes	16.3%
Total	100.0%

Figure 9.2: Percentage of total expenditure by type of service (Tshs 1999/00)



In United States dollars, an annual total of US \$113 million was spent on government hospitals in 1999/00. Approximately US \$45 million was spent in non profit hospitals and US \$35 million was spent in private hospitals. US \$59 million was spent on vertical programmes in Tanzania in 1999/00.

Table 9.8: Annual funds provided from financing agents to health providers (US\$ 1999/00)

Financing Agents / Providers	Districts	Regions	Ministry of Health	Households	NGOs	Other Ministries	Private insurance	Total
Administration	8,184,213	1,355,714	33,430,347					42,970,275
Dispensaries / Health Centres	22,788,942			22,394,347				45,183,289
District/Regional/Referral Hosp	7,367,632	12,954,192	19,935,557	72,421,044				112,678,426
Non profit Dispensaries / Health Centres				6,286,132	3,469,149			9,755,282
Non profit hospitals			5,109,833	31,620,951	8,094,681			44,825,465
Private Dispensaries / Health Centres				10,607,849			1,514,527	12,122,376
Private Hospitals				27,156,408			7,618,482	34,774,891
Vertical Programmes	32,406,908	446,129	8,994,926		13,055,394	3,900,934		58,804,290
Total	70,747,695	14,756,035	67,470,663	170,486,732	24,619,225	3,900,934	9,133,009	361,114,293

The highest annual per capita expenditure (US \$3.54) occurs in government hospitals. Tanzania spends US \$1.85 per capita on vertical programmes.

Table 9.9: Annual per capita health expenditure by provider (US\$ 1999/00)

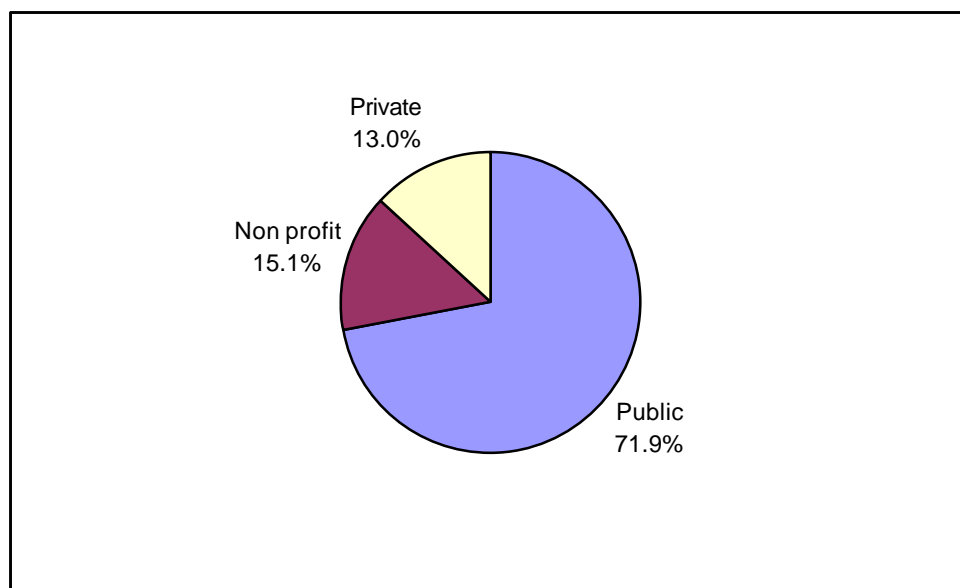
Provider	Total	Per Capita
Administration	\$ 42,970,275	\$ 1.35
Dispensaries / Health Centres	\$ 45,183,289	\$ 1.42
District/Regional/Referral Hosp	\$ 112,678,426	\$ 3.54
Non profit Dispensaries / Health Centres	\$ 9,755,282	\$ 0.31
Non profit hospitals	\$ 44,825,465	\$ 1.41
Private Dispensaries and Health Centres	\$ 12,122,376	\$ 0.38
Private Hospitals	\$ 34,774,891	\$ 1.09
Vertical Programmes	\$ 58,804,290	\$ 1.85
Total	\$ 361,114,293	\$ 11.34

An annual average of US \$8.15 is spent on public services. This represents 72% of total expenditure. An average of \$1.71 is spent on non profit services and \$1.47 is spent in the private sector.

Table 9.10: Annual per capita health expenditure by type of provider (US\$ 1999/00)

Provider	Per Capita
Public	\$8.15
Non profit	\$1.71
Private	\$1.47
Total	\$11.34

Figure 9.3: Percentage of out of pocket expenditure by type of provider



1.3 Financing agents by level of care

Expenditure by financing agents can also be assessed based on the level or type of health services or care provided. For the purposes of this study, three types of care were identified:

- preventive, including health promotion and prevention programmes, vaccines and research
- outpatient care, including outpatient care provided at clinics, dispensaries, health centres and hospitals
- inpatient care

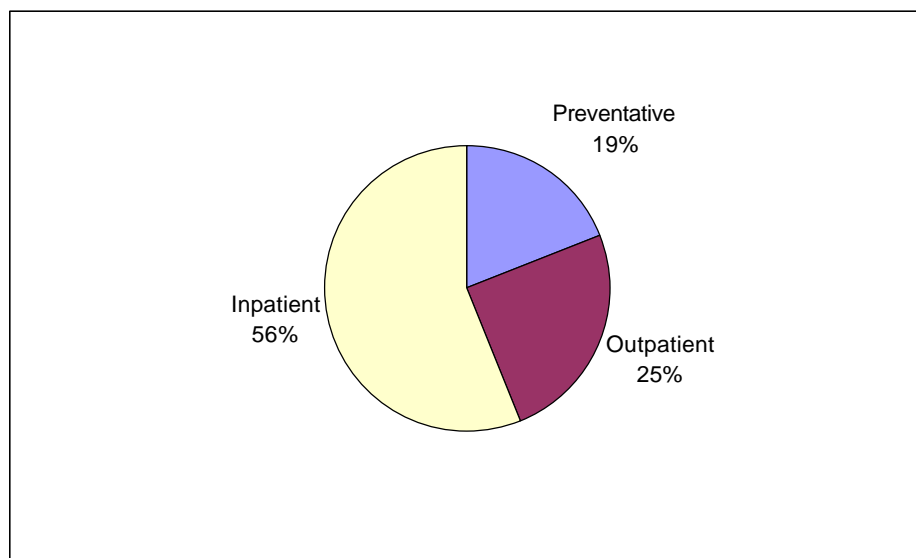
Approximately Tshs 155 billion was spent on inpatient care in Tanzania in 1999/00. This compares with Tshs 69 billion spent on outpatient care and Tshs 52 billion on prevention.

Table 9.11: Annual funds provided from financing agents by level of health care (Tshs 1999/00)

Financing agents / Level of care	Districts	Regions	Ministry of Health	Households	NGOs	Other Ministries	Private insurance	Total
Preventive	27,961,052,790	374,834,285	13,603,276,387		9,961,265,624			51,900,429,085
Outpatient	20,317,319,602		3,105,356,975	39,969,325,723	3,264,585,004	306,570,474	1,911,261,485	68,874,419,262
Inpatient	5,702,119,261	10,884,020,777	34,771,482,163	90,112,050,862	5,558,617,709	2,669,841,894	5,057,224,761	154,755,357,427
Total	53,980,491,652	11,258,855,062	51,480,115,525	130,081,376,585	18,784,468,337	2,669,841,894	6,968,486,246	275,530,205,775

On an annual basis, 56% of health expenditure in Tanzania goes toward inpatient care. One-quarter of health expenditure is allocated to outpatient care and one-fifth to prevention. The combination of preventive services and outpatient care can be assumed to represent primary care. Thus, 44% of health funds are spent on primary care.

Figure 9.4: Percentage of annual health funds by level of health care (Tshs 1999/00)



A total of US \$ 203 million was spent on inpatient care in Tanzania in 1999/00. This represents \$6.37 per capita. On average, \$2.14 per capita was spent on prevention and \$2.83 per capita was spent on outpatient care.

Table 9.12: Annual per capita health expenditure by level of care (US \$ 1999/00)

Level of care	Total	Per capita
Preventive	68,021,532	\$ 2.14
Outpatient	90,267,915	\$ 2.83
Inpatient	202,824,846	\$ 6.37
Total	361,114,293	\$ 11.34

Suggested institutional arrangements

1.4 Introduction

In this section, we outline suggested institutional arrangements for ensuring that in future data will be collected and the national health accounts updated on a regular basis.

In the methodology section, we outlined the approach we used to gather and analyse information and problems encountered. We have also mentioned some of the problems or constraints in data collection and analysis. Building on these constraints we provide recommendations which will ensure sustainability and the ease with which the national health accounts will be updated.

1.5 Constraints in data collection

A major constraint which our team faced was availability of data. We had to collect data from many different sources and in some cases key data were not available or took a lot of time to be made available to the team. Such delays were caused by the administrative bureaucracy that we had to follow to get access to the data. Particular areas of difficulties in data collection and their reasons include:

- Financial information from councils was difficult to obtain due to inadequate record keeping and delays in closing the council accounts. In addition, there is very low rate of compliance with the requirement for councils to submit their reports to the President's Office, Regional Administration and Local Government in Dodoma. In the case of councils we visited there was a problem of reluctance of council staff to provide data possibly because of fear that they are being audited, etc. As a result of these difficulties it was not possible to establish how much of council's own revenue is allocated to health services.
- Health expenditure data from other ministries and departments were not available centrally due to inadequate information flows between institutions reporting to the ministries e.g. agricultural training and research centres, secondary schools, etc. Likewise there is no mechanism for the Ministry of Health to capture data on health related activities carried out by other ministries and activities carried out by some of the vertical programmes.
- Absence of proper systems for reporting between voluntary agencies' facilities and their umbrella organisations as well as the ministry. Consequently all the umbrella organisations do not have comprehensive data on health expenditure and sources of financing. Health facilities provide this data on ad hoc basis to the umbrella organisations.
- The difficulty of capturing data on donor funds disbursed directly by their head offices abroad instead of channelling the funds through their resident offices.
- The difficulties of capturing off budget expenditure such as cost sharing income, community health funds, drug revolving funds, and off budget donor contributions. The main causes of the problem in this area are first, the fact that the systems for these initiatives are not well developed and therefore there are still a lot of problems as far as reporting is concerned. Secondly, most of the off budget donor contributions are reported separately to each donor. They are therefore not part of the ministry's appropriation accounts or annual accounts of the councils. The ministry therefore needs a separate mechanism for capturing this expenditure.
- Lack of full and accurate data on health expenditure by the private sector, NGOs, insurance companies, employers, etc. This is due to deliberate efforts to conceal the information for tax reasons as well as fear that the release of this kind of data may be used by competitors.

Thus to ensure that the national health accounts are updated on a regular basis, it is important that we suggest solutions which address each of the above problems. These are discussed along the same lines as the difficulties mentioned above.

1.6 Recommendations

1.6.1 Council health expenditure

There are two alternatives for ensuring availability of data from the councils. First is to emphasise compliance with reporting requirements. For example, there is a requirement for submission of reports accounting for the block grants and council health basket funds through the Regional Secretariat and RALG. Failure to submit the reports the council is taking a risk of not receiving further funding. This requirement could be extended to other non reforming councils at the same time strengthen the capacity of the RALG to review these reports. The Ministry of Health could then easily extract the relevant data from these reports through a member of the NHA co-ordination committee representing the RALG.

Secondly, TEHIP has developed the district health accounts, a tool which captures most of the information required for the NHA analyses. The Ministry should expedite the introduction of this tool and roll it out to other districts apart from Morogoro and Rufiji where it was piloted. Once all councils are implementing this tool copies of the reports generated at year-end should be submitted to the Ministry of Health for use by the NHA team.

1.6.2 Ministries and institutions operating directly under the ministries

We understand that accounting officers disburse funds to institutions in the regions through regional sub treasuries. When accounting officers disburse funds they issue a warrant of funds detailing allocation of funds by item of expenditure in accordance with the chart of accounts. This system operates on Platinum SQL software and daily transactions at each sub treasury are sent to the Treasury via modem link. These transactions update the accounting officers on expenditure by item and balance of funds available for each item.

The problem with the system has been communication break down between the sub treasuries and the treasury. Once this is solved it should be possible for the ministries to get information on what is happening in institutions operating under the ministries. Also, it will be possible to obtain all data on health expenditure at the treasury. In the absence of electronic transfer of data, the treasury and the relevant ministries should insist on receiving hard copies of annual reports from the sub treasuries.

In situations where other ministries implement health related programmes or activities, the Ministry of Health should liaise with these ministries or departments to obtain copies of annual reports. We were informed that some of the programmes have representatives from the Ministry of Health in their top management team / boards. In such cases the Ministry of Health representative should take the responsibility to obtain a copy of the annual report for submission to the NHA team.

1.6.3 Voluntary Agencies

We noted above that the voluntary agencies do not have proper reporting mechanisms to facilitate data capture on health expenditure and sources of health care financing. The Ministry of Health should advise the umbrella organisations to set up a mechanism for receipt of annual reports from their health facilities. The umbrella organisation should then prepare a summary report covering all facilities and submit this report to the Ministry of Health. The NHA team can then use this information to update the national health accounts. This will be useful not only to the ministry but also the umbrella organisations as it will be possible to get a snap shot picture of what is happening in the health services provided under their umbrella. This approach can also be adopted by the private sector under the umbrella of the Association of Private Health Care Providers.

Another alternative both for voluntary agencies and the private sector is for the ministry to require these facilities to provide their annual reports as part of the process of supervision and monitoring to ensure that

they still comply with the requirements for registration. Under this alternative annual reports will be submitted to the Registrar at the Ministry of Health and the NHA team can access the information through the office of the Registrar.

1.6.4 Donors and NGOs

There are two alternatives for capturing donor funds disbursed directly by their main offices. First, the MOH should advise the resident offices to request their main offices to provide them with information on funds disbursed for health services. Secondly, the information could be captured by the district health accounts once fully operational. The district health accounts tool could also be used to capture NGO funds provided the districts are able to establish good working relations with NGOs operating in the health sector. The Ministry of Health should also make deliberate efforts to establish good working relations with NGOs so as to be able to obtain the relevant data from their country head offices.

Likewise, the district health accounts will be able to capture data on donor programmes carried out at the district level whose funds are not channeled through the treasury or the Ministry of Health. For off budget donor support at central level data can be obtained directly from donors or by requesting the relevant programme to submit copies of their annual reports to the Ministry.

1.6.5 Other recommendations

In general for the above recommendations to be implemented there is a need for sensitisation of all the key actors in the health services to ensure that they understand the national health accounts exercise and appreciate the need for providing the relevant data. Then it will be easy to get them to co-operate in providing the required data.

We understand that the Ministry of Health has trained a number of people on the national health accounts. These personnel are some of the members of the NHA co-ordination committee. To ensure sustainability of the exercise we recommend that these staff and their counterparts from other ministries and / or departments constitute a team responsible for gathering data and updating the health accounts on a regular basis.