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SCH Strengthening
Capacity in
Health Financing
Fostering Financial Sustainability in Tanzania

Options for Financial Management and Reporting

February 2014
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Acknowledgements

This report was prepared by Stephen Musau and Tim Cammack. Research for the report was contributed by Tim Cammack and Paul Nandrie. We would like to warmly thank staff of the Ministry of Health and Social Welfare, Prime Minister's Office – Regional Administration and Local Government and the Ministry of Finance for making themselves available for interviews and providing key documents for this paper. We are also grateful for the Wajibika Project and GIZ who also provided information on the current status of financial management in the regions and local authorities that they support.

The authors are grateful for the coordination for the paper provided by Dr. Daniel Ngowi, Chief of Party, Strengthening Capacity in Health Financing in Tanzania Project and editorial review provided by Avril Kaplan and Debbie Ventimiglia. We are also particularly grateful to the Ministry of Health and Social Welfare Technical Working Group-Health Financing for their valuable guidance.

Funding for this study was made available by the United States Agency for International Development (USAID) through the Strengthening Capacity in Health Financing Project and through Kreditanstalt fuer Wiederaufbau (KfW).

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Acronyms

ACCGEN	Accountant General
BIR	Budget Implementation Report
Bn	Billion
CAG	Controller and Auditor General
CC	City Council
CCHPs	Comprehensive Council Health Plans
CDR	Council Development Report
CFR	Council Financial Report
CHF	Community Health Fund
CHMT	Council Health Management Team
CIDA	Canadian International Development Agency
DC	District Council
DMO	District Medical Officer
DPP	Division of Policy and Planning
FAU	Finance and Accounts Unit
FMO	Financial Management Officers
FY	Fiscal Year
HSDG	Health Sector Development Grant
HSSP	Health Sector Strategic Plan
ICT	Information and Communications Technology
IFMS	Integrated Financial Management System
IPSAS	International Public Sector Accounting Standards
LGDG	Local Government Development Grant
LGAs	Local Government Authorities
LPO	Local Purchase Order
MDGs	Millennium Development Goals
MMAM	Primary Health Services Development Program
Mn	Million
MNH	Muhimbili National Hospital
MoF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTEF	Medium-Term Expenditure Framework
NAO	National Audit Office
NASA	National AIDS Spending Assessments
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NSGRP (MKUKUTA)	National Strategy for Growth and Reduction of Poverty (<i>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania</i>)
OC	Other Charges
PE	Personal Emoluments
PER	Public Expenditure Review
PFM	Public Financial Management
PFMRP	Public Financial Management Reform Program
PHSDP	Primary Health Service Delivery Program
PMO-RALG	Prime Minister's Office, Regional Administration and Local



	Government
PPRA	Public Procurement Regulatory Authority
RAS	Regional Administrative Secretary
RS	Regional Secretariat
SWAp	Sector-Wide Approach
TIKA	Tiba kwa Kadi (urban equivalent of the CHF)
TZS	Tanzanian Shilling
USD	U.S. Dollar

Executive Summary

The Health Sector Strategic Plan III (HSSP III) is the cross cutting strategic plan for the health sector of Tanzania for the period July 2009 – June 2015. The Health Financing Strategy, and within that- Financial Management and Reporting- is a major focus of the HSSP. The headline strategic area which this study addresses is one of nine strategic areas identified in the Health Financing Strategy¹. In that strategic analysis the Financial Management and Reporting (FMR) Study is intended to make recommendations for improving accountability and timely availability of funds. The focus of the report is largely on assessing processes and tools for management and reporting of health resources, including human resources thereof, and the improvements that may be needed to achieve greater efficiency, cost effectiveness, and more responsible use of health resources and delivery of services.

The Government of Tanzania (GoT) has made progress in initiating major public financial management (PFM) reforms which, if fully implemented, will create a credible PFM system that is reliable for internal as well as external users. However, there is still a lot of work to be done in the areas highlighted below.

MOHSW level

FINANCIAL MANAGEMENT ENVIRONMENT:

The environment for financial management and budgetary activity is a major factor in its effectiveness. This includes the quality of office space and the availability of filing space, as well as the availability of computer hardware, software, Internet, and e-mail. The offices of the Finance and Accounts Unit (FAU) are sometimes cramped with three or four people working in a small space, and corridors and passageways being used for filing and storage. Some of this is undoubtedly inevitable, but reorganization and disposal of old documents may create a better working environment.

Recommendations:

- FAU together with Division of Policy and Planning (DPP) Planning and Budgeting Section (and more widely MOHSW) to prioritize the development of an electronic office space using modern technology fully including (1) computer numbers/specifications to be assessed and where necessary replaced (2) FAU staff and Budget Officers to have extensive training in Excel based upon a system whereby those who embrace it more completely can be selected for more advanced courses, and (3) FAU staff and Budget Officers to have training in use of email as

¹ Others are: *minimum benefit package(s)*: options to sustainably structure access to benefits; *insurance market structure*: options for the social and private health insurance architecture; *performance financing*: options for linking allocations to performance of service providers; *equity-based financing*: options for improving the equity targeting of (esp. budget) resources; *inclusion of poor & vulnerable*: options for identification and financing of services for this group; *CHF reforms*: options for the re-design of the CHF system; *private sector resources*: options strengthening equitable funding from the private sector; and, *innovative financing and fiscal space*: options for increasing public financing for health.



well as use of email storage software, and be assisted to establish email addresses where they do not already have them. The use of email storage software would compensate in part for erratic internet or limited connectivity since it would make it possible to read and write mail offline. Finally, the establishment of group or departmental Dropboxes could make file sharing easier.

MAJOR TRANSFERS TO HEALTH INSTITUTIONS

Grants and transfers comprise 68% of the recurrent budget for fiscal year (FY) 2013-14, or 57% if transfers to health facility accounts at Medical Stores Departments (MSD) are excluded. The top three items – Muhimbili, Designated District Hospitals (DDHs) and Voluntary Agency Hospitals took 60% of the FY2011-12 total.

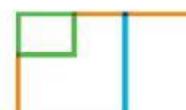
Recommendations:

- Engage a consultant to work with the MOHSW to establish accountability arrangements in place for this large component of the Recurrent Budget. The review should cover at least the top eight items in Table 5 which would represent over 90% of the transfers. It should consider specifically how the Ministry ensures that the funds are allocated efficiently and effectively, by reviewing e.g. whether the agencies have functioning boards and how responsive they are to the Ministry; what internal audit arrangements exist and the frequency/intensity of visits; what budget setting, financial, and performance reporting arrangements exist; whether the agencies have service agreements with the Ministry, and if so what they contain and how they are monitored; whether external audits have been carried out in a timely manner; what processes exist within the Ministry to follow up internal and external audit recommendations; and to what extent these recommendations have been followed up. In the case of the transfers to District Designated Hospitals and Voluntary Agency Hospitals, which consist of transfers to multiple organizations that total Tshs 44bn, the review would need a slightly adapted approach using sampling techniques.

The review should propose a process for ensuring strong accountability going forward indicating the roles and responsibilities of key players including the Permanent Secretary, Director of Policy and Planning, the Chief Accountant, and others.

The review should consider the merits of a solution which distinguishes technical oversight and corporate oversight (adopted in other countries including the UK). Technical oversight might continue to be provided by the relevant technical departments of MoH (in full cooperation with any Board that may exist) while corporate oversight (e.g. financial, corporate regulations, audit, compilation of performance monitoring) may be provided by a central team covering all third party organizations (again, in full cooperation with any Board that may exist). This would have the twin advantage of a) freeing up the technical department to concentrate on substantive issues within its specialist competence and b) enabling the Ministry to develop a team with the in-depth financial and other professional skills necessary for the effective management of third party organisations. This would help to ensure consistency and provide guidance both to arms-length bodies themselves and to the sponsor department.

- Explore the possibility of developing Service Agreements between the Ministry and these agencies, and ensure that there is adequate capacity for subsequent monitoring. Such agreements should include indicators to track performance in cost efficiency; external



audit performance; staffing of critical PFM functions; performance in Public Procurement Regulatory Authority (PPRA) audits; budget execution; etc. Some agencies that receive grants from MOHSW, especially hospitals, also receive revenues, and some may not be maximising their revenue possibilities, which also this needs to be tracked..

- Enhance revenue by (1) having Internal Audit look at central and regional hospital revenue collection patterns in relation to certain significant statistics such as catchment area population; number of beds; number of outpatients or inpatients; graph the results and examine for outliers with relatively low revenue collection in terms of the other data, and (2) share ideas on improving National Health Insurance Fund (NHIF) collections.
- Consider establishing a small central team at MOHSW to provide “corporate” oversight and monitoring of these institutions. This team would monitor the financial, governance, compliance, audit, and risk management aspects of their business, as distinct from the technical oversight that would continue to be provided by the relevant sponsoring department. This would help strengthen quality and consistency of oversight on PFM issues.

DEVELOPMENT BUDGET OF DONOR-FUNDED PROJECTS:

The Development budget is dominated by external funds, especially the Global Fund and the Health Basket. Effective financial management initiatives can use this information to focus reform and value for money initiatives on major areas of spending. In view of the large sums of money flowing through donor-funded projects, a more detailed review of the management of development projects is needed to introduce a more formal process of financial scrutiny to highlight slow implementation, or to ensure that the resources are in place to enable implementation, and to clarify project financial management responsibilities.

Recommendations:

- All financial reports on development projects should be signed off by the Chief Accountant prior to release to ensure that all necessary reconciliations and verifications have been carried out.

ADEQUACY OF IFMS

The Epicor Integrated Financial Management System (IFMS) has significantly strengthened financial management in line ministries. However, several weaknesses have been observed including:

- Inability of IFMS to record arrears because it only allows commitments to the point that spending has been authorized for the period.
- Inclusion of the Recurrent Budget in its entirety on a day-to-day basis, but only part of the Development Budget, which comprised 49% of spending in FY 2012-13. The Health Basket (9% of the Development Budget) is recorded fully on IFMS, but larger projects, such as Global Fund, make numerous payments using IFMS and record them in Excel spreadsheets.
- Standard suite of reports is designed by the Accountant General with a view to control and centralize reporting, but without regard to the internal management



requirements of line ministries. There is no flexible report generator, and as a result, some ministries (for instance the Ministry of Water) have been developing their own capabilities in this area.

- Bank reconciliations cannot be performed on the IFMS.

Recommendations:

- Develop a plan for moving to the use of web-based systems "thin client" to minimise bandwidth requirements and extended usage privileges.
- Enable the budget office in the DPP to have access to IFMS so that they can produce their own reports. The lack of reporting may be a licensing issue, but possibly not. KPMG reported in a 2010 review of IFMIS that there were "a total of 225 IFMS licenses installed at Accountant General (ACCGEN). However for the current year ACCGEN has paid for 554 licenses."
- Extend access to Epicor so that users can see reports. This would remove the need to keep their duplicative Excel Cash Books.

HUMAN RESOURCES FOR FINANCIAL MANAGEMENT

The current PFM structure of the GoT does not give adequate weight to financial management, which is always managed by a "Unit." Even though the Chief Accountant has director status, the perception is that financial management is a less critical activity and the Chief Accountant a less critical player. There is no strategic view of financial management in the health sector – there is only a strategic view of health financing in the DPP. The Chief Accountant is fully engaged in the management of the day-to-day requirements of the accounting process.

Recommendations:

- Create a position of Director of Finance with responsibility to oversee a Finance Department that incorporates all the functions of the current Finance and Accounting Unit, but also has a strategic view of financial management. The strategic view includes sector inputs to financial management reforms. It is acknowledged that since this is a national structure there is little that the Ministry can do on its own.
- Another option which requires a broader GoT restructuring, would be to group the DPP budgeting and FAU accounting functions relating to MOH's own funds i.e. vote 52 under a Finance Director role, as is done in the private sector, in parastatal organizations, and in government departments in other countries.
- Give another DPP unit (e.g. the current policy unit, building on its current PER and National Health Account responsibilities) responsibility for the wider sector budgetary planning, value for money and expenditure efficiency tracking, supported by a strong data management and analysis unit.
- In addition to the staff members indicated above there is an international Technical Assistant in Finance based in the Ministry and financed by Danida. His current contract will continue until 2014. He is engaged and knowledgeable and possibly



underutilized in view of his wide experience. His terms of reference could be expanded, in discussion with the MOHSW, to include helping to develop and monitor a PFM improvement plan (based in part on this report), and evaluating parts of the Ministry that aren't working so well (e.g. review of Development budget reporting).

- In view of the increasing importance of the development budget, a position of Director of Finance supported by Chief Accountant (Recurrent) and Chief Accountant (Development) is easily justified. However, this may prove difficult to carry out in the present structure of government. In that circumstance the option should be to have at least a Principal Accountant (Recurrent) and a Principal Accountant (Development) reporting to the Chief, with other sections reporting to them.

EXTERNAL AUDIT

The Management Letter, which accompanied the financial statements for the year ending 30, June 2012, shows recommendations from previous years that have not been dealt with totaling TShs.71.2 billion.

Recommendations:

- Consider CAG recommendations seriously and ensure that they are followed up. However, ensure also that the issues raised are correctly interpreted by stakeholders and that their significance is appropriately assessed.
- Consider allocating a mid-level staff person to the resolution of audit queries to release the Senior Accountant (Expenditure) for her routine duties.

PUBLIC FINANCIAL MANAGEMENT REFORM IN THE HEALTH SECTOR

The Budget section responds to the Ministry of Finance (MOF) on budget and Medium Term Expenditure Framework (MTEF) reform and FAU responds to the Accountant General (ACCGEN) on issues concerning the IFMS and International Public Sector Accounting Standards (IPSAS). The reforms are monitored by the Deputy Director Budget or by the Chief Accountant in MOHSW. PFM reform at the sub-national level is managed by the Prime Minister's Office, Regional Administration and Local Government (PMORALG). While the Ministry should take an interest because such reforms may improve the information flow or strengthen budget execution for health, it is primarily an observer.

This lack of central coordination results in a missed opportunity to look at the financial management needs of institutions that are similar throughout the sector, but differ from others within a district (e.g. hospitals are likely to have more similarities to other hospitals across district boundaries than to schools within a district).

Although the Ministry is no longer a component of the central PFM Reform Programme, there are many actions that can be taken to strengthen PFM in the sector. It would be helpful for the FAU to draw together a summary of reforms, audit issues, staffing requirements, computer capacity reviews, trainings, etc. and bring them all into one annual PFM improvement plan under a senior focal staff member.



Recommendation:

- MOHSW, through FAU, needs to develop a PFM improvement plan that reaches throughout the sector and is consistent with Public Financial Management Reform Program (PFMRP) IV, but also wider to embrace internal management objectives and follow up on audit recommendations.

Medical Stores Department

The Permanent Secretary of MOHSW is the Accounting Officer for MSD, and under the Public Financial Management Act has responsibility for the effectiveness of its accounting systems and internal controls. There is one financial professional on the MSD Board (FY2011-12), with skills in finance and economics. Importantly, she chairs the meetings of the Audit and Risk Management Committee and attended four of their five meetings in FY2011-12, including all Extraordinary Meetings. However, the Finance and Administration Committee of the Board, which is responsible for oversight of financial management, human resources and administration, has no members with skills in financial management.

There are also a number of financial management issues adversely affecting the functionality of MSD. Three issues are of particular importance. The first is the disbursement process, which tends to provide the health facility accounts at MSD with too little funding too late in the year. The second is the failure to reimburse MSD for the costs associated with the clearance, storage, and distribution of goods received in-kind. Finally, the third is the absence of a strategy to prevent the erosion of working capital, which has undermined the ability of MSD to perform according to its mandate.

Recommendations:

- Implement the recommendations of the Special Audit report of 2012, the Plan of Action, and the financing recommendations of the Strategic Review, especially:
 - Include all vertical programme handling charges in the MTEF and budget; pay the debt in full and put in place procedures to ensure that future charges are paid within 90 days.
 - Ensure that MSD has sufficient working capital, and carry out a recapitalisation review.
- Strengthen the financial management representation on the Board with a professionally qualified accountant who is knowledgeable in financial management strategies for wholesaling and distribution operations.
- Include financial analysis and business planning as part of the Terms of Reference for the upcoming Danida-financed consultancy in support of MSD's new 5 year Medium Term Strategic Plan 2013-2018.
- Continue to strengthen the organizational capacity of the MSD as a central delivery vehicle for medicines.



Muhimbili Hospital

On the whole, it appears that financial management at the Muhimbili National Hospital (MNH) is strong, with adequate controls over revenues and expenditures. The Controller and Auditor General (CAG) issued a clean audit report in FY2011-12, which is a good indicator of adherence to government financial regulations.

The Board of Trustees has noted that the operating losses in FY2011-12 and in the previous year result from shortfalls in subventions received against the budgeted amount. These losses have taken their toll on the liquidity of the hospital. MNH is aiming to maximize its revenues from hospital income and monitors it closely. Possibilities are limited since 40% of patients are exempted under national regulations and prices have not been increased since 2009. It is understood that there is an Internal Audit report on revenue collection at MHN and that there has subsequently been a review of revenue management by PriceWaterhouse Coopers.

Recommendations:

- Management and Board of Trustees review the findings of the internal audit and the PWC review. Based on the review, develop a time bound Action Plan that can be monitored in the long term (this may already be underway).

Local Government Authorities

PLANNING AND BUDGETING

Councils are required to prepare their Comprehensive Council Health Plans (CCHP) in accordance with the CCHP Guidelines and the PlanRep3 tool in order to make sure that their plans are in line with national health and development priorities. Despite the availability of comprehensive guidelines, the preparation of the CCHP has been challenging. Most councils are not able to get their plans approved and have to go through several reviews before they are considered of good enough quality for funding.

Recommendations:

- Make the CCHP Guidelines easier to follow and more user-friendly. If a modular structure was adopted, whereby information is clustered under several broad areas, a user can pull out only the section that is relevant to them. The CCHP Guidelines should also avoid heavy technical (economic) content that is not applicable to all guideline users. Additional information can be relegated to the annexes.

BUDGET EXECUTION – INABILITY TO SPEND BUDGETARY AND OTHER ALLOCATIONS

A major challenge at both the central and Local Government Authority (LGA) levels is lack of capacity to utilize funds. The lack of capacity to spend may be due to a combination of factors, including: the late disbursement of funds, mostly in the third and fourth quarter of the fiscal year, which derails effective implementation of plans; overstretching of staff who cannot implement extra activities because of their low existing numbers and poorly supported ICT systems; and inadequate familiarity with rules and procedures for the disbursement of funds thus delaying disbursement and expenditures.



COMMUNITY HEALTH FUND

During FY2011-12, a review of 38 Councils was completed to examine the management of Community Health Fund (CHF) operations. The review found that Councils had unspent balances of Shs.1,709,747,559, which was mainly caused by not opening and operating separate accounts in respect of CHF and delays in the release of matching grants.

Recommendations:

- Councils should acquaint themselves with the regulations governing the operations of the CHF, including banking and spending rules.

HEALTH SERVICES DEVELOPMENT GRANTS

A test check by CAG on the financial performance and utilization of Primary Health Services Development Program (PHSDP) funds received by Councils for improving accessibility and quality of the health service noted unspent balances of Shs. 2,586,057,984 in respect of 32 Councils as at 30th June, 2012.

Recommendations:

- Local Government Authorities (LGAs), the Ministry of Health and Prime Minister's Office Regional Agency and Local Government (PMO-RALG) should ensure that the limited health resources available are being used to achieve intended health outcomes. Supportive supervision by the Council Health Management Team (CHMT) and Regional Health Management Team (RHMT) should also include this in their menu of interventions during their supervisory visits.

TRANSFERS OF FUNDS

An analysis of the system of transfers indicates that it is overly complex, consisting of numerous different grants with different allocation criteria of variable transparency. Elements of the transfer system have been designed with the intention of allocating resources to LGAs in an objective, fair and transparent manner through the use of a formula-based approach.² However, the approach no longer appears to be working as intended with the formulas not always being applied in a consistent and transparent way. The problems have been recognised by the MOF and a mapping exercise on transfer of funds to LGAs has been conducted (MOF, 2013). The exercise seeks to harmonize the multiple transfers and to make the system work in a way that adheres more closely to the principles of the formula that is currently in place.

² 70% by population, 10% by Number of poorer residents 10% by Council medical vehicle route, and 10% by under-five mortality. The allocations by LGA were subjected to the assessment results (100% for Very Good, 80% for Good, 50% for Poor and 50% for Failed).



Recommendations:

- Improve communication between the MoF, Regional Administrative Secretary (RAS) and LGAs so that as soon as funds are released, the information goes to the RAS as well as the LGA.
- MoF should endeavor to release funds in a timely manner and communicate delays to the RAS and LGA for their own cash flow planning.
- LGAs should aggressively follow up to plan for and use, unspent CHF funds.
- LGAs should develop systems for claiming and collecting from the NHIF.
- LGAs need to be knowledgeable of all procurement regulations and be able to conduct proper project and cash flow planning in order to minimize the unspent balances in their books.

EXTERNAL AND INTERNAL AUDIT OF LGAS

In recent years, the number of LGAs that received a clean audit opinion has improved from 54% (72 out of 133 councils) to 78% (104 out of 134 councils) in FY2011-12. The continued poor performance by some LGAs is partly due to changes in accounting standards adopted by the GoT. Since FY 2009, all LGAs are required to adhere to the IPSAS. This requirement has exerted pressure on the weak human capacity in LGAs to fulfill the conditions of the IPSAS. In addition, only limited training has been provided to staff to implement accrual based accounting required by the IPSAS. LGAs have struggled to achieve minimal standards and basic procedures. For example, bank reconciliation remains an area of concern.

Despite the improved overall audit performance, the year's audit still included the following serious issues:

- Financial statements are not directly generated from the IFMS as they are supposed to be, resulting in the improper preparation and presentation of financial statements.
- Deficiencies in Internal Control Systems: As noted in previous years' reports, the internal control systems in some of the LGAs are not adequate owing to use of manual accounting system, ineffective internal audit units, and poor performance of the Audit Committees.
- Weaknesses in revenue management from own sources resulted in TSh 18.6 billion of uncollected revenue.
- In the audit report on LGAs for FY2011-12, CAG has expressed concern regarding the low level of compliance with procurement procedures, laxity in control over contract payments, poor supervision of LGA projects, procurements being made without Tender Board approval, the missing documentation in LGAs relating to procurement, and the manner in which several of the assessed LGAs ordered and paid for goods that were not delivered.



Recommendations:

- Formalize the relationship and the flow of information between LGAs and the Internal Auditor General (IAG). This may require an amendment to the Local Government Finance Act to give the IAG more authority over local internal audit units.
- LGAs need to strengthen their internal control systems, including the internal audit function.
- Every effort should be made to collect Own Revenue that goes uncollected every year due to poor LGA systems for planning and monitoring revenue collection.
- All LGAs should have a risk assessment and fraud prevention plan in place.
- LGA Procurement Management Units (PMU) need to be strengthened with training on all procurement regulations. Training should also be extended to heads of department as well as Councilors so that the councilors are not a bottleneck to the approval process.

INTEGRATED FINANCIAL MANAGEMENT SYSTEMS AND OTHER INFORMATION TECHNOLOGY SYSTEMS

PMO-RALG has developed plans for improvement of the IFMIS. In 2012, the system was upgraded to Epicor 9.05. This has improved its functionality and addressed some of the concerns identified by the National Audit Office (NAO) and other evaluators. Epicor version 9.05 currently covers all Ministries, Departments and Agencies (MDAs), the 22 sub-treasuries, the regional administrations, and 133 LGAs. Recent creation of new districts has brought the number of LGAs to 167, of which 34 remain unconnected.

Despite much improvement of the IFMIS from previous versions, there are several challenges that must be overcome to improve further financial management and control:

- Lack of human capacity to operate the IFMIS to its full potential.
- Inconsistencies in the allocation of responsibilities that constrain the efficient working of Epicor. Some of these inconsistencies result from differences in the provisions of the relevant legislation. The Epicor system is managed by the District Treasurer; Procurement Management Units are, according to the Public Procurement Act, supposed to issue Local Purchase Orders (LPOs) after validation of the availability of funds, but most of them do not have access to Epicor.



Recommendations:

- Streamline organizational arrangements and the legislative framework to enable the IFMS to more fully achieve its goals.
- Use the Epicor system to register all commitments, including both multi-annual and annual contracts.
- Train all relevant LGA staff (e.g. District Treasurer; Internal Auditor; accounts staff; PMU staff) to use Epicor so that they can better manage and control finances.

FINANCIAL REPORTING

LGAs are required to prepare and submit the Council Financial Report (CFR) to the PMO-RALG on a quarterly basis. This report is also distributed to the MOHSW, but it appears that no action is taken to monitor spending on health. The CFRs have also tended to be of variable quality from one LGA to another and reliability of the information reported has been an issue partly because they are not reviewed by the council finance committee before submission.

Recommendations:

- The council finance committee should review the CFR and CDR before submitting to PMO-RALG to ensure that information contained therein is accurate.
- Share CFR and CDR with the public in a user-friendly format for added accountability.
- MOHSW should take a more active interest in health spending at LGA level and monitor it more frequently than during the annual Public Expenditure Review (PER).

Human resources for PFM in PMO-RALG, regions and LGAs

The Local Government Finance section is headed by an Assistant Director Local Government (Finance). He works with a team of seven whose task is to evaluate financial management at the LGAs and support them to achieve better results. The team is also responsible for ensuring that LGA planning and budgeting follows guidelines, and ensuring that budgets are posted correctly in the accounting system. The ICT team is responsible for the design and application of the Epicor software. However, design of the software does not currently include qualified accountants.

At the regional level, Financial Management Officers (FMOs) are responsible for supervising LGA financial management. These FMOs are fairly junior and in many cases inexperienced. Until June 2013, there was a position of Regional Technical Advisor attached to Local Government Management Services reporting to the RAS, but this position was discontinued despite being one of the key support mechanisms for council PFM. In the council, council treasurers oversee financial management activities and are also responsible for developing capacity in the Epicor application with assistance from PMO-RALG ICT staff in Dodoma. Staffing at the regional and local government levels require strengthening, as there are some serious gaps.



Recommendations:

- Restore the Regional Technical Adviser (or a similar) position staffed with people who have financial management skills and demonstrated experience.
- Include qualified accountants in the design of Epicor in the ICT team to advise on the most appropriate reports and other features to be included in the on-going customization of the software.
- Fill all council treasurer and other senior staff positions that are currently vacant.

Regional and district hospitals

District hospitals are affected by the same financial management weaknesses presented above under the LGA. Regional hospitals express the need for management training for staff, as well as the RHMT that are supposed to supervise them.

Recommendations:

- Build management skills of hospital senior management. Particular attention should be placed on use of IFMS and the health information systems in decision-making, and especially in the control over resources and revenue collection.
- Identify well-managed hospitals (DDH or public) and use these as learning centers where other hospital managers can observe how financial management systems function and can be implemented.

Monitoring and evaluation

The systems of DPP and FAU in MOHSW, PMORALG and their equivalents in MSD, and hospitals constantly monitor financial management indicators; audits are the institutionalized evaluation process. This report outlines ways to strengthen these systems.

The MOHSW conducts annual Public Expenditure Reviews (PERs) and National Health Account estimations approximately every two years. National AIDS Spending Assessments are produced periodically by the Tanzania Commission for AIDS (TACAIDS). This is a laudable success that has not been accomplished by many countries in Africa. A plan for institutionalizing the production of these resource tracking activities is in place, though it needs to be updated and costed. To avoid conflicting messages, the MOHSW should adopt a more thorough definition of expenditures.

Recommendations:

Use of PFM needs to figure more strongly in strategic planning documents and indicators should be revised to include financial management more fully. Options include:

- A revised audit report indicator to separated "pure" health institutions from the LGAs. For example, MoHSW; MSD; Central Hospitals (weighted percentage); and LGAs (unweighted percentage).



- An appropriately weighted procurement indicator based upon PPRA reviews.
- Rates of financial execution (that is to say, spending as a percentage of resources received).
- Some important areas of financial management do not lend themselves to indicators and must be monitored qualitatively. These include follow up of audit recommendations and improvements in financial reporting. Indicators could be developed for the second of these to be followed up at a lower level than the HSSP itself, such as within a Health Sector Financial Management Improvement Plan.
- Update the MOHSW's resource tracking institutionalization plan to include clear definitions of expenditure indicators and possible data sources.

Conclusion

While many issues need to be addressed, PFM in the MOHSW and LGAs is in a process of improvement. The MOF, MOHSW and PMO-RALG have been informed of the many challenges through evidence emerging from stakeholder studies and evaluations. To further improve PFM, the MOHSW needs to take consistent steps to implement these recommendations, the most important of which are repeated in this document. In addition, the MOHSW needs to come to agreement with stakeholders on a clear plan to strengthen PFM. PFM is a cross-sectoral issue involving in particular the MOF and PMO-RALG as well as development partners.

Quick wins:

This report presents a series of recommendations. It will be important to selectively identify what can be implemented with minimal structural or inter-ministerial coordination. Furthermore, it is important to accelerate initiatives that are already under way. Quick wins include:

- Development of a PFM plan for the MOHSW.
- Establishment of a small central team at MOHSW to provide the “corporate oversight and monitoring of institutions that receive budgetary transfers from the ministry.
- Strengthened internal controls, including functioning of Internal Audit.
- Building procurement capacity beyond the PMUs at LGA to include heads of departments and councilors.
- Strengthened RHMT financial management capacity to supervise LGAs by adding to the team Regional Technical Advisors with financial management experience.
- Resolving CAG recommendations both at central and LGA levels.
- Fixing critical functionalities of Epicor, e.g. reporting and bank reconciliations and including qualified accountants in the ICT design team in Dodoma.
- Ensuring that transfers to health institutions include service agreements and a team at central MOHSW to monitor performance.



- Ensuring that MSD implements the recommendations of the Special Audit report of 2012, the Plan of Action, and the Financing recommendations of the Strategic Review.



1. Introduction

1.1 Background

The Health Sector Strategic Plan III (HSSP III) is the cross cutting strategic plan for the health sector of Tanzania for the period July 2009 – June 2015. It provides an overview of the priority strategic directions across the health sector, and is in turn guided by the National Health Policy, Vision 2025, the National Strategy for Growth and Reduction of Poverty Reduction (MKUKUTA) and the Millennium Development Goals (MDGs). HSSP III serves as the sector’s comprehensive national plan and guiding framework for the detailed planning and implementation of health sector activities by all levels and partners. The Health Financing Strategy, and within that Financial Management and Reporting, is a major focus of the HSSP.

This study addresses one of nine strategic areas identified in the Health Financing Strategy³. As a strategic analysis of Financial Management and Reporting (FMR) in Tanzania, this study is intended to identify options for improving accountability and timely availability of funds. The overall objective of this assignment is to develop comprehensive, adequate, and feasible reform strategies/options for Financial Management and Reporting.

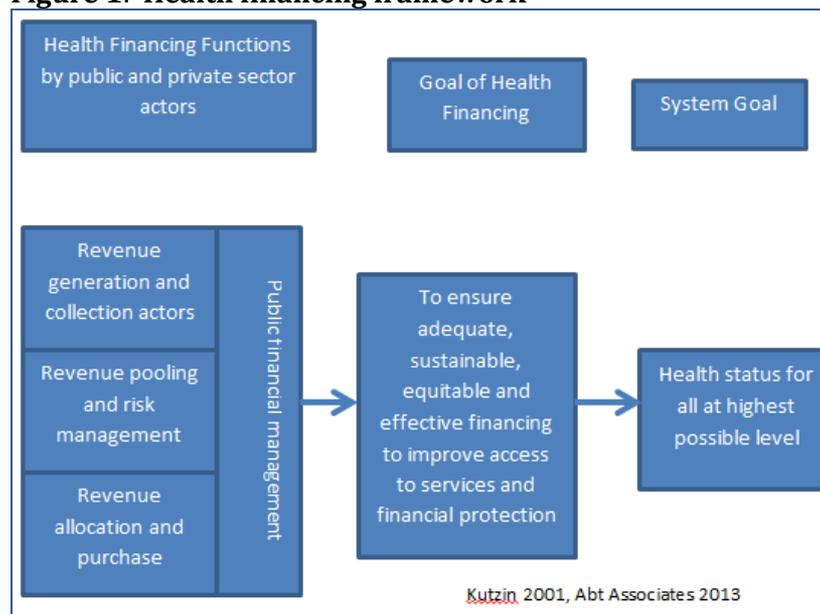
Financial management and reporting (or more broadly, Public Financial Management (PFM)) is a key component of any health financing strategy. PFM is defined as the “system by which financial resources are planned, directed, and controlled to enable and influence the efficient and effective delivery of public service goals.”⁴ It includes procedures and practices for planning, budgeting, monitoring, organizing, controlling, and reporting of public financial resources. This clearly fits with the objectives of a health financing strategy of resource mobilization, resource pooling and purchasing, as it cuts across all three components as depicted in Figure 1 below. Strengthening financial management systems that underpin health service delivery is critical to a successful health financing strategy.

³ Others are: *minimum benefit package(s)*: options to sustainably structure access to benefits; *insurance market structure*: options for the social and private health insurance architecture; *performance financing*: options for linking allocations to performance of service providers; *equity-based financing*: options for improving the equity targeting of (esp. budget) resources; *inclusion of poor & vulnerable*: options for identification and financing of services for this group; *CHF reforms*: options for the re-design of the CHF system; *private sector resources*: options strengthening equitable funding from the private sector; and, *innovative financing and fiscal space*: options for increasing public financing for health.

⁴ Chartered Institute of Public Finance and Accountancy. Public Financial Management – A whole systems approach. Volume 1.



Figure 1: Health financing framework



PFM is usually a low priority in discussions of health financing strategies. Given the challenges facing the Government of Tanzania (GoT) in financing health for its citizens, it is important to establish a comprehensive approach to strengthening financial management capacity. The approach should aim to align budgets and financing to strategies and objectives. Furthermore, it should aim to monitor spending in order to assess the degree of alignment attained and the basics of financial management and accounting. The result of a comprehensive approach will be institutionalized financial management systems that ensure budgets are executed, financial controls are in place, audits are completed, and information is transparent and available to stakeholders. This will increase the effectiveness and efficiency of resources, and also build confidence among citizens that the health sector is accountable with minimal corruption or misuse of public funds (thereby enhancing the probability of receiving additional allocations).

Increased competition for public resources means that financial management is becoming more important. Government is more focused on productive sectors, as emphasized by the Big Results Now program,⁵ which does not include health as a focal sector. Without better use of existing resources through improved financial management, it is unlikely that the health sector will obtain a larger share of government resources in the near future.

⁵ As part of the Tanzania Government's effort to transition the country from low to middle-income economy, Tanzania is set to adopt the Malaysian Model of Development – “The Big Fast Results Initiative” - in its own development outlook to be implemented beginning of 2013-2014 financial year. A comprehensive system of implementation will focus on six priority areas of the economy: i) Energy and natural gas (ii) Agriculture (iii) Water (iv) Education (v) Transport (vi) Mobilization of resources. <http://www.pmoralg.go.tz/quick-menu/brn/index.php>



1.2 Objectives and scope

The objective of this consultancy is to examine mechanisms for stronger management of health resources at the central and local levels, while defining the roles of stakeholders in two key areas:

1. Management and oversight of health service delivery.
2. Planning, budgeting, accounting and reporting at the local government level.

The study assesses processes and tools for management and reporting of health resources, including human resource needs for financial management and reporting. It seeks to identify improvements that may lead to greater efficiency, cost effectiveness and more responsible use of those resources.

A specific objective of the recent Mid Term Review (MTR) was to review the financing of the health sector from 2009 to 2013, including funding mechanisms and modalities, GoT and development partner commitment and contributions, fund utilization, reporting, and overall efficiency and harmonization of these modalities in delivering HSSP III strategic objectives. This study makes every effort to harmonize with the MTR and to avoid duplication.

1.3 Methodology

The study team completed primary data collection through key informant interviews as well as observation of field practice.. The team completed a comprehensive review of existing literature, which included both published documents as well as other reports that stakeholders made available to the study team. To gain a clearer understanding of on-going initiatives, successes, and challenges the study team consulted with projects engaged in PFM activities at the central and LGA levels.

The Terms of Reference (ToR) for this assignment cover a wide array of PFM issues, requiring data to be collected from multiple sectors. The team took advantage of the many PFM assessments already completed in order to reduce duplicative data collection efforts. The team collaborated with the MTR consultants to gain access to any relevant data, to minimize duplication and to ensure consistency of recommendations.

Substantially, financial management policies and procedures are determined centrally. As a result, this review considers the levels of health sector compliance with national policies and procedures, and explores how those policies and procedures support or constrain health service delivery. In addition it goes beyond this to examine financial management issues specific to the sector.

For the purposes of this study, central agencies of the health sector are considered to be the Ministry of Health and Social Welfare (MOHSW); the Medical Stores Department (MSD); and the Central Hospitals. The Prime Minister's Office for Regional and Local Governments (PMO-RLG) is also a central agency with a significant responsibility for health, but for expository purposes, it is considered together with the subnational health institutions, and again within the institutional framework analysis in Section 3.1 below.



1.4 Context and enabling environment

This review addresses financial management in the health sector, but in many respects, financial management regulations and procedures are determined by national legislation or by central government ministries and departments. The study therefore focuses on financial management in the health sector, but takes into account nationally-determined legislation, regulations and procedures that are established through central government ministries and the Parliamentary process. Relevant legislation includes the Public Finance Act 2001 (amended 2004 and 2010); the Public Finance Regulations; the Public Procurement Act of 2004; the Procurement Regulations of 2005; and the Public Audit Act of 2008.

1.5 Key actors in health sector financial management

The MoF is responsible for many PFM functions: oversight of the national planning and budgetary process; monitoring of revenue management and collection, including sectoral revenues; disbursement of funds and the cash rationing system; and implementation of the Public Financial Management Reform Programme.

Through the Accountant General, the MoF is also responsible for the provision of finance staff to all ministries using the accounting common service. In addition, the MoF via the Accountant General establishes and maintains the accounting systems and procedures, including the Integrated Financial Management System (IFMIS) currently using the Epicor accounting software.

The MOHSW is responsible for the development of the central health Recurrent and Development budgets in accordance with MoF provided ceilings and other guidance. Furthermore, MOHSW is responsible for management and reporting on the expenditure of budgets in accordance with regulations and relevant instructions from the MoF. Within the MOHSW, the Department of Policy and Planning (DPP) is responsible for the development and monitoring of budgets, whilst the Finance and Accounts Unit (FAU) is responsible for budgetary execution, including making payments, management of bank accounts and expenditure reporting. More comprehensive financial reporting is undertaken by both FAU and DPP, with DPP producing performance reports.

PMO-RALG is responsible for oversight of Local Government Authority (LGA) finances, including the consolidation and review of the plans, budgets and financial reports of District Councils; the maintenance of the planning and budgeting software in use at the subnational level (PlanRep); and the maintenance and use of the Epicor IFMIS at the subnational level.

Finally, the LGAs are responsible for management and reporting of funds under their control, which include formula based recurrent block grants for the grant-aided sectors (education, health, roads, agriculture and water) as well as a General Purpose Grant (GPG); other transfers from Ministries Departments and Agencies (MDAs) for recurrent purposes; and development grants and funds including the Local Government Development Grant (LGDG).

Other actors with a major role in health sector financial management include: Central Hospitals and the MSD - both funded from the MOHSW budget; and the Regional Secretariats with the Regional Health Management Teams and Regional Hospitals, which



are funded from the relevant health sector block grant. The NHIF and the Community Health Fund (CHF) provide a pooling mechanism for health insurance premiums.



2. Situation analysis

2.1 Overview of current public financial management

2.1.1 EVALUATIONS OF FINANCIAL MANAGEMENT

This study draws upon other evaluations of financial management in government. There are few evaluations of financial management specific to the health sector, but national level Public Expenditure and Financial Accountability (PEFA) reports are prepared periodically. The 3rd draft of the 2013 PEFA was circulated in August 2013. It recorded significant progress in strengthening PFM systems, but noted two key areas of weakness. First, non-salary internal control systems are compromised because of non-compliance with financial regulations. The PEFA noted that expenditure commitments are entered without having an approved budget or cash availability, leading to a build-up of payment arrears; that public funds are used wastefully at the expense of service provision; and that non-compliance tends to continue because of insufficient follow-up by MDAs on the CAG's recommendations. Second, the PEFA expressed concern over the fiscal risk to the budget posed by some public enterprises, which may be less of an issue in the health sector. However, the PEFA went on to note that these two areas of weakness and lack of financial control have led to a cash rationing system whereby monthly budget allocations are determined by cash availability, rather than submitted cash flow requirements. In practice, now there is a circular effect: shortages and unpredictable availability of cash have led to breaches of expenditure control, and the lack of adherence to expenditure control forms a rationale for cash budgeting. Lastly, the PEFA also comments at length on improvements in control over the payroll. This is elaborated further in the health sector context in Section 3.11.

There is an array of financial audits completed by the Controller and Auditor General, whose main findings are summarized in four volumes and published annually relating to: central government; public authorities; local government; and donor projects (National Audit Office, 2012 (1), (2), (3), and (4)). Periodically, other assessments of PFM are carried out including fiduciary risk assessments⁶. The recent Belgian Technical Cooperation (BTC) Fiduciary Risk Assessment (BTC, 2013) ranged over many issues highlighting fragmentation of Information Technology (IT) systems; cash rationing and its magnified impact on service delivery; payment arrears; disruptions to the flow of funds; weaknesses in budget execution including IFMS issues and absent internal controls; difficulties with bank reconciliations; and concerns about the quality and timeliness of in-year reporting.

Procurement Reviews are carried out annually on all public enterprises under the auspices of the PPRA.

⁶ E.g. DFID/AfDB, 2011 or BTC, 2013



2.1.2 PFM REFORMS AND THE HEALTH SECTOR

The GoT is committed to strengthening PFM systems at both the national and local levels. Since 1998, the GoT has undertaken PFM reforms, resulting in continuous improvement of financial management and reporting. However, additional improvements are still needed. Box 1 provides a summary of the PFM reforms to date.

Box 1: Evolution of the Public Financial Management Reform Program (PFMRP)

Tanzania's PFMRP evolved in the following phases:

PFMRP I: 1998-2004

This Phase implemented from 1998-2004 had an objective of controlling expenditures, introducing aggregate fiscal discipline, and contributing to stable macro-economic growth. PFMRP I focused on minimizing resource leakage, strengthening financial control, and enhancing accountability by reforming budget processes and introducing an Integrated Financial Management System (IFMS).

PFMRP II: 2004-2008

The objective of Phase II was to gradually modernize the original processes, procedures and systems involved in PFM through the implementation and use of 'best practice' tools, techniques and methodologies to improve revenue forecasting and resource allocation for strategic priorities.

PFMRP III: 2008-2011

The objective of Phase III was to ensure greater predictability and availability of medium term resources to executing agencies. The thrust was about getting the tools, techniques, methodologies and systems that were introduced in the previous phase to work efficiently and effectively in an integrated manner.

Source: Public Financial Management Reform Programme Strategy Phase IV, June 2012.

Recently, the GoT initiated Phase IV of the PFM reform that will be implemented during FY2012-13 through FY2016-17. This new PFM reform is intended to address past observed weaknesses in an effort to further improve financial management and accountability in the country. The PFM reforms focus on five Key Results Areas (KRAs), namely: (1) revenue management; (2) planning and budgeting; (3) budget execution, transparency, and accountability; (4) budget control and oversight; and (5) change management and program management including capacity building and training, IFMS and electronic service delivery, PFM institutional and legal framework, program coordination, monitoring, and communication. The GoT is resolute about implementation of this PFM reform program and has the support of development partners as well as high level political commitment.

At the local level, the PFM reforms are firmly grounded in the Local Government Finance Act (1982, as amended in 2000), the Local Authority Financial Memorandum (LAFM, 2009), the Local Authority Accounting Manual (2009), and the Planning and Management Guide (PMG). These documents specify the financial procedures and management control of local government finances as well as relationships among stakeholders from different levels of the local government structure.



2.2 Overview of budgets in the health sector

In conformity with the decentralization by devolution process within Tanzania, health budgets are located across several institutions. The MOHSW has a recurrent budget and a development budget. The recurrent budget of MOHSW houses the budgets for medicines, which flow through to health facility accounts held at MSD as well as budgets for central and other hospitals. Other budgets are held with Regional Secretariats (for Regional Hospitals and Block Grants); with PMO RALG (for the Local Government Development Grant (LGDG)); and with LGAs for the staff and operating costs of primary level health facilities. The amounts for FY2011-12 (the last year for which we have seen an analysis) are presented in Table 1 below.

Table 1: Shares of health budget by level FY2011-12

Level	Amount (TShs. billion)	% of total
Central	669.7	57.6
Region	69.1	5.9
LGAs	422.5	36.3
PMORALG	2.3	0.2
Total	1,163.6	100.0

Source: PER data

Table 1 shows that 57.6% of the budget is managed at the central level. However, this includes funds for medicines and medical supplies that are managed at the central level but also benefit regional and district levels. Effective strengthening of PFM means targeting areas that manage the greatest amount of resources. As a result, this paper focuses primarily on the central level and the LGAs.



3. Financial management in MOHSW

3.1 Financial management framework in MOHSW

The MOHSW is responsible for the development of the central health recurrent and development budgets in accordance with MoF-provided ceilings and other guidance, and for managing and reporting on the expenditure of these budgets in accordance with regulations and relevant instructions from the Accountant General. Within the MOHSW, the Department of Policy and Planning (DPP) is responsible for the development and monitoring of budgets through its budget section, whilst the Finance and Accounts Unit (FAU) is responsible for budgetary execution including the making of payments, the management of bank accounts and financial reporting.

The FAU and DPP are at the heart of financial management in the MOHSW. FAU staff are employees of the Accountant General, under the common accounting service of the GoT. Under this arrangement, they may be transferred from one MDA to another at the direction of the Accountant General. In accordance with national policy the FAU is headed by a Chief Accountant (CA) who is not a Director, but whose post is accorded director status. Data provided by the CA show that there are 141 approved positions in the FAU (including the CA), of which 101 are filled.

DPP is led by the Assistant Director - Planning and Budgeting (ADB), with an immediate team of four economists, and a Budget Officer in every department of the Ministry. All report to ADB – and are part of his budget “community.” They receive direction from ADB and his central team. The budget officers are separate from the accountants in each department.

Budgeting for each LGA is coordinated for the MOHSW by the District Health Services (DHS) unit. This unit provides guidance on the preparation of the Comprehensive Council Health Plans. These plans and their attendant budgets are submitted to the MOHSW and PMO-RALG. Financial reports are submitted quarterly to PMO-RALG for entry into a database where they are consolidated, with a copy to the DHS.

Responsibilities in MOHSW for sector budgeting, planning and financial and performance reporting are therefore scattered across several sections, all producing separate outputs that need further work to ensure overall coherence and integration. The responsibility to integrate the many positions is not currently “owned” or resourced. This results in inconsistent, confusing and delayed reporting. Key data sets, particularly for Health Management Information System (HMIS), district budgeting, Comprehensive Council Health Plans (CCHP) planning and reporting, and MOHSW planning and reporting are all separately managed and used, inhibiting IT and system development synergies.

Recommendation:

- Establish a new section in the DPP to take lead responsibility for guiding the planning and budgeting of the health sector, and for consolidating financial and performance reporting for the sector. This section should include a management information systems (MIS) team to develop and manage a sector data warehouse, as well as HMIS and PlanRep Macro (for CCHP reports).



3.2 Financial management environment

The environment for financial management and budgetary activity is a major factor in its effectiveness. The environment includes the quality of office space and the availability of filing space, as well as the availability of computer hardware, software, internet and e-mail. The offices of the FAU are sometimes cramped with three or four people working in a small space, and corridors and gangways being used for filing and storage. Tight spaces are inevitable, but reorganization and disposal of old documents may create a better working environment.

Many staff have access to computers and there are two computer rooms. One room is for data entry by staff within the Ministry. The second room is used by visiting members of projects and also doubles as a meeting room. However, in the main computing room, only three machines are functioning because some are in need of repair and others do not have the specifications to handle Epicor 9.05.

Internet technology and e-mail is not advanced in the FAU. Availability of Internet throughout the Ministry was reported to be erratic, but significantly improved over the last 6 months. E-mail is not widely used as a communication medium, nor are e-mail applications with the ability to store mail off-line such as Microsoft Outlook. In the absence of an intranet, file sharing facilities do not exist.

Many informants commented that Excel knowledge is not widespread in the FAU, and a minority of staff have good Excel skills. Excel is fundamental to modern accounting. It is particularly useful for manipulating data obtained from computer systems such as Epicor, as well as for generating a wide variety of accounting schedules promptly, accurately and neatly.

Recommendation:

- FAU together with DPP Planning and Budgeting Section (and more widely MOHSW) should prioritize the development of an electronic office space using modern technology. To reach this objective, the unit should first complete an assessment of computer numbers and specifications to determine which machines need to be replaced; FAU staff and Budget Officers should undergo extensive training in Excel based upon a system whereby those who embrace it more completely can be selected for more advanced courses; and FAU staff and Budget Officers should be provided with training in the use of email, the use of email storage software, and also be assisted to establish email addresses where they do not already exist. The use of email storage software would compensate in part for erratic internet or limited connectivity since staff would be able to read and write emails offline. Finally, the establishment of group or departmental Dropboxes could make file sharing easier.

3.3 Observations on planning and budgeting

3.3.1 GENERAL OBSERVATIONS

The planning and budgeting process of the MOHSW is centrally determined and carried out according to Planning and Budgeting Guidelines circulated by the MoF. The process is coordinated through DPP and includes the development of a Medium Term



Expenditure Framework (MTEF) as well as annual budgets for recurrent and development revenue and expenditure. The recent PEFA observed that in principle, the annual budget preparation system supports the strategic allocation of resources, but in practice, the second year of the MTEF “is not a meaningful starting off point for the preparation of next year’s budget and a meaningful medium perspective to budgeting has yet to be properly developed (United Republic of Tanzania, 2013).” This is expected to be equally true for the individual ministries, including MOHSW.

The annual budget is impaired by the monthly cash rationing system that is currently in place. Cash rationing results in better and more regularly defined (on a monthly basis) budgets and priorities, and the proportions allocated to activities and/or specific departments may be significantly different from the proportions in the original budget. Little that can be done at sector level to remedy this, except to adopt a new system. It is understood that a system does exist to protect and prioritize certain expenditures, but details have not been shared with the authors of this report.

It would assist predictability in the MDAs if the budget releases were based upon collections in month n-2, instead of n-1 as at present. On this basis, September releases, for example, could be announced in early August to facilitate planning. The authors of this report recognize that it is beyond the capacity of the MOHSW to effect this change, and this observation is therefore not raised to the status of a recommendation.

3.3.2 BUDGETS AND KEY EXPENDITURES IN MOHSW IN TSHS. BILLION

The two budgets of the MOHSW are the recurrent budget and the development budget. For FY2013-14, the recurrent budget totals TShs. 282.6 billion (FY2012-13: 298.2 billion) and the development budget totals TShs. 471.3 billion (FY2012-13: 283.5 billion). As a result of a 66% increase in the development budget, the proportions between recurrent and development have changed markedly, with the foreign share of the development budget rising to represent 57.7% of the total MOHSW budget (2012-13: 45.4%).

Table 2: MOHSW budgets

Budget	2011-12 Actual	2012-13 Approved Estimates	% of total	2013-14 Estimates	% of total
Recurrent	246.7	298.2	51.3	282.6	37.5
Development – Local	9.9	19.1	3.3	36.1	4.8
Development – Foreign	252.3	264.4	45.4	435.2	57.7
Total MOHSW	508.9	581.7	100.0	753.9	100.0

Source: MoF Budget Estimates

3.3.3 RECURRENT BUDGET

3.3.3.1 STRUCTURE OF THE RECURRENT BUDGET

The recurrent budget of the MOHSW can conveniently be broken down into funds managed directly for personal emoluments (PE) and Other Charges (OC) and funds which it passes to third party agencies such as MSD, hospitals etc. Table 3 presents the budget for FY2013-14.



Table 3: Recurrent Budget 2013-14 in TShs. billion

Item	Amount (TShs. billions)	% of total
Salaries & Wages and related costs	48.4	17.2
Other Operational Charges	39.7	14.0
<i>Total PE and OC</i>	<i>88.1</i>	<i>31.2</i>
Medical Supplies	33.1	11.7
<i>Total Medical Supplies</i>	<i>33.1</i>	<i>11.7</i>
General Grants	43.2	15.3
Grants to Academic Institutions	28.7	10.2
Grants to international Organisations	0.4	0.4
Subsidies to non-profits	75.2	75.2
Grants to other levels of government	13.9	13.9
<i>Total grants and subsidies</i>	<i>161.4</i>	<i>57.1</i>
Total	282.6	100.0

Source: MoF Budget data

An interesting feature is that the majority (69% - 57.1% and 11.7%) of recurrent expenditure is managed by other organisations on behalf of the Ministry. In Table 3 above, only the totals for PE and OC are directly managed by the Ministry, and these total TShs. 88.1 billion or 31.2% of the total. Under Vote 52 of the Public Finance Act, the Permanent Secretary of MOHSW is the Accounting Officer for all of these funds. From a financial management perspective, it becomes important to ask how these funds are effectively managed and what processes are in place to ensure that fiduciary risks are controlled and value for money is obtained.

Other notable features of the recurrent budget are that the central Ministry payroll and related costs account for 17% of total expenditures⁷ and medical supplies represent 11.6% of the total. The recurrent budget is structured by department and by economic classification (expenditure category), whereas non-payroll expenditures are structured within the MTEF by activity and output.

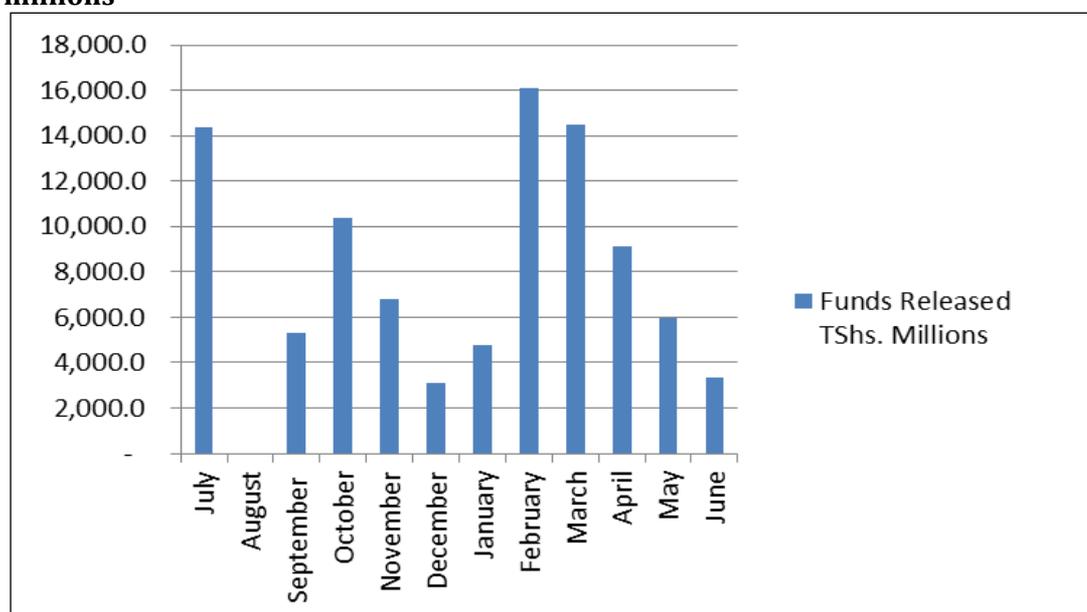
3.3.3.2 BUDGET RELEASES AND THE CREDIBILITY OF THE RECURRENT BUDGET

The last year for which we have full information on budgetary releases is FY 2011-12, and in that year, a total of TShs. 247 billion was released against the recurrent budget including allowed retentions of revenue. The time profile of releases for PE was even and on time throughout the year. The time profile of releases for OC is somewhat more erratic, as indicated in Figure 2 below.

⁷ Many of the payments to other institutions are grants to cover wages and salaries.



Figure 2: Time profile of FY2011-12 budget releases for other charges - TShs. millions



Source: DPP, MOHSW

Despite being erratic, the release profile shows only modest bunching towards the year end. In fact, the quarterly releases are 21%, 21%, 38% and 20%. The relative stability of the MOHSW OC budget may derive from the fact that in its grants and transfers, it includes more payroll funding for hospitals and other institutions⁸, and this would logically be prioritized by MOFEA⁹. The financial statements for the year ended June 30th 2012 (page 25) comment that "the most critical and prominent challenge that impinges smooth implementation of activities set is the delay in release of funds from Treasury and inadequate allocation which does not match with departmental cash flow." However, it appears that for MOHSW in FY2011-12, this challenge was somewhat less than it might have been in earlier years.

The recurrent budget is moderately credible in aggregate as seen in Table 4 below. Only in FY 2011-12 is it more than 10% off the original estimate¹⁰.

Table 4: Credibility of the original recurrent budget

Year	Original Budget	Actual Expenditure	% Execution
2009-10	218.4	221.7	101.5
2010-11	230.0	220.9	96.0
2011-12	219.4	246.7	112.4

Source: DPP, MOHSW

The composition of spending by department was variable against budget proportions in FY2011-12. Curative services (which normally account for 70% of the recurrent budget) took almost all the additional allocation of TShs 43 billion. All other units and

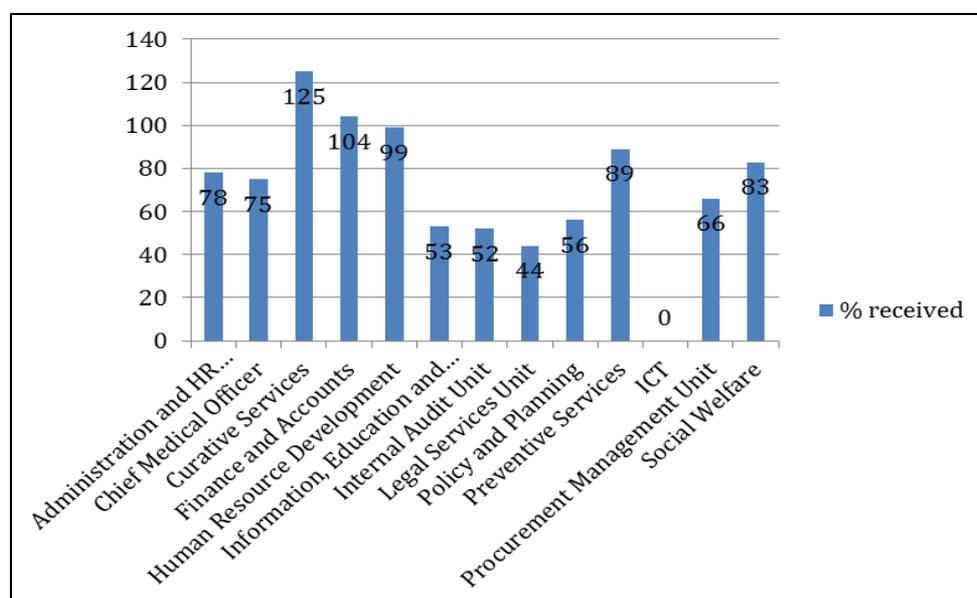
⁸ In 2013/14 Tshs 133bn out of Tshs 161bn (ie 83%) of total grants and subsidies is budgeted for payroll

⁹ With effect from FY2012-13, the releases for PE included under grants and subsidies comes as a separate exchequer warrant so there are now 3 monthly recurrent warrants – PE, "parastatal" PE, and remaining OC

¹⁰ The authors understand that 2011/12 was a somewhat unusual year with significant in-year changes to the recurrent budget – the original estimate of Tshs 219bn, increased to Tshs 262bn.

departments, with the exception of the finance department, received less than the budgeted amount. Information Education Communication, Internal Audit, Legal Services and Policy and Planning all received less than 60% of their budgets as demonstrated in Figure 3 below: ¹¹:

Figure 3: Percentage of Recurrent Budget spent by Department in 2011-12



Source: DPP, and 2011-12 Audited financial statements, MOHSW

It is clearly difficult for the departments severely affected by cash rationing and the payroll imperative. Both the Internal Audit Unit and the Procurement Management Unit are critical to sound financial management and received 52% and 66% of their budgets respectively. It is not clear whether this reflects understaffing in either Unit or other sacrifices that would have hindered performance.

In FY2011-12, there was clearly some discretionary re-budgeting through allocation of the shortfall. Cash rationing is generally thought to be in conflict with the MTEF, because one provides certainty for planning purposes and the other undermines it.

3.4 Arrears

Arrears pose a threat to effective budget execution in the MOHSW. However, the available information does not provide a consistent picture. The PEFA reports that arrears in Health were as follows:

June 30 th 2011	TShs. 6.3 billion
June 30 th 2012	TShs. 65.2 billion
March 31 st 2013	TShs. 72.9 billion

The financial statements provided to the team for year ended 30th June 2012 mention in a note that MOHSW has liabilities of TShs. 64.9 billion, but the accounts themselves are

¹¹ The zero spend for ICT appears to reflect an error in the 2011-12 Financial Statements but it is not material (it may have been combined with another department).

prepared under cash basis IPSAS and reflect zero payables, and only TShs. 4.2 billion of other liabilities. The management letter refers to liabilities of 64.9 billion. In the meantime MSD arrears are an outstanding audit query (Management Letter page 7).

The arrears are understood to comprise primarily a liability to MSD to cover costs they incur in clearing, storing and distributing goods in kind (40 billion out of the 65 billion) some salary arrears and many smaller items. The salary arrears accrue because staff join MOHSW and their salaries are not immediately put into the system, or they receive promotions and their salary increases are not immediately put into the system. This is expected to diminish since MOHSW now has the capacity to enter data directly¹². The MSD liability is understood to be the subject of an agreement, but the team has not seen it. Neither of these liabilities can be settled without specific funding from MOFEA.

3.5 Management of grants and transfers

Grants and transfers comprise 69% of the recurrent budget for FY2013-14, or 57% if transfers to health facility accounts at MSD are excluded. Table 5 below shows the budget execution information for the major transfers to health institutions in 2011-12:

Table 5: Major transfers to health institutions 2011-12 - TShs. millions

	Budget	Payment	Execution	% of total budget	% of total paid out
Muhimbili NH	38,899.51	33,871.35	87.1%	27.8%	25.5%
DDHs	23,549.47	23,527.79	99.9%	16.8%	17.7%
Voluntary Agency Hospitals	21,265.85	21,174.74	99.6%	15.2%	15.9%
KCMC	11,668.72	11,665.72	100.0%	8.3%	8.8%
MOI	10,906.16	10,905.16	100.0%	7.8%	8.2%
NIMR	9,115.26	8,713.77	95.6%	6.5%	6.6%
Bugando Medical Centre	8,749.33	8,749.33	100.0%	6.3%	6.6%
ORCI	4,806.36	4,806.36	100.0%	3.4%	3.6%
TFDA	3,765.95	2,852.74	75.8%	2.7%	2.1%
TFNC	3,501.15	2,780.66	79.4%	2.5%	2.1%
Dar Regional Hospital	1,381.44	1,333.66	96.5%	1.0%	1.0%
Government Chemist	1,255.33	1,180.79	94.1%	0.9%	0.9%
Mbeya Referral hospital	1,185.03	2,921.41	246.5%	0.8%	2.2%
Mirembe and Isanga	754.11	852.26	113.0%	0.5%	0.6%
Kibong'oto Hospital	685.41	1,147.28	167.4%	0.5%	0.9%
Sub-total	141,489.09	136,483.03	96.5%	101.2%	102.6%
Other transfers	5,399.68	3,719.66	68.9%	3.9%	2.8%
TOTAL transfers	146,888.76	140,202.69	95.4%	105.1%	105.4%

Source: DPP

The table is sorted to show the agencies/categories according to the percentage of budget allocated. The top three items – Muhimbili, Designated District Hospitals (DDHs)

¹² The PEFA analysis shows this as a reducing issue at MDA level – Tshs 23bn for all MDAs at June 30th 2012 falling to Tshs 12.5bn at 31st March 2013.



and Voluntary Agency Hospitals took 60% of the FY2011-12 total. The accountability for these grants varies, and an in-depth analysis is beyond the scope of this study. However, some facilities such as Muhimbili are responsive to Boards, whilst all others are potentially subject to internal audit and annual audit by the CAG. The strength of in year accountability arrangements should be clearly established.

The Office of the Treasury Registrar (TR) has powers to oversee all government investments in public enterprises and commercial entities (referred to in Tanzania as Public Authorities and Other Bodies (PA & OBs)). Their activities will be relevant in establishing the oversight of some of these organizations. However, the PEFA (pp. 53-56) noted that the legal framework is still insufficient to ensure that the TR has sufficient resources to supervise all entities and monitor fiscal risks. The process was accorded a “C” in the assessment.

Recommendations:

Engage a consultant to work with the MOHSW to establish what accountability arrangements are in place for this large component of the recurrent budget. The review should cover at least the top eight items in Table 5, which would represent over 90% of the transfers. It should consider in particular how the Ministry ensures that the funds are allocated and used in the most efficient and effective way, by reviewing whether the agencies have functioning boards and how responsive they are to the Ministry; what internal audit arrangements exist and the frequency/intensity of visits; what budget setting, financial and performance reporting arrangements exist; whether the agencies have service agreements with the Ministry, and if so what they contain and how they are monitored; whether external audits have been carried out in a timely manner; what processes exist within the Ministry to follow up internal and external audit recommendations; and to what extent these recommendations have been followed up. In the case of the transfers to District Designated Hospitals and Voluntary Agency Hospitals, which consist of transfers to multiple organizations that total Tshs 44bn, the review would need a slightly adapted approach using sampling techniques. The review should propose a process for ensuring strong accountability going forward indicating the roles and responsibilities of key players including the Permanent Secretary, Director of Policy and Planning, the Chief Accountant and others.

The review should consider the merits of a solution which distinguishes technical oversight and corporate oversight (as adopted in other countries including the UK). Technical oversight might continue to be provided by the relevant technical departments of MoH (in full cooperation with any Board that may exist) whilst corporate oversight (e.g. financial, corporate regulations, audit, compilation of performance monitoring) may be provided by a central team covering all third party organizations (again, in full cooperation with any Board that may exist). This would have the twin advantage of a) freeing up the technical department to concentrate on substantive issues within its specialist competence and b) enabling the ministry to develop a team with the in-depth financial and other professional skills necessary for the effective management of third party organisations. This would help to ensure consistency and provide guidance both to the arms-length bodies themselves and to the sponsor department.

- MOHSW should also explore the possibility of developing Service Agreements between the Ministry and these agencies, and ensure that there is adequate capacity for subsequent monitoring. Some agencies that receive grants from MOHSW, especially hospitals, also receive revenues and some may not be maximising their revenue possibilities.



- The MOHSW can enhance revenue by (1) having Internal Audit look at central and regional hospital revenue collection patterns in relation to certain significant statistics, such as catchment area population; number of beds; number of outpatients or inpatients; graph the results and examine for outliers with relatively low revenue collection in terms of the other data, and (2) share ideas on improving NHIF collections.
- Lastly, the MOHSW can consider establishing a small central team to provide the “corporate” oversight and monitoring of these institutions. This team would monitor the financial, governance, compliance, audit, and risk management aspects of their business, as distinct from the technical oversight that would continue to be provided by the relevant sponsoring department. This would help strengthen quality and consistency of oversight on PFM issues.



3.6 Payroll

During FY2011-12 payroll management was decentralized to the MDAs, with the MDAs inputting changes into personnel records directly rather than providing the data manually to President's Office-Public Service Management (PO-PSM). This process has been adopted at the MOHSW, and Ministry payroll staff advise that it has improved timeliness of changes (recruitments, promotions etc.) and that a consequence has been the potential to reduce the amount of salary arrears.

In the absence of a recent payroll audit for the MOHSW, the PEFA observation (p 87) is valuable, indicating as it does a generally positive trend even prior to the payroll decentralization:

Reports prepared by the Internal Auditor General (IAG) during 2011/12 on the payroll of the Health, Education and Agriculture sectors in the pre-Lawson period indicated delays by MDAs, Regional Secretariats and LGAs in adjusting their personnel records to reflect dismissals, absconders, retirements and deaths as representing significant payroll control issues in the form of 'ghosts'. Payroll cleansing exercises over the last 2 years arising from these reports and facilitated by the HCMIS upgrade have resulted in a sharp reduction in ghosts. PO-PSM considers that HCMIS is now 90 percent clean. The annual reports of the CAG also note delays in updating personnel records resulting in ineligible salary payments, but the amount of such payments decreased sharply in recent years (TZS 1.8 billion in 2009/10, TZS 142.7 million in 2010/11 and TZS 55.7 million in 2011/12.

The PEFA goes on to indicate that more such audits are planned. Clearly, this commitment should be monitored by the MOHSW and its stakeholders including development partners, its findings widely disseminated and its recommendations implemented. In the light of this clear commitment from GoT, no additional recommendations are made here.

3.7 Financial reporting in MOHSW

Financial reporting of the recurrent budget can be considered on three levels: within year reporting for internal management purposes; within year reporting for other government agencies and external stakeholders; and end of year financial reporting. Financial reporting can be considered in terms of frequency and timeliness; accuracy and reliability; completeness; accessibility and user friendliness; linkages with performance; and distribution.

Within year reporting for internal management purposes comes from standard Epicor reports, and particularly, the *Itemized Commitment and Expenditure Report by Warrant Holder* known universally as "the Itemized". The Itemized is a budget comparison statement, and for each account code, it establishes the approved estimates; funds allocated to date; expenditure to the previous month; expenditure in the current month; expenditure to date; commitments to date; total expenditure and commitments; the funds balance; and finally the budget balance. This report is run when required to establish the budget position. It is used almost exclusively in the FAU, but can be used to answer questions from directors and other budget managers. Since Epicor is only available in the FAU, DPP officers and budget managers request this information from them, leading to unnecessary delays and bottlenecks.



The Epicor itemized budget execution reports (one for recurrent and one for development) are provided to management on a weekly basis, at the management meetings. The PS obtains full copies of both reports, and each director obtains the reports for his/ her area. The full report shows the total position (budget, releases, expenditure, balances) on the front page, but does not include a summary. For example, it does not provide information by department or by project. The quarterly Budget Implementation Report (BIR) is also prepared for and distributed to MOF by the ADB.

Two major reports relevant to financial management are prepared on a quarterly basis: the quarterly financial statements, which are generally prepared within a month of the quarter end; and the Annual BIR, which includes budget and expenditure data on activities and outputs. The quarterly financial statements are extensive and follow the format of the annual financial statements. However, they are not easily understood by those without financial training, and they are not distributed widely within the Ministry. Staff in the FMU report that the quarterly financial statements make preparation of the annual financial statements quicker and easier.

The BIR is commissioned and compiled by the Planning and Budget Section (PBS) using multiple sources. It covers performance against indicators; progress against milestones; narrative details of implementation progress by sub-vote; financial performance for recurrent and development using data from PBS and FAU; and a human resource review. Since it uses data from many sources, it is time consuming to produce. Departmental information is coordinated by Budget Officers. The Annual BIR is prepared when financial information is also being collected, reviewed and adjusted, and before it has been audited. As a result, it is likely that financial information in the Financial Statements will differ from that in the BIR. The team did not have the opportunity to test this hypothesis, but it should be explored within the Ministry.

As a combined financial and performance report, the BIR has great potential for supporting decision making in MOHSW. It is provided to MOFEA, PS Health, all MOHSW Directors and all MOHSW Heads of Institutions. The team did not have the opportunity to explore how it is used by them and how it may be tailored to more closely align with the needs of its readers. However, a review of the process and format may be valuable, to ensure accuracy and user-friendliness.

The Annual Financial Statements of the Ministry are extensive, informative and prepared in a timely manner. Undoubtedly, this process is facilitated by Epicor. However, there are three points to note. First, there needs to be better attention to the quality of the draft submitted to the auditors. The CAG observed in the 2012 Management Letter (page 1) that the submitted draft financial statements had various irregularities such as errors, omissions, understatements and overstatements of figures, non-disclosures and improper disclosures amounting to 3 billion TShs. This suggests that similar errors may exist in the unaudited quarterly financial statements, and that quality assurance processes need strengthening.

Recommendations:

- First, a Senior Accountant who is not involved in the detailed preparation of the financial statements, or possibly the Technical Assistant, should review the draft for consistency and coherence before it is released.
- Second, there are a number of steps to take to make the financial statements more user-friendly. It would help if the statements themselves, including the notes and some schedules, were shown in TShs. millions instead of at present, where each



figures is reported in shillings to 2 decimal places. The descriptive sections can be more succinct, fresh, relevant and policy focused, as they currently tend to repeat the observations from previous years.

- Third, some key information is not included in the balance sheet due to the basis (IPSAS Cash basis) on which the financial statements are currently prepared – e.g. accruals, fixed assets, project accounts, and consolidation of subsidiaries. There is a related discussion concerning consolidation of the MOHSW financial statements with those entities that are under its control. These may include MSD and some of the Central Hospitals. It will be important to establish which, if any, entities will be consolidated under IPSAS and to produce the appropriate consolidated statement.

3.8 Development

3.8.1 STRUCTURE OF THE DEVELOPMENT BUDGET

The Development Budget for FY2013-14 stands at TShs. 471.3 billion (FY2012-13: TShs. 283.4 billion), an increase of 66% over the previous year. It can be viewed by source and by Department as follows:

Table 6: Development budget 2013-14 by source and department

MOHSW Department	Total	Local	Global Fund	Health Basket	AfDB	Other
Policy & Planning	68.6	1.0	48.0	4.0	14.0	1.6
Curative Services	84.2	32.0		29.2	20.0	3.0
Preventive Services	305.8		282.6	10.0		12.3
Social Welfare	2.1	1.2				0.9
Human Resource Development	10.3	0.7				9.6
Total	471.0	35.8	330.6	43.2	34.0	27.4

Source: Compiled from MTEF by MOHSW

The development budget is dominated by external funds, especially the Global Fund and the Health Basket. Effective financial management initiatives can use this information to focus reform and value for money initiatives on major areas of spending.

Global Fund projects account for 70% of the total budget and more than half of the total recurrent budget. However, like other development projects, these are accounted for by project units in what are effectively financial silos. The responsible project accountants in FAU report primarily to the head of the project who in turn reports to the PS and the donors. The reporting is almost exclusively required by donors, and in donor format. In spite of the huge sums of money involved, it is not reported through the Chief Accountant and senior management in the same way and with the same regularity as the much smaller OC spending. As a result, management is only aware of problems when they become critical since there is no high level internal monitoring of performance or financial milestones or traffic lights.



Many of the current challenges are a result of the divided responsibilities between DPP and FAU, which is difficult for the Ministry to address directly. In the split FAU/ DPP world, the responsibility falls on the PS to marry financial and performance issues, and to secure the clarifications he needs from DPP and FAU respectively. The FAU ensures expenditures are reported correctly and are in accordance with budget. However, a higher level of conjoined oversight is needed to provide the necessary budget review, update, and challenge that together provide the full cycle approach required for project financial management and oversight. A deeper review of the management of development projects might introduce a more formal process of financial scrutiny to highlight slow implementation, or to ensure that the resources are in place to enable implementation. As things stand, the role of FAU in the management of development projects seems to be passive, and the DPP role in monitoring progress is not well defined.

Recommendation:

- In view of the huge sums of money flowing through donor-funded projects, a more detailed review of the management of development projects is needed. This review should introduce a more formal process of financial scrutiny to highlight slow implementation, or to ensure that the resources are in place to enable implementation, and to clarify project financial management responsibilities.

3.9 Budget releases and the credibility of the development budget

Budget releases against the development budget are reported in the financial statements for FY2011-12. A time profile graph would not be especially meaningful since development funds are expected to be released when requested and not according to an annual cycle. In addition, many project payments are entered into Epicor by means of a journal adjustment at year end, and the dates of releases are thus obscured.

A comparison of the original aggregate development budget with final expenditure for FY2009-10 to FY2011-12 in Table 7 shows that, in the first of those years, the budget was highly credible on an aggregate basis. However, execution rates of 55.1% in FY2010-11 and 71.9% in FY2011-12 show that budget credibility in those years was extremely poor.

Table 7: Credibility of the Original Development Budget

Year	Original Budget	Actual Expenditure	% Execution
2009-10	260.6	258.6	99.2
2010-11	448.4	246.9	55.1
2011-12	364.8	262.2	71.9

Source: DPP, MOHSW

This is not unusual since development funds are known to be highly volatile. They are often affected by delays in meeting conditionalities or other factors that may have to do with the budgeting cycle of the development partner in question. They often have high infrastructure content, which is prone to delay. Development funds are understood not to be affected by the government's cash rationing, which applies only to recurrent funds.



However, poor execution of development projects undermines service delivery and remains a real concern. PFM weaknesses are an important factor, and there are three main issues. First, there is pressure to over-budget because it is difficult to spend funds later a budget is not established at the start of year. Second, oversight of development projects and budgets is poor as indicated above, since they are each managed within a silo and are not adequately connected to the divided financial management arrangements of MOHSW where both DPP and CA have responsibilities. Finally, reporting to donors is of poor quality and often delayed (especially financial reporting).

Recommendations:

- In view of the dramatic increase in development funds, it would be timely to review the process by which they are managed in more detail. In particular, such a review should explore the process in practice, identify bottlenecks and delays, and review the adequacy of the currently articulated roles of DPP and FAU. It should also explore how a high level monitoring process, which draws together planning, M&E, financial and performance management might operate. In addition, it should determine whether a senior role such as Chief Accountant (Development) liaising closely with DPP might lead to better outcomes¹³.

3.10 Financial Reporting

Financial reporting for development projects varies by the type of project. Financial reporting is usually specified in the contract negotiated with development partners. Projects tend to send reports directly to the development partners concerned with a copy to the Chief Accountant. However, it would be preferable if financial reports, including those specific to development projects, were approved by the Chief Accountant prior to external distribution. Financial reporting arrangements for the two major areas of development funding are set out below.

In addition to the reports prepared for development partners, expenditure against development projects is reported in aggregate in the quarterly and annual financial statements. However, the reporting in those financial statements is limited to a brief summary comparing actual spending against the budget of broader economic categories.

Recommendation:

- Financial reports on development projects should be signed off by the Chief Accountant prior to release. The Chief Accountant should assure that all necessary reconciliations and verifications required to ensure accuracy have been completed.

3.11 Health basket

The Health Basket Fund (HBF) is a funding mechanism initiated in 1999 as part of the GoT's decision to pursue a sector wide approach (SWAp) in the health sector. The basket is funded by a number of development agencies that pool un-earmarked resources to

¹³ There is a strong argument for a Director of Finance and Budget role which would oversee both the DPP and FM function at a level below that of the PS. However, since this would go against the wider structure of GoT, it is not pursued in this sector study.



support the implementation of the HSSP III. The HBF represents a significant portion of health expenditure, comprising 13% of public expenditures for health in FY2012-13. At the LGA level, it is the largest source of health funding, excluding PEs, accounting for between 14% and 55% of the total health budget according to a special CAG audit of the HBF¹⁴.

Increasing basket funding is one of the targets of HSSP III. In the first three years, there were positive achievements, with the HBF increasing from US\$82 million in FY2009-10 to US\$104 million in FY2012-13 (Table 8). However, over the last two years, three donors representing approximately US\$28 million (27%) of the total funding that was discontinued to the HBF. Further, the current Memorandum of Understanding (MOU) between GoT and the HBF partners will come to an end in June 2015.

Table 8: Donor contribution to the Health Basket Fund (USD)

Donor	2009/10	2010/11	2011/12	2012/13	2013/14
					Estimated
Denmark [DANIDA]	11,978,678	10,756,303	17,942,000	12,933,264	12,257,000
Ireland [Irish Aid]	10,060,000	8,856,360	8,810,100	8,142,750	9,068,916
Netherlands [RNE]	21,395,924	20,879,911	23,384,874	14,066,811	-
Switzerland [SDC]	5,513,186	3,051,290	3,244,997	4,302,926	4,276,000
UNFPA	600,000	600,000	600,000	600,000	600,000
UNICEF	1,500,000	1,500,000	1,000,000	1,000,000	1,000,000
World Bank [WB]	15,900,000	15,000,000	10,000,000	25,000,000	25,000,000
UN System (UNFPA)	800,000	850,000	-	-	-
Germany [KFW]	5,621,250	10,387,683	9,430,169	8,986,229	-
Canada [CIDA]	-	9,506,655	24,492,995	29,205,000	28,727,395
Norway	5,617,076	6,333,695	5,216,484	-	-
Refund from MOH	3,120,773				
Totals	82,106,887	87,721,897	104,121,619	104,236,980	80,929,311

Source: MOHSW Basket Finance Reports.

The HBF supports health related interventions at MOHSW, PMO-RALG and LGAs (regional and council levels). Table 9 shows HBF allocations to the various recipients between FY2008-09 to FY2013-14.

Table 9: Use of Health Basket Funds (TSH, billion)

	2009/10	2010/11	2011/12	2012/13	2013/14	5-year average
District	66.4	68.25	80.99	89.3	87.9	55.9%
MSD*	0	10.5	31.15	27.5	20.3	12.7%
MOHSW	50	46	41.09	36.2	23	27.9%
Region	4.2	4.2	4.2	4.2	3.8	2.9%
PMO-RALG	0.79	0.69	0.69	0.69	0.62	0.5%

¹⁴ Special Audit on the use of Health Basket Grant by districts in the years 2010/11 and 2011/12. Draft Report. September 2013.



Total	121.39	129.64	158.12	157.89	135.62	100.0%
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Source: MOHSW Basket Finance Reports.

* HBF for MSD in FY2009-10 may have been included in the MOHSW allocation and not separately reported.

As shown in Table 9, District Councils are the largest beneficiaries of the HBF, taking on average nearly 56%. District Councils are followed by MoHSW with an average of nearly 28 % over the last five years. The HBF is therefore somewhat less dependent on the central MOHSW. Since FY2011-12, HBF allocation to MSD and MOHSW appears to show a declining trend, despite the increasing need for MOHSW/MSD to increase procurement of medicines and other medical equipment.

Some key challenges that this funding mechanism faces include:

- Delays in disbursing the basket funds by donors and, once received, from the central government to the LGAs. This results in low implementation of council health plans. The delays can be several months long. For example, for FY2012-13, funds for the third and fourth quarters (January/March; April/June 2013) were received in May 2013, one month before the end of FY2015.
- Some development partners are pulling out of the HBF, implying fewer resources are likely to be available in the future. The MOHSW should liaise with the comprehensive government-development partner coordination mechanism (TC-SWAp) group to garner greater support for the HBF and iron out any challenges the fund faces.

3.12 Global Fund

The Global Fund accounts for TShs. 225.3 billion in the FY2013-14 development budget spread across several projects. The Global Fund has a standard reporting approach using a Progress Update and Disbursement Report (PUDR) that is reviewed by a Local Fund Agent, PriceWaterhouse Coopers. The PUDR is highly customized, requiring statistics on project progress as well as financial information. The Global Fund only requires that it be signed off by the Primary Recipient, but given the importance of Global Fund grants, it is essential that the Chief Accountant approve as well.

3.13 Adequacy of the Integrated Financial Management System (IFMS)

The central IFMS runs on Epicor software and has recently been upgraded across the government from version 7 to version 9.05. IFMS prepares the LPO and produces Payment Vouchers with electronic approval; creates Voucher Lists; pays listings for recurrent budget items (for payment exclusively by Electronic Funds Transfer (EFT)); bank reconciliation; creates financial reports for management purposes; and creates elements of the quarterly and annual financial reports.

The Epicor IFMS has significantly strengthened financial management in line ministries. Documented weaknesses include the inability of IFMS to record arrears because it only

¹⁵ Special Audit on the use of Health Basket Grant by districts in the years 2010/11 and 2011/12. Draft Report. September 2013.



allows commitments to the point that spending has been authorized for the period. Commitments beyond available funding (even though they may be within budget) cannot be entered into the system. Arrears must therefore be manually compiled, and the expenditure control function (by limiting the entry of commitments without preventing them from being incurred) is ineffective.

A second documented weakness is that IFMS includes the recurrent budget in its entirety on a day-to-day basis, but only part of the development budget. The development budget comprised 49% of spending in FY2012-13, and comprises 63% of the FY2013-14 budget. The Health Basket (9% of the development budget) is recorded fully on IFMS, but larger projects (such as the Global Fund) make numerous payments off IFMS and record them on Excel spreadsheets¹⁶ in the absence of other accounting systems at project level. The configuration of Epicor IFMS offers a standard suite of reports that are not suited to the needs of development projects and the donors who finance them. MOHSW staff are attempting to overcome this difficulty by establishing stand-alone systems for projects using the Epicor IFMS.

A third weakness is that the standard suite of reports is designed by the Accountant General to control and centralize reporting but does not take into account the internal management requirements of line ministries. As a result, there is no flexible report generator, and some ministries (for instance Water) have been developing their own capabilities in this area¹⁷.

A fourth documented weakness (PEFA, 2013) is that bank reconciliations cannot be performed on the IFMS.

A review of the IFMS by KPMG for the National Audit Office (KPMG for NAO, 2010) pointed out a number of challenges and has resulted in an action plan that is being monitored in subsequent audits (CAG, 2012). The points identified in the KPMG/NAO study were numerous including:

- Poor quality of training in IFMS
- Uncontrolled access to the vendors database which may facilitate fraudulent transactions
- Purchase orders being raised manually instead of through IFMS, thus circumventing expenditure control
- Weak purchase order controls making it possible to print multiple LPOs
- Significant unreconciled bank transactions
- System not able to generate bank reconciliation reports in the sub-Treasuries

Finally, many Ministry staff at the central and district levels do not have consistent access to Epicor reports. DPPs reported only connecting briefly to the system at budget time, and at PMORALG, the LGA Finance section is not connected. Part of the reason for poor connectivity is weak bandwidth given the large number of users.

¹⁶ The use of Excel as an accounting system is highly insecure since Excel does not have the normal audit trail and security controls found in computerised (and indeed manual) systems. The incompleteness of IFMIS scope therefore engenders high risk practices.

¹⁷ In a commendable initiative, staff of the MoHSW have been in contact with Water to adopt a similar approach in their own Ministry.



Recommendations:

- Develop a plan for moving to the use of web-based systems "thin client" to minimise bandwidth requirement and extend user privileges.
- The budget office in DPP should have access to IFMS so that they can produce their own reports. The current shortfall may be a licensing issue. *But maybe not.* KPMG reported in the 2010 review of IFMIS that there were "a total of 225 IFMS licenses installed at ACCGEN. However for the current year ACCGEN has paid for 554 licenses (KPMG for NAO)."
- Access to Epicor should be expanded so that users can consistently access reports. This would obviate the need to maintain duplicative Excel Cash Books.
- Given that there are many Epicor users (MOHSW, MSD, LGAs) who do not talk to each other, the Ministry could establish an Epicor users forum.

3.14 Bank Account Management

Bank account management is central to effective budget execution and the avoidance of error and fraud. Proper control over expenditures, comprehensive recording of receipts and payments, and prompt reconciliation of bank accounts can be established by knowing which bank accounts exist and by eliminating dormant accounts at the earliest opportunity. Box 2 summarizes why bank account management and bank reconciliations are vital to PFM.

Box 2: Bank account management and bank reconciliations

*Bank accounts are important because they keep money safe. From an accounting perspective, they are also vital because they provide an **externally produced record** of receipts and payments that serves to corroborate the accounting records. Each bank deposit is documented, and each cheque payment or transfer creates a numbered record in the bank statement. In addition, the bank statement provides a running balance of money held, which can be reconciled back to the balance in the accounting record. When the reconciliation is complete there is an **external verification** of the accounting record. External verification is a form of triangulation, and is a strong form of audit evidence and underlies several accounting controls. It is an important underpinning of Value for Money in MOHSW.*

The bank reconciliation does more than prove the closing balance. If the balance in the accounting record at the beginning of the year was also reconciled to the bank statement, the net movement in the balance for the year is also verified. Often, in government bank accounts, the total receipts are already known to the central or the state government because they came through transfers. Therefore, the total payments can also be verified. The bank account, and the bank reconciliation, can therefore provide strong verification of the total payments made during a period. This is a sound foundation for any financial report, and evidence that bank accounts were satisfactory reconciled is a vital to support the accuracy of financial reporting.

Knowing the number of bank accounts in existence and their balances is equally critical. Dormant bank accounts with significant balances create opportunity for fraudulent activity.



The MOHSW maintains two types of bank accounts. The first type comprises a virtual share of an account held in the Bank of Tanzania that finances the recurrent budget. The second is a suite of accounts primarily for development projects that are held in commercial bank accounts. The MOHSW has approximately 20 accounts according to a schedule shown to the team, but more specific details have not been shared.

Bank accounts of the first type are managed entirely by the Accountant General. All payments through the accounts are made by EFT. The reconciliation process is therefore much easier since there are no outstanding cheques. There is no requirement for the MOHSW to engage in bank reconciliation work. This is not the case for the development bank accounts. Cheques are issued on these accounts and it is the responsibility of each project to prepare the monthly bank reconciliation. Cash Books for these projects are generally maintained in Excel and are susceptible to the usual risks of that medium. The representative of the National Audit Office (NAO) resident at the Ministry advised the team that all development bank accounts are being reconciled in a timely manner and correctly managed. There were no adverse comments on bank reconciliation in the Management Letter for the year ended 30 of June 2012¹⁸.

At the national level, there bank account numbers are excessive. Over recent years, there has been a major effort to reduce their numbers and close dormant accounts. There is considerable progress in this effort. The IMF 5th PSI review reports that 16,760 dormant accounts were closed during FY2010-11 and FY2011-12, with an additional 8,256 identified for closure (IMF, 2013). The PEFA, using information from ACGEN, reports that in April 2013 there were 29, 022 accounts open with commercial banks holding a total amount of TShs. 832.8 billion, many of which had been opened at the request of development partners (pp. 83-84). However, the NAO representative at the Ministry advised that all dormant accounts in MOHSW had been closed¹⁹. Nonetheless, it would be a useful exercise to review the ACGEN list of bank accounts referred to in the PEFA to ensure the validity of all MOHSW accounts in that list.

3.15 Human resources for financial management

Financial management activity is split between the budget section of DPP and the FAU. The budget section comprises only five people: the Deputy Director Budget and four Budget Officers. The FAU is much larger and is staffed as indicated in Table 8.

¹⁸ However, the team did not scrutinise all individual Project Audits and it may be that bank reconciliation issues were identified there but not raised to the level of the Ministry Management Letter

¹⁹ The team endeavoured to obtain a list of MoHSW bank accounts from the Accountant General in order to compare with those reported by the Ministry, but were informed that the Accountant General does not maintain a database of bank accounts. Rather, the AccGen depends upon periodic circularization of commercial banks to establish the numbers of accounts in existence.



Table 8: Staffing in the Finance and Accounts Unit

Position	Approved number	Filled positions	Gap
Chief Accountant	1	1	-
Principal Accountant ²⁰	2	1	1
Senior Accountant	2	1	1
Accountant 1	66	50	16
Accountant II	40	20	20
Assistant Accountant	20	20	-
Accounts Assistant	10	8	2
TOTAL	141	101	40

Source: Chief Accountant

A total of 101 positions out of 141 are filled (72%). The team formed the impression that senior staff were heavily occupied and the absence of a second Principal Accountant and a second Senior Accountant had an adverse impact on capacity. The FAU now has all graduate entry, and 8 staff members including the Chief Accountant are members of the Association of Certified Public Accountants of Tanzania.

Brief job descriptions exist for the Chief Accountant and senior members of the team in an undated organogram. The job descriptions tend to list processes from the Accounts Manual and are not sufficiently detailed for management purposes. For example, they rarely include time bound targets. Job descriptions for staff working on the recurrent budget procedures are relatively clear and standardized across ministries. However, it is particularly important that those managing staff, and staff working on development projects have clear and detailed job descriptions.

The current PFM structure of the GoT does not give adequate weight to financial management that is always managed by a "Unit." Even though the Chief Accountant has director status, the perception is that financial management is a less critical activity and the Chief Accountant a less critical player. There is no strategic view of financial management in the health sector – there is only a strategic view of health financing in DPP. The Chief Accountant is fully engaged in the management of the day-to-day requirements of the accounting process.

Recommendations:

- One option for MOHSW would be to create a position of Director of Finance with responsibility for a Finance Department. This person would have responsibility for all the functions of the current FAU, but also for a strategic view of financial management that includes sector inputs to financial management reforms. It is acknowledged that since this is a national structure, there is little that the Ministry can do on its own.
- Another option which requires a broader GoT restructuring, would be a) to group the DPP budgeting and FAU accounting functions relating to MOHSW's own funds (e.g. vote 52 under a Finance Director role, as is done in the private sector, in

²⁰ This number conflicts with an undated organogram provided to the team which shows five Principal Accountants responsible for Examination of Payment Order, Expenditure, Revenue and Cash Flow Management, Project Management and Audit and Risk Management.

parastatal organizations, and in government departments in other countries) and b) give another DPP unit (e.g. the current policy unit, building on its current PER and NHA responsibilities) ownership for the wider sector budgetary planning, value for money and expenditure efficiency tracking, supported by a strong data management and analysis unit.

The Development budget has become increasingly important over time and the overall budget has expanded significantly. Actual spending on development managed by MOHSW has expanded from TShs. 56 billion in FY2006-07 to TShs. 186 billion in FY2010-11. In FY2013-14 the budget is TShs 471 billion.

- The structure of the Director of Finance supported by Chief Accountant (recurrent) and Chief Accountant (development) is easily justified. However, this may prove difficult to carry out in the present structure of government. In the current circumstance, a Principal Accountant (recurrent) and a Principal Accountant (development) should report to the Chief, with other sections reporting to them.
- Senior vacancies should be filled as a matter of urgency.
- In view of the recent significant increases in the health budget, especially in the area of development, a review of staffing needs in the FAU would be timely.
- In addition to the staff members indicated above there is an international Technical Assistant in Finance based in the Ministry, financed by Danida. His current contract will continue until 2014. He is engaged and knowledgeable, yet possibly underutilized in view of his wide experience. His terms of reference could be expanded, in discussion with the MOHSW, to include helping to develop and monitor a PFM improvement plan (based in part on this report), and evaluating parts of the Ministry that aren't working so well (e.g. review of Development budget reporting).

3.16 Internal Audit

The Chief Internal Auditor reports that his budget is adequate²¹ and that he has a sufficient quota of skilled staff to carry out his duties due to recent staff increases. However, he struggles to have his recommendations implemented. The CAG expressed concern in the 2012 Management Letter that the internal audit charter was still in draft form; that not all internal audit plans were finalized; and that internal audit recommendations were not monitored to confirm implementation. However, it appears that ad hoc activities interfered with planned activities.

The reports of the Internal Auditor are reviewed and monitored by the Ministry Audit Committee, which is headed by the Chief of the Legal Unit. It meets regularly but the fourth quarterly meeting was held after the end of the financial year.

²¹ Although the Ministries response to the Management Letter reported that the Unit received only TShs. 145 million out of a budget of TShs. 276 million.



3.17 External audit

3.17.1 NAO PRESENCE AND PERFORMANCE IN MOHSW

The NAO has an office in the MOHSW, which was staffed and busy at the time of the team's visit. External Audit is generally well rated by the recent PEFA scoring of "B" for each of adherence to International Organization of Supreme Audit Institutions (INTOSAI) standards and timeliness. The financial statements of the MOHSW were audited in a timely manner in 2012, and the preparatory meeting for the audit of FY 2012-13 took place in August 2013.

3.17.2 ISSUES RAISED BY THE CAG

The annual CAG report provides a thorough analysis of the reasons for qualifications in audit reports as well as general observations on the state of financial management in MDAs. Some key issues raised in the last year included:

- Contingent increase in liabilities to TShs. 1.3 billion at June 30, 2011
- Internal audit plans are not finalized (the unit only received 144.1 million out of 276.7 million)
- Poor control over contract management
- No proof of goods being received
- Missing receipt books
- Payments without appropriate supporting documents
- Assets not recorded in the fixed assets register (although Ministry says this is now done)
- Budget arrears

3.17.3 FOLLOW UP OF CAG ISSUES

The Management Letter that accompanied the financial statements for the year ending 30 June 2012 shows recommendations from previous years, which have not been addressed totaling TShs.71.2 billion. These items identified require urgent resolution. However, it is equally important for all stakeholders including development partners to appreciate the difference in significance amongst them. Some recommendations are more serious than others, and consequently the overall magnitude cannot be easily gauged from the total figure alone. For some audit queries, the amount is important. For others, the significance derives from the internal control failures that they indicate. The four items with significant financial implications are summarized in Table 9.

Table 9: Selected CAG Issues

Issue	Amount (TSH billions)
Transfers to Health Development without approval from Treasury	3.1
Expenditure charged to wrong codes	3.9
Outstanding liabilities (of which MSD is 37.5)	44.0
Non-current Assets not recorded in the Fixed Asset Register	16.4
Other items	3.8
Total	71.2



Whilst these clearly reflect accounting issues that require resolution, more than half of the total amount is made up of a debt of TShs. 37.5 billion owed to MSD. The main reason it is included in the list is likely because it was not included in the financial statements. Management needs to put a debt register in place and this appears to have been done (page 15). The other items are budget transfers without approval, misallocations and an incomplete Fixed Asset Register. Some misallocations are likely to be identified every year, and the important thing will be to ensure that they remain at a manageable level.

Recommendations:

- MOHSW should take CAG recommendations seriously and ensure that they are implemented. However, MOHSW should also ensure that the issues raised are correctly interpreted by stakeholders and that their significance is correctly assessed.
- MOHSW should consider allocating a mid-level staff person to the resolution of audit queries to release the Senior Accountant Expenditure for her routine duties.

Box 3: Sequencing of PFM reforms – financial compliance is paramount

In a recent guidance note (Diamond, 2013) on the sequencing of PFM reforms, Jack Diamond seeks to interpret PFM reform experience through a reconciliation of key approaches including the “basics first” (associated with Schick), the more recent “platform approach,” which argues for coherent clusters of reforms (associated with Brooke) and Tommasi’s hybrid, which argues that the first platform should establish “basic” reforms. Diamond acknowledges that sequencing should be tailored to country circumstances but argues nonetheless that, in all environments, sequencing decisions should focus on the three main PFM priorities determined by the principal deliverables of PFM systems. First, establish controls to ensure some minimal level of financial compliance (fiscal control). Second, establish mechanisms to improve fiscal stability and sustainability. Finally, introduce systems to promote the efficiency and effectiveness of service delivery.

In this approach, the first priority in PFM reform is to establish a minimum operational level of core PFM functions that focus primarily on financial compliance and fiscal control. A realistic budget can, together with financial compliance, be considered as part of the “core” functions. Before advancing to further reforms, it is important to establish an adequate IT basis, accounting system and regulatory framework on which to anchor subsequent reforms. Attempts to leapfrog this fundamental approach to sequencing have generally led to unsuccessful reforms.

3.18 PFM reform program and the health sector

MOHSW is no longer a recognized component of PFMRP IV. However, along with other social sector line ministries, MOHSW is part of many key reforms. It has recently upgraded the IFMS to Epicor 9.05 and the challenges of that upgrade are recounted elsewhere in this study. The MOHSW is introducing the IPSAS Accrual Basis and is facing challenges as it seeks to bring in revenue when contracted, to account fully for its non-current assets, and to consolidate certain components of the Ministry that are currently outside the financial statements.

In the Tanzanian decentralised environment there is no clear coordinator of PFM reform for the health sector. Budget section responds to the MoF on budget and MTEF reform,



and FAU responds to ACCGEN on issues concerning the IFMS and IPSAS. The reforms are monitored by Deputy Director Budget or by the Chief Accountant. PFM reform at the sub-national level is managed by PMORALG. Whilst the Ministry may take an interest because such reforms may improve the information flow or strengthen budget execution for health, it is primarily an observer.

This lack of central coordination results in a missed opportunity to examine the financial management needs of institutions that are similar throughout the sector, but differ from others within a district (e.g. hospitals are likely to have more similarities to other hospitals across district boundaries than to schools within a district).

Although the Ministry is no longer a component of the central PFM reform program, there are many factors that can be examined to strengthen PFM at sector level, some of which are documented in this report. In the team's opinion, it would be helpful for the FAU to draw together a summary of reforms, audit issues, staffing requirements, computer capacity reviews, trainings, etc. and bring them all into one annual PFM improvement plan under a focal staff member.

Recommendation

- MOHSW, through FAU, needs to develop a PFM improvement plan that reaches throughout the sector and is consistent with PFM RP IV but is also wider to embrace internal management objectives and follow up on audit recommendations.

3.19 Key messages and perspectives on fiduciary risk

While transaction approvals are thorough, fiduciary risks continue to exist in key areas of budget execution, including payroll management, unauthorized budgetary reallocations resulting from cash rationing, the oversight of grants and transfers to third-party organizations, and in procurement.



4. Financial management at Medical Stores Department

4.1 Introduction

The MSD is an autonomous department of MOHSW that was created under an Act of Parliament in 1993 with the objective of providing essential medicines and medical supplies of acceptable quality to government and non-government health facilities. It is a major health institution in its own right, with sales of TShs 164 billion²² in FY2011-12 (2010/11: TShs 187 billion). It is a revolving fund, which is mandated to operate on a commercial basis and is expected to procure its inventory using the revenues from sales and be financially self-sustaining. It is accountable to a Board of Trustees whose chair is appointed by the President and whose members are appointed by the Minister of Health. The Director of Finance and his staff are responsible for its financial management.

Sales are of three types: Normal, Special and Vertical. Normal sales are sales of medicines and medical supplies that have been purchased directly by MSD as part of their routine business. Special sales are for items that have been procured on special orders at the request of customers. Both Normal and Special sales are sold at a mark-up benchmarked at 14% to cover overheads. On the other hand, vertical sales are sales of goods-in-kind that are provided free of charge under vertical programs. They generate a service charge rather than a mark-up, which is intended to cover the costs of clearance, storage and distribution. It was calculated to be 14% of the value of goods in 2010. At that time, it was agreed that 6% should be paid by the vertical program and the remaining 8% by the GoT (MOHSW, 2013). The non-payment of the second element has resulted in a significant debt owing to MSD.

The team held one meeting with senior staff of MSD, and also met with the Chief Pharmacist, his predecessor and the Technical Assistant. The content of this section is derived from those meetings as well as secondary documentation.

4.2 Oversight process by MOHSW

The Permanent Secretary of MOHSW is the Accounting Officer for MSD, and under the Public Financial Management Act has responsibility for the effectiveness of its accounting systems and internal controls. He discharges his responsibility through consultation with the Minister on appointment of appropriate members of the Board; attendance of his Director of Curative Services at Board meetings; review of in-year reports on MSD performance and financial statements; meetings with the Acting Director General; and review of year-end financial statements and reports from the CAG. The Chief Accountant is well informed on some key financial matters at MSD, such as the amount owed by MOHSW to MSD, but has not been directly engaged in the oversight process, which is primarily in the hands of non-financial professionals²³.

²² For comparative purposes, this is approximately equivalent to 60% of the total of LGA health block grants budgeted for the same year.

²³ Development of a parastatal monitoring framework is part of the PFM RP IV. The team were not able to establish whether this will include MSD.



There is one financial professional on the Board, Mrs Monica Mwamunyange (MSD Financial Statements 2011-12) whose skills are in finance and economics. Importantly, she chairs the meetings of the Audit and Risk Management Committee and attended four of their five meetings in FY2011-12 including all Extraordinary Meetings. However, the Finance and Administration Committee of the Board, which is responsible for oversight of financial management, human resources and administration does not have any members skilled in financial management.

There should be a professionally qualified accountant on the Board at all times, and preferably that accountant should be skilled in the strategic financial management of wholesaling and distribution organisations. This individual should take a keen interest in financial management matters and internal controls and support the Permanent Secretary in his role as Accounting Officer. In addition, this person should also clearly and forcefully represent the health sector in forums to ensure that the MSD has appropriate pricing and profitability to prevent the erosion of its working capital.

4.3 Financial management issues affecting the functionality of MSD

There are a number of financial management issues adversely affecting the functionality of MSD. First, the disbursement process tends to provide the health facility accounts at MSD with too little funding too late in the year. Second, MSD is not reimbursed for the costs associated with the clearance, storage and distribution of goods received in-kind. Third, the absence of a strategy to prevent the erosion of working capital has undermined the ability of MSD to perform according to its mandate.

4.4 Disbursement process and role of MOHSW

MoF/MOHSW disburse too little funding to the health facility accounts at MSD. Release of these funds is skewed towards quarters 3 and 4, causing inefficiencies in their distribution as well as exacerbating cash flow problems at MSD. The total funding has not been adequate, resulting in rationing and prioritization in health facility orders and making demand forecasts more challenging for MSD. Table 10 presents figures from the most recent report (MOHSW, 2013), that illustrate the shortfall in disbursement against the original allocation in the MOHSW budget. The shortfall varies from 14 to 20%:



Table 10: Shortfall in funding of the health facility accounts

	Allocation	Disbursement	Shortfall	Shortfall %
2011/12	123.4	98.0	25.4	20.6%
2010/11	82.1	70.5	11.6	14.1%
2009/10 ²⁴	75.7	62.7	13.0	17.2%

Source: Reported in MOHSW, 2013

The CAG Special Audit of 2012 (National Audit Office, 2012 (5) page vi) reported that most disbursements to the hospitals were made towards the last quarter of the financial year. Funds disbursed in June of each year ranged from 17% to 46% of the total.

The late disbursement of these funds affects the facilities because they are unable to order from MSD. However, it also contributes to the dysfunctionality at MSD. The system for funding health facility accounts held at MSD was designed to ensure that adequate working capital was available for procurement. In normal circumstances, erratic disbursement to the facility accounts might not be an issue. Cash flow for procurement planning and payment of suppliers should be met primarily from working capital, which should be adequate for 6 months of stock for priority items. MSD is not supposed to wait on the disbursement of funds to the customers in order to fulfill the procurement plan. However, the erosion of working capital has increased the significance of disbursement irregularities.

4.5 Accumulation of bad debts

The working capital of MSD, and its ability to procure sufficient stocks in a timely manner, is further undermined by the non-payment of monies due to the clearance, storage and distribution of vertical funds. These debts have been accumulating since FY 2006-07 ((National Audit Office, 2012 (5) page v). The audited financial statements of MSD for the year ended 30th June, 2012 indicate that the amount outstanding at that date was TShs. 42.5 billion against TShs. 35.2 billion a year earlier.

As a result of not receiving money to finance the distribution of vertical program medicines, the MSD Board has authorised MSD staff to charge facilities receiving medicines from vertical funds an additional 20% of the value of those medicines.²⁵ This means that the already reduced essential medicines budget will be spread even more thinly. Furthermore, the burden of charges will be felt at the Care and Treatment Centres (CTC) for HIV patients, which are about 30% of all primary health care facilities. Finally, profitability and working capital will continue to be affected by the changes in the composition of sales, as it will include more vertical sales and fewer normal sales. This process is likely to be exacerbated by the Global Fund VPP program. It will become even more important for vertical sales to be fully compensated.

²⁴ The shortfall was reported by the CAG as being only 4% in 2009/10.

²⁵ This is in addition to the flat rate charge of 120,000 T shillings per district to cover the cost of transporting supplies directly to the facility.



4.6 Strategy to avoid erosion of working capital

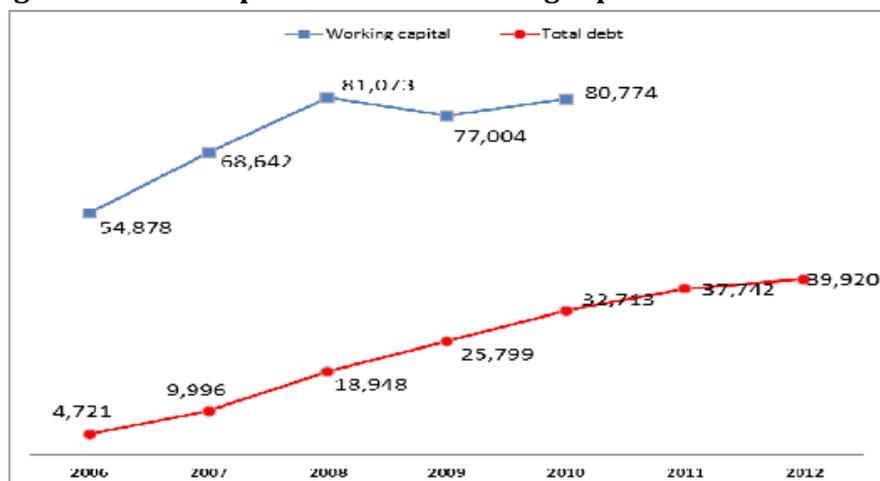
Any recapitalisation review should include a strategy to avoid the future erosion of working capital. This can be done by carefully examining the relationships between procurement lead times; the ratio of inventory to Sales/Cost of Sales; and by ensuring that pricing and expected profitability will lead to steady increases in working. This will require expert consultation.

The issue of pricing of both sales and services requires urgent attention. Working capital tends to increase *in nominal terms* by the amount of profits realized, which are not invested for the longer term (as in property plant and equipment for instance). However, nominal increases in working capital are not sufficient. For working capital to increase *in real terms*, profits must also cover the erosion of existing working capital as a result of inflation. However, in both FY2010-11 and FY2011-12, MSD was allowed to make losses of TShs. 3 billion and TShs. 0.6 billion respectively. With inflation at approximately 7% in FY2011-12 and using the figure of working capital in the Strategic Review at TShs. 80.8 billion in June 2011, a profit of TShs. 5.6 billion (80.8 billion x 7%) was required simply to maintain the real value of existing working capital. This is not consistent with the establishing Act, which requires MSD to operate in a commercial manner.

4.7 Working capital issues and amounts owed by MOHSW

The impact of debt on working capital is demonstrated by this diagram from the Strategic Review of the National Supply Chain (MOHSW, 2013):

Figure 4: MSD – impact of debt on working capital



The diagram demonstrates that accessible working capital (working capital less irrecoverable debt - the gap between the blue and red lines) has not increased since 2006, even in nominal terms and despite significant growth in the throughput of MSD. There is a lot of discussion of recapitalisation of MSD, making a capitalisation review necessary. However, the recapitalisation is only required because of poor strategic financial management of MSD. If MSD is properly managed, no future recapitalisation of MSD will be required except in exceptional circumstances (e.g. a major new responsibility). It is important that MSD should be paid its budgets in full, reimbursed according to agreements and that those agreements together with its pricing are adequate to increase its working capital over time in line with increasing sales (and cost



of sales). This can be managed through the analysis of procurement lead times, cash flow and accounting ratios (especially numbers of months of inventory required to be held).

4.8 PPRA Results

PPRA Procurement Review results are positive for FY2011-12. The MSD website reports that overall compliance of MSD was 81% using 13 performance indicators. The scores for the 13 indicators were as follows:

- Establishment and Composition of the CTB: 91%
- Establishment and Composition PMU: 84%
- Functioning of AO, Tender Board and PMU: 75%
- Preparation of Annual Procurement Plan: 65%
- Approvals: 90%
- Advertisement of Bid Opportunities: 100%
- Publication of Awards: 90%
- Time for Preparation of Bids: 100%
- Method of Procurement: 90%
- Use of Standard Tender Documents: 95%
- Records keeping: 65%
- Quality Assurance: 55%
- Contract Implementation: 53%

Clearly, there are many positive developments at MSD, but room for improvement in record keeping, quality assurance and contract implementation.

A useful test of procurement of medicines is to compare prices achieved against a benchmark price list, such as the one produced by Management Sciences for Health²⁶. However, it is understood that an analysis of prices has not recently been completed, and it may be a useful indicator of the achievement of value for money.

4.9 Accounting system

After experiencing some difficulties with the Orion accounting system, in 2012 MSD switched to use the Epicor system (Version 9), which is also in use across the GoT. This resulted in some introductory challenges and a negative impact on customer care has been noticed by both suppliers and health facilities (MOHSW, 2013). In August 2013, the finance team at MSD reported that they had still not set up all the necessary reports, but were working with an Epicor support team based in Europe to resolve the outstanding issues and hope to have full functionality by December 2013.

4.10 Financial Statements

The financial statements of MSD are well prepared and informative. They include considerable detail of operations. They also include helpful information on the regularity of the meetings of the Committees of the Board. The accounts for FY2011-12 are qualified (but this may be on something of a technicality).

²⁶ <http://www.msh.org/resources/international-drug-price-indicator-guide>



4.11 Other issues from CAG Reports

The Special Audit of 2012 (National Audit Office, 2012 (5)) also reports that:

- Health facilities are not notified when funds are disbursed on their behalf to MSD. If this happened they would be able to hold MSD more accountable (page vi).
- Late and inadequate disbursement of funds by MOHSW to MSD makes it difficult for the PMU to plan for procurement of medicines, leading to unavailability of stocks (pp. 44-45).

Recommendations:

- Implement the recommendations of the Special Audit report of 2012, the Plan of Action, and the Financing recommendations of the Strategic Review, especially:
 - Inclusion of the vertical programme handling charges in full in the MTEF and budget; paying the debt in full and putting in place procedures to ensure that future charges are paid within 90 days.
 - Ensuring that MSD has sufficient working capital, and carrying out a recapitalisation review to include measures to ensure that pricing will ensure maintenance of working capital in future years.
- Strengthen the financial management representation on the Board with a professionally qualified accountant who is knowledgeable in financial management strategies for wholesaling and distribution operations.
- Financial analysis and business planning should form part of the Terms of Reference for the upcoming Danida-financed consultancy in support of MSD's new five year Medium Term Strategic Plan 2013-2018.
- In mature economies medicines are distributed to health facilities through private sector channels, and it is not known whether the GoT is planning such changes in the medium-term. For as long as it is the central delivery vehicle, it is critical that MSD be a strong and growing organization.



5. Financial Management at Muhimbili Hospital

5.1 Financial Performance

Muhimbili National Hospital (MNH) is wholly owned by the GoT and in the year ended June 30th 2012, received income of TShs. 54.4 billion and recorded expenditures of TShs. 59.5 billion. This resulted in a loss of 5.1 billion as shown in Table 11 below.

Table 11: MNH income and expenditure 2011-12, TShs. billion

	2011-12	2010-11
	TShs. billion	TShs. billion
Income	54.4	46.3
Expenditure	59.5	52.3
Surplus/(Deficit)	(5.1)	(6.0)

Source: 2011-12 Financial Statements

Income primarily consists of government subventions and hospital revenue, as shown in Table 12, with income from government subventions accounting for 75-80% of the total.

Table 11: MNH Revenue sources, TShs. billion

Income type	2011-12		2010-11	
	TShs. Billion	% of total	TShs. billion	% of total
Government subventions	43.8	80.5	35.6	76.9
Hospital revenue	9.2	16.9	8.6	18.6
Other	1.4	2.6	2.1	4.5
Total	54.4	100.0	46.3	100.0

Source: 2011-12 Financial Statements

In their preamble to the financial statements for FY2011-12, the Trustees of the Board notes that the losses in the year and in the previous year result from shortfalls in subventions received against the budgeted amount. These losses have taken their toll on the liquidity of MNH. Liquidity is typically measured by the ratio of current assets (cash and near- cash) against current liabilities (amounts payable within 12 months). This ratio stood at a comfortable 2.36 at the end of FY2010-11, but had dropped to a problematic 1.46 by the end of FY2011-12. Current liabilities had risen in nominal terms by 76%.

The team noted that payments received from MOHSW are not listed. The team was informed that, as with many government agencies, PE funds are received in a timely manner but OC funds can arrive more than a month late, making planning of expenditures difficult.

5.2 Hospital revenue

MNH is aiming to maximize its revenues from hospital income and monitors it closely. Summaries of revenue are reviewed and discussed at weekly meetings of the Executive Management Team. Possibilities are limited since 40% of patients are exempted under national regulations and prices have not been increased since 2009. It is understood that there is an Internal Audit report on revenue collection at MHN and that there has subsequently been a review of revenue management by PriceWaterhouse Coopers. The team has not seen these reviews.

Recommendations:

- The management and Board should process findings of the internal audit and the PriceWaterhouse Coopers review. They should develop a monitorable and time bound Action Plan (this may well be underway).
- Prices, which have remained static over several years, should be revised immediately based on a transparent formula. Prices should be updated on an annual basis.

5.3 Bank accounts and bank reconciliations

A review of bank accounts and bank reconciliations indicated that MNH has 16 bank accounts, including two interest-bearing accounts and two US dollar accounts. Bank reconciliations appear to be carried out in a timely manner and are approved by a senior staff member.

5.4 Staffing of the finance function

The finance establishment comprises of 76 posts, of which 72 are filled as indicated in table 12 below.

Table 12: Finance establishment at MNH

Designation	Establishment	In post	Excess/ (Deficit)
Director of Finance (Principal Accountant)	1	1	-
Head of Accounts (Principal Accountant)	1	1	-
Senior Accountants	3	-	(3)
Accountants	4	3	(1)
Assistant Accountants	23	30	7
Accounts Assistants	34	24	(10)
Registry Assistants	2	2	
Office Assistants	4	3	(1)
Claims Officers	2	1	(1)
Secretary	2	2	
Accounts Technician	-	5	5
Total	76	72	(4)

Source: MNH Communication



Comprehensive job descriptions exist for the Director of Finance, the Head of Accounts, the head of the Final Accounts and Budget Unit, the Revenue Manager and the Expenditure Accountant. In most cases, these job descriptions include agreed objectives with times and deadlines for critical actions and attributes of good performance.

5.5 Issues raised by the CAG

Few material issues were raised by the CAG in the 2012 Management Letter. The issues raised were more concerned with patient management than with financial management. The financial statements were signed without qualification, and confirm compliance with the Public Procurement Act of 2004 and its related regulations.



6. Local Government Authorities Financial Management

6.1 Introduction

LGAs have been going through various reforms through the Local Government Reform Program II (LGRP II). Decentralization by Devolution (July 2009–June 2014) is aimed at transferring greater responsibility for service delivery and resource management to LGAs. It is an initiative that has offered opportunities to build financial management capacity of LGAs to be able to operate independently of central and regional authorities to manage health service delivery as well as other services in education, agriculture, water and sanitation. However, this goal has not been fully realized. Given that LGAs carry the responsibility of service delivery at the local level, it is critical that they are able to deliver services efficiently, effectively and economically. Traditional PFM has tended to focus more on financial accountability in the sense that regulations have been followed in all transactions. There has been little regard for whether the expenditure made sense in regard to the goals and objectives of the LGA: to impact the welfare of its citizens.

The current phase of the PFMRP addresses five key results areas (KRA), some of whose elements are of specific relevance to LGAs. Table 13 presents the KRAs.

Table 13: PRMRP key result areas

KRA 1 Revenue management	
Output 1.2	The Government improves efficiency in domestic revenue mobilization both at the policy and the administration levels by updating legal instruments towards international best practices
Output 1.3	Strengthened capacity of local government authorities to collect revenue by 2015
KRA 2 Budgeting and Planning	
Output 2.1	Strengthened capacity of MDAs, RSs and LGAs in implementing program based budgeting by June 2016.
Output 2.2	Increased effective utilization of planning and budgeting tools by 2016
Output 2.3	Strengthened capacity of LGAs for MTEF preparation by 2015
KRA 3 Budget execution, transparency and accountability	
Output 3.3	Strengthened capacity of MDAs, RSs and LGAs in Cash management by 2015
Output 3.5	Improved integrity and content of government financial statements and the migration from IPSAS cash to IPSAS accrual accounting for all government accounts is progressing in accordance with plans.
Output 3.6	Improved accountability in management of government assets for supporting migration to IPSAS accrual
KRA 4 Budget control and oversight	
Output 4.1	Increased coverage and quality of the internal audit functions by 2016
KRA 5 Change management, program management and communication	
Output 5.2	Utilization of EPICOR modules increased from seven to ten
Output 5.3	All software development and module upgrades are coordinated with the overarching plans for ICT integration.



Output 5.4	Improved communication and public access to key fiscal information to stakeholders
Output 5.5	Coordination and standardization of PFM training achieved.
Output 5.12	National systems and processes for intergovernmental transfers to LGAs Streamlined and rationalized

The MoF is the overall coordinator of the implementation of the PFMRP in Tanzania. PMO-RALG supports the implementation of the PFMRP within the regions, districts/councils, and lower levels in the context of implementing the LGRP II. PMO-RALG has a specific budget for this purpose. However, budget constraints have restricted the amount of resources available to PMO-RALG to fully implement activities in this area. Budget allocations and disbursements in the recent past are summarized in Table 14.

Table 14: Budget allocations and disbursements to PMO-RALG for PFMRP

Year	Budget allocation	Amount disbursed	Amount spent	Balance
2012/13	1,045,000,000	0	0	0
2011/12	3,619,610,000	2,105,096,973	2,105,096,973	0
2010/11	7,500,000,000	7,465,724,000	7,465,724,000	0

The quality of local financial management impacts the local government's ability to execute its responsibilities in all other areas. Hence, it is important to ensure that financial management systems are functioning properly and in a consistent manner. Boex and Muga in their study on the determinants of local government financial management performance conclude that councils with better financial management practices, better planning and budget processes, and higher project implementation scores, generally achieve better local financial management performance. This suggests that specific improvements to local government practices can indeed lead to improved local financial management performance. Local administrative practices are therefore a relevant factor in assuring the more effective use of decentralized public finances²⁷.

The SWAp in the health sector has enhanced dialogue with health stakeholders (government, donors, NGOs, private sector), and accountability and transparency in the management and use of health resources. Several dialogues have been ongoing between MOHSW and its collaborating partners regarding the development of health policies, health strategic plans and the health financing strategy. The MOHSW recognizes that dialogue is an important way to enhance accountability and transparency, thus attracting other donors to join common planning, funding and monitoring of plans of action. Annual health PERs and National Health Account reviews have been completed and involve many health stakeholders in an effort to track spending and enhance accountability of health resources.

The devolution of responsibilities for health facilities and health planning to the councils supported by financial resources (through the Health Basket Fund and Block Grants) has ushered in support for the health management systems. The organizational elements have also been established to allow the councils and their health management teams to undertake meaningful budgeting through the CCHP and to supervise and

²⁷ What Determines the Quality of Local Financial Management? The Case of Tanzania. Jameson Boex and Matitu C. Muga. IDG Working Paper No. 2009-02. February 2009.



operate local health facilities, including putting in place financial management and control procedures. This has also included strengthening of council level health services, supported by the upgrading of staff skills, and ICT infrastructure, although many challenges still remain unresolved.

The ongoing PFM strengthening initiatives recently received a boost through the World Bank-funded Basic Health Services Project (BHSP), which aims to provide funding for capacity building in local governments by improving PFM at the local level, in health sector institutions and at related LGA and regional oversight structures.

6.2 Legal framework

LGAs are governed by the Local Government Finances Act No.9 of 1982 as amended by the Finance Act 2012. This Act provides the funding of LGAs and also sets out their financial management responsibilities. Orders 11 through 14 of the Local Government Financial Memorandum (LGFM) 2009 require Councils to establish and support a sound system of internal control. In addition, Order 31 places responsibility on the Councils' management to prepare financial statements in accordance with the laws, regulations and directives issued by the Minister responsible for Local Governments, the Local Government Financial Memorandum and the International Public Sector Accounting Standards (IPSASs) accrual basis of accounting²⁸. These international standards require that accounts are prepared on an accruals basis where an expenditure is recognized when it is incurred, rather than when it is actually paid for. Accrual based accounting also means that revenues are recognized when earned, rather than when the cash is received. This provides a more accurate view of income and expenditure performance. Due to low staff capacity at LGAs, this transition has not been an easy one and many LGAs continue to struggle²⁹ to implement this requirement. This means that LGAs still do not accurately capture their accounts payable and receivable, as these are recorded off the IFMS in spreadsheets. They do not capitalize fixed assets either, making control over use and disposal open for abuse.

The Local Government Finances Act guides the funding of LGA operations, allowing them to collect local revenues that can be used to finance their own priorities. The Act also makes provision for intergovernmental transfers to enable the LGAs to fulfill their mandate for provision of key social sector services, such as public health services and basic education (which are national priorities but are delivered locally). These are expected to be funded by sectoral "block grants" provided from the central government. The central government is required to provide each LGA with a block grant that is determined based on the cost to be incurred by the local authority for the delivery of public health services. The law further requires a formula-based approach to be used in determining the relative level of need for health services in each local government area³⁰.

²⁸ Annual general report of the Controller and Auditor General on the financial statements of Local Government Authorities for the financial year ended 30th June, 2012

²⁹ Fiduciary Systems Assessment. Tanzania – Urban Local Government Strengthening Program. World Bank. 2012

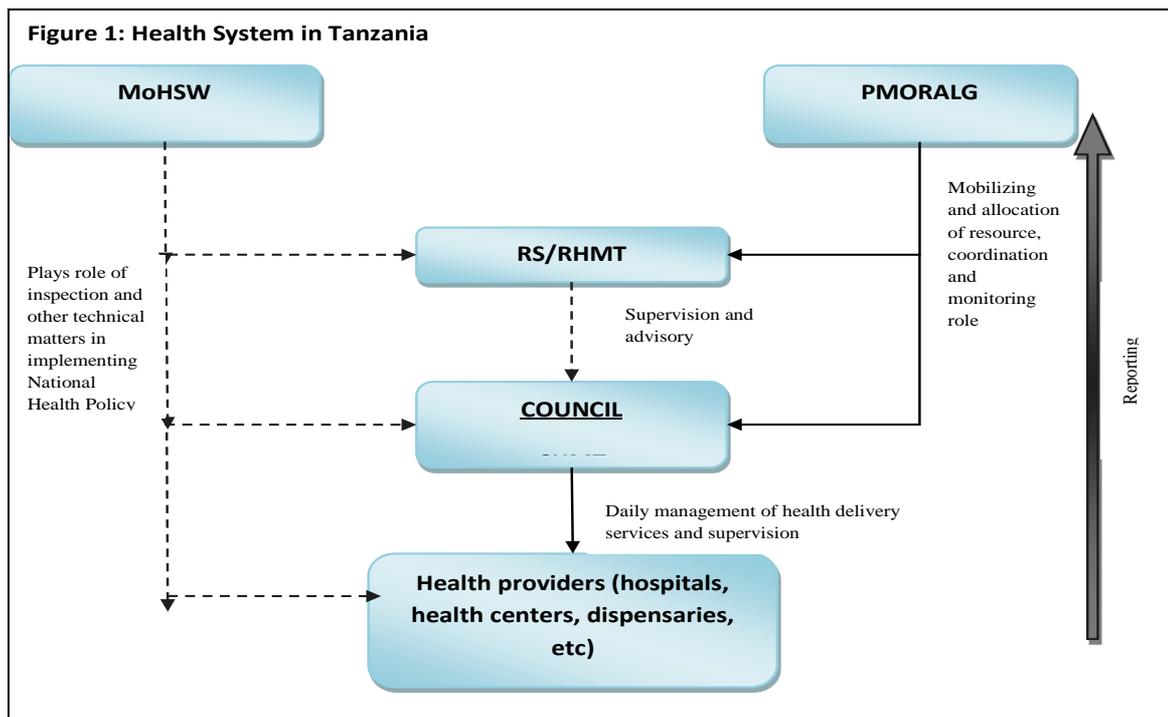
³⁰ Jamie Boex and Selemani Omari. Strengthening the Geographical Allocation of Resources within the Health Sector in Tanzania: Towards Greater Equity and Performance. Dar Es Salaam. Tanzania. June 2013



6.3 LGA public financial management framework

The health system in Tanzania has many players, including the MOHSW, PMORALG, donors, private providers and other stakeholders. The MOHSW plays a lead role in setting and implementing health policies, and its associated strategic plan. PMORALG plays a major role in allocating (and through local revenue, mobilizing) health resources at the local government level. At the LGA level, the Councils manage public health facilities such as health centers, dispensaries and district hospitals through the CHMT, headed by the Municipal or District Medical Officer (DMO). At the council level, the Health Management Information System (HMIS) requires each public health facility to report quarterly and annually to the DMO (Figure5).

Figure 5: Health system in Tanzania



Source: National Audit Office (2008)- adapted

Key financial reports include the quarterly Council Financial Report (CFR) and the Council Development Report (CDR). The CFR is the key financial report that councils produce on a regular basis through the year, other than the annual financial statements that are submitted for audit by the CAG. It is produced from the Epicor and is submitted electronically to the RS and on to PMORAL. Each council is responsible for monitoring and evaluation of performance of its public health providers. Information from HMIS and supportive supervision are the major tools in assisting the Councils with monitoring and evaluation of public health provider's performance. Financial management and reporting mechanisms have also been established to ensure efficient resource use and service provision.

The CCHP is the primary planning tool used by LGAs to plan and budget for their health activities. The CCHP is a comprehensive plan that identifies and prioritizes health needs in the council (based on national guidelines, burden of disease and other factors) as well as the total resources available from all sources to finance them. The CCHP is part of the PlanRep tool that councils use to consolidate their planning for the different sectors. The



CCHP is therefore a key element in PFM at the LGA level, as it drives the use of resources.

6.4 Planning and budgeting

Planning for health services at LGA is the responsibility of the CHMT whose head is the DMO. The CHMT prepares the CCHP that feeds into the main council budget, consolidating the budgets of all the other sectors. Councils are required to follow the participatory process of Opportunities and Obstacles to Development (O&OD) in their plan preparation. Guidelines for CCHP are issued by the MOHSW headquarters.

Councils are required to prepare their Comprehensive Council Health Plans (CCHPs) in accordance with the CCHP Guidelines and the PlanRep3 tool in order to make sure that their plans are in line with national health and development priorities. The CCHPs are supposed to bring together all stakeholders, including the communities that use health services, address all priority health issues and take into account all available resources for the financing of the plan. The current CCHP Guidelines were issued in 2011. The document itself is very comprehensive, running to over 200 pages including annexes. While it covers all aspects of preparing the CCHP, it is not an easy document to read, as some of the technical detail can be confusing to the reader. The purpose of the guidelines is to provide a one-stop shop for the user in the preparation of the CCHP, as well as all the procedures that govern the monitoring and reporting of the resources planned. The guidelines go beyond planning to briefly describe the financial management requirements regarding accounting, procurement, stores and auditing.

The CCHP is an important input into the PFM process at the LGA level. It establishes a planning process that ensures stronger oversight over health activities and spending as it involves all stakeholders from the community level to the council. However, it requires users to be properly trained to be able to prepare it accurately. Some of the complexity of the CCHP guidelines is understandable given the complex nature of health care delivery.

Production of the CCHP is assisted by the use of the PlanRep tool. PlanRep was introduced by PMO-RALG in 2007 as a tool for integrated district planning. The tool at that time did not adequately permit health sector planning, and districts were using the District Health Accounts tool that had been developed under the Tanzania Essential Health Intervention Project (TEHIP) project. The two tools were combined to create PlanRep2, which has now been upgraded further to version 3. PlanRep is based on the MTEF and all health activities must be entered under the appropriate objective and cost center (e.g. DMO's office; District Hospital etc), and assigned the correct Government Financial Statistics (GFS) code. PlanRep consolidates all the individual sector plans into the council plan and budget for submission to the MoF through the RS/PMOR-RALG. The plan is to make PlanRep3 fully compatible with Epicor 9.05 so that budget data can be imported/exported across the two software. However, this is not yet possible and data have to be downloaded from PlanRep into an intermediary Excel file that is then uploaded into Epicor for budgetary control over expenditure.

Recommendations:

- The guidelines could be easier to follow if a modular structure was adopted whereby information could be clustered under several broad areas. Users could then pull out only the section relevant to them.



- The guidelines should be written in a more user-friendly manner and in language that is clear and easy to follow, especially given that many users at the lower government levels may not have a strong command of English.

6.5 LGA sources of funds

LGAs receive their funding from four sources: 1) block grants (PE and OC), 2) local government development grants, 3) Health Basket Fund, and 4) own revenue. Funds are allocated according to predetermined formulae for all but the local revenue, which is at the discretion of the Council.

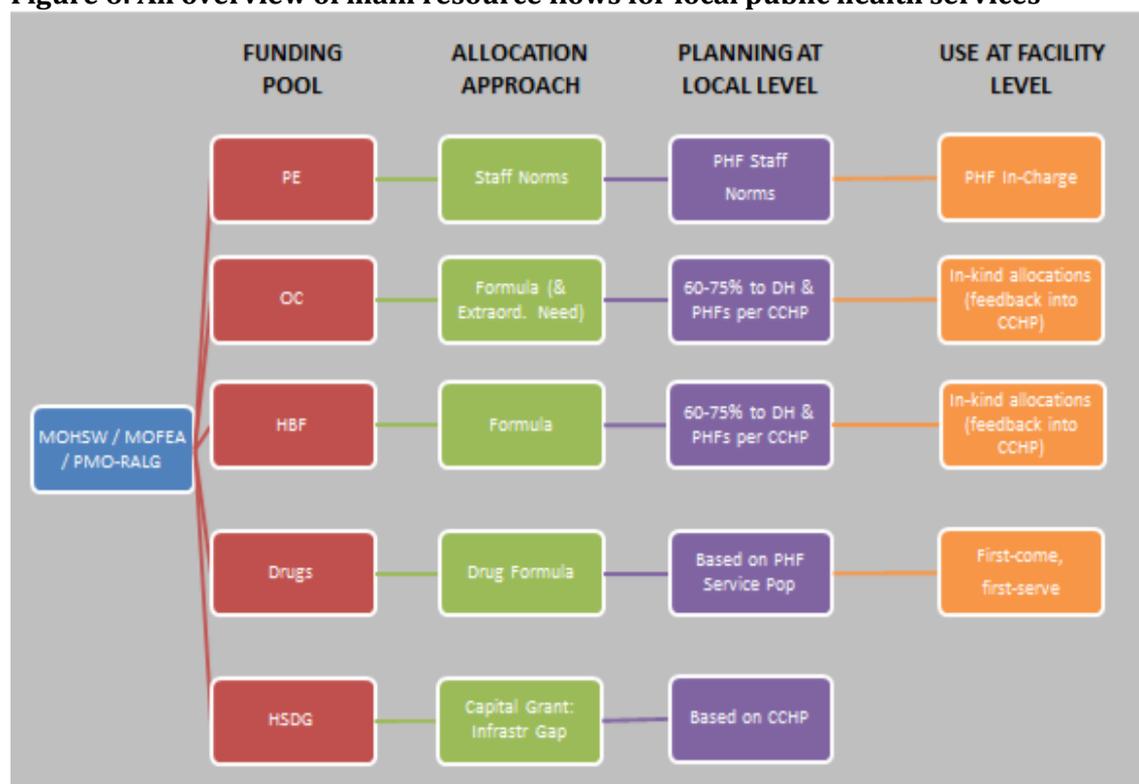
Table 15: LGA health funding excluding own revenue

	2010/11 Actual TSh.'000	2011/12 budget TSh.'000	2012/13 Budget TSh.'000
Health PE	146,401,509	242,360,873	303,176,029
Health OC	24,578,860	32,783,826	32,331,353
Development	127,149,849	228,011,323	129,372,317
Total	298,130,219	503,156,022	464,879,699,000

Currently, health spending at LGA accounts for approximately 13% (2011/12 budgets) of total LGA spending.

Figure 6 below depicts the five key funding flows of funds for local health services. This does not include centrally funded vertical programs such as HIV/AIDS.

Figure 6: An overview of main resource flows for local public health services



Source: Boex and Omari. *Strengthening the Geographical Allocation of Resources within the Health Sector in Tanzania: Towards Greater Equity and Performance*

According to Boex and Omari, for each funding stream, four decisions connect the funding pool to the delivery of front-line services. First, the size of the resource pool

(determined by the central government) determines overall resource availability. Second, the allocation approach for each of the five main resource pools, which may be formula-based or non-formula-based, determines the horizontal distribution of resources among LGAs. Third, the planning process at the local or council level determines the use of resources at the local level, including the share of resources that are passed on to the local health facilities and the intra-district allocation of resources. Finally, decisions are made at the facility-level that impact the effectiveness with which financial resources are used at the facility level³¹.

6.5.1 BLOCK GRANTS

Financial management systems at the LGA cut across all sectors. The MoF releases funds of the HBGs directly to LGAs upon request from PMORALG to transfer an approved amount of money. The allocation of HBGs follows the normal government procedure whereby the approved budget is allocated to the council as requested by PMORALG from MoF. The PMORALG notifies the Regional Secretariat to follow up to ensure the funds are received as requested. Allocation to LGAs, both for the HBG and health Basket Fund (BF) uses a formula: Population (70%), Poverty count (10%), District Medical vehicle route (10%), and Under-five mortality (10%). However, there does not appear to be consistent use of the formula, neither is it updated to take into account changes in any of the variables (e.g population) over time. The HBG allocation pays primarily the PEs, which comprises close to 90% of the allocation as this is driven by the filled staff positions and whatever is left is used to fund OCs.

6.5.2 HEALTH BASKET FUNDS

The allocation and accounting of Health Basket Funds follows a slightly different route from the Block Grants. Health Basket Funds are disbursed by the MoF after receiving an approval from the Basket Fund Committee (BFC) on how much should be allocated to each LGA. The Regional Secretariat reviews progress reports of the respective councils and submits an assessment report to the PMORALG. PMORALG recommends the councils to be funded to the BFC, and gives reasons for those councils that are not included in the list. Some of the reasons to deny disbursement may include: lack of submission of CCHPs and/or progress reports or shortfalls discovered in the use of previous funds.

6.5.3 LOCAL GOVERNMENT DEVELOPMENT GRANTS

In order to provide incentive for LGAs to perform their PFM functions effectively, various grants are made to them on performance basis. Since 2004, the Local Government Development Grant (LGDG) system provides councils with discretionary, performance-based and formula-based Council Development Grants (CDG) as well as Capacity Building Grants (CBG). To qualify for the CBG, councils only need to demonstrate that they have developed capacity building plans and that they have accounted for all past CBG disbursement. Only councils that have met certain minimum conditions are eligible for the CDG, and councils receive a performance-incentive based

³¹ Jamie Boex and Selemani Omari. Strengthening the Geographical Allocation of Resources within the Health Sector in Tanzania: Towards Greater Equity and Performance. Dar Es Salaam. Tanzania. June 2013



on the results of an annual assessment of local government performance³². LGAs receive CDG funding ranging from 25% to 100% depending on the results of the assessment. LGAs classified as “Very Good” performers will receive 100% of the allocation. Those classified as “Good” receive 80%, while those classified as “Poor” receive 50% of the allocation. LGAs that fail to meet the minimum conditions receive 25% of the LGDG allocation, and are subject to strict oversight from PMORALG and RSs. According to an MoF study on mapping of transfer of funds to LGAs, “The System seeks to promote compliance with national policies and regulatory frameworks as well as creating an incentive system that allows for adjustment of the annual grant allocation to each LGA depending on the level of achievements against the set of minimum conditions and performance indicators. Clearly, LGDG is intended to be the government system of intergovernmental funds transfer for development expenditure at sub-national level.”³³

In addition to the CDG and CBG, local governments also receive sector specific grants under the LGDG: for the health sector, it is the Health Sector Development Grant (HSDG).

6.5.4 HEALTH SERVICES DEVELOPMENT GRANT

The HSDG is a window within the Local Government Development Grant system targeted at providing ear-marked grants to the health sector for capital developments in support of the Primary Health Services Development Program (PHSDP (MMAM in Swahili)). The PHSDP aims to decentralize quality primary health services to the community level through constructions, rehabilitation and equipping of health facilities. The PHSDP hence targets primary health services at the level of dispensaries, health centers and district hospitals. This ten year program runs from 2007 to 2017.

The allocation of HSDG funds to LGAs is formula and performance based, consistent with the LGDG system. Performance is determined as part of the annual LGDG assessment. The HSDG allocation formula follows the allocation of block grants and council health basket funds, reflecting health needs and poverty levels of the LGAs, as described above. LGAs that do not meet the minimum LGDG conditions receive 50% of their grant, but under strict oversight by PMO-RALG and RS in collaboration with MOHSW.

LGAs face difficulty in budgeting for the HSDG because of the timing of the annual assessment that determines the level of funding they receive. Until the results of the assessment are released, councils have no idea how much to include in their budgets for the following year and have to make estimates based on prior years or their best estimate of their likely performance. One of the key inputs into the assessment is the report of the CAG. As a result, there is a need to harmonize the timing of the assessments with the CAG reporting, and for the results to be communicated to LGAs in time for their budget submissions. This may require changing the requirements: instead of using the previous CAG report, using the report from two years ago as the primary input into the assessment may prevent delays waiting for the CAG report.

³² Evaluation of LGSP Implementation (Component 1 and 3) to Inform the Preparation of the Project Implementation Completion Report. DEGE Consult in association with Urban Institute Washington. PMORALG. Draft 2013.

³³ Tanscott Associates. Study on mapping of transfer of funds to local government authorities. Ministry of Finance. September 2013. Dar Es Salaam.



6.5.5 DRUGS

Funding for drugs is provided through the MSD. The MSD receives instructions from the Chief Pharmacist on how much is allocated to each health facility. The allocation amount is based on an allocation factor that takes into account the population served, poverty rate and under-five mortality, in the proportions 70%, 15% and 15%. This formula system replaced the old “push” system that allocated drug budgets based on the type of health facility. Health facilities and councils can use cost sharing and council health basket funds to procure from alternative suppliers if they run out of MSD-supplied drugs and medical supplies.

6.6 Budget execution

6.6.1 OVERVIEW

Budget execution is performed through Epicor, which has become more robust with the new upgrades in 2012 to version 9.05. The Epicor is now installed in 133 local governments. New councils have been added to bring the number to 167 (164 implemented to date) as of June 2013, and most of the new ones are yet to be connected, but are planned to be connected by June 2014. The budgetary control system in Epicor allows for the use of “Commitments,” which prevents any spending to occur if there are not sufficient funds. An LPO is required before a commitment is entered, and is only issued to financial codes with adequate funds³⁴. Councils are allowed to carry over any unspent funds to the next financial year.

LGAs continue to cite challenges with the transfer of non-PE funds from the MoF because the information is relayed to the LGA via the RAS, who is considered to be the Account Holder. While the release of the funds by the MoF may happen quite quickly, information on the purpose of the transfer relayed to the LGA does not arrive until much later because it has to be routed through the RAS. The LGAs will therefore have money in their accounts that they cannot spend because it has not been posted to the relevant ledger account in Epicor. The system will not allow them to spend until instructions are received and the money is correctly accounted for.

A major challenge at both the central and LGA levels is lack of capacity to use funds effectively. Lack of capacity to spend may be due to a combination of factors, including: the late disbursement of funds, mostly in the third and fourth quarter of the fiscal year that derails effective implementation of plans; over-stretching of staff who cannot implement extra activities and are not supported ICT systems; inadequate familiarity with rules and procedures for the disbursement of funds, thus delaying disbursement and expenditures; lack of skills to manage development projects leading to slow execution that affects payments; or too many stakeholders (on-budget and off-budget) each demanding separate reports (depending on the source of financing) thus exerting pressure on the few human resources available.

Efforts are currently under way to strengthen LGA procurement management units. The PPRA is building procurement capacity with assistance from the Enhancement of Procurement Capacity of Local Government Authorities Project.

³⁴ Belgian Technical Corporation. Fiduciary risk assessment of using national execution for public financial management and procurement in projects in Tanzania . June 2013.



6.6.2 RECURRENT AND DEVELOPMENT FUNDS DISBURSEMENT TO LOCAL GOVERNMENTS

There has been deterioration in release of LGDG funds during FY 2011-12. CAG's Audit Report for FY2011 provides details of releases and demonstrates that only a little over 50% of LGDG funds were released during FY2011 and there were major shortfalls in releases for LGDG core funds, as well as for health and agriculture. No funds were released for rural water supply. Considering the fact that LGDG Core funds are only one of two unconditional grants available to LGAs, this has adversely impacted the credibility of the program and is an issue that needs to be addressed. Due to budgetary (cash) constraints, even when the government does release the development funds, they are often released during the last quarter of the fiscal year, leading to the problem of carry-over of funds into the following fiscal year. The carry-over also poses budgeting problems, as they will have missed the budgeting cycle for the year that they are rolled over and are therefore not included in that year's available resources.

Table 16: Disbursement of local government development funds FY2011-12 (TZS. Billion)

Fund	Budget	Releases	Amount not released	% not released
LGDG Core	175.3	109.3	66	37.6%
HSDG	30.3	17.4	12.9	42.6%
ASDG	55.6	43.7	11.9	21.4%
RWSSP	63.2	0	63.2	100.0%
Total	324.4	170.4	154	47.5%

Source: CAG's Annual Audit Report of Local Government for FY 2011/12

6.6.3 PERFORMANCE OF INTERGOVERNMENTAL TRANSFERS OF HEALTH FUNDS

The intergovernmental transfer of health resources for FY 2010-11 and FY 2011-12 is shown in Table 17. Overall, the performance of the transfers as measured by comparing the budget plan with actual transfers shows that there was a decline in the block grant between FY2010-11 (87.5%) and FY2011-12 (63.5%). This is partly explained by delays in recruiting of new health staff in FY2011-12.

Table 17: Intergovernmental transfer of health funds (TShs, million)

Budget Item	2010/11			2011/12		
	Budget	Disbursed	Performance (%)	Budget	Disbursed	Performance (%)
Health recurrent block grant	229,180	200,620	87.5	369,109	234,261	63.5
Health basket fund	73,479	64,242	87.4	81,265	76,225	93.9
Health sector development grant	36,190	32,570	89.4	32,612	11,555	36.1

Source: Mapping Exercise on Funds Transfers to LGAs



As for the health basket fund, performance was above 87.4%, while performance of the development grant was very low in FY2011-12 (36.1%) compared with 89.4% in FY2010-11. This implies LGAs were largely unable to accomplish their planned health-related development activities.

6.6.3.1 HEALTH SERVICES DEVELOPMENT GRANTS

A test check by CAG on the financial performance and utilization of HSDG funds received by Councils noted unspent balances of TShs. 2,586,057,984 in respect of thirty two Councils as at 30th June, 2012 as shown Table 18.

Table 18: Trend of unspent balance for health services development grants

Year	Amount unspent	No. of councils
2010-11	5,848,829,864	48
2011-12	2,586,057,984	32

Source: Controller and Auditor General (CAG) General Report on LGAs 2011/2012

As shown in Table 18, the trend of unspent amount decreased by TShs.3, 262,871,880, equivalent to 55.8%, which is a positive trend. However, the unspent amount is still very large. Having an unspent balance of TShs.2.6 billion implies that the planned health related activities (e.g. construction and equipping of new facilities) were not fully implemented, and therefore the targeted community could not benefit from the projects that were not implemented.

Recommendation:

- This area warrants close attention by all LGAs and follow up by the MOHSW as well as PMO-RALG to ensure available limited health resources are being used to achieve intended health outcomes. Supportive supervision by the RHMT should also include this in their menu of interventions during their supervisory visits.

6.6.3.2 PREDICTABILITY AND TIMELINESS OF INTERGOVERNMENTAL FUNDS FLOWS

Field work completed by the study team indicates that funds transferred to LGAs were not predictable and are not made available in a timely manner to achieve more efficient resource use. Table 19 (below) further confirms this observation and illustrates the timeliness and completeness of transfers to LGAs.



Table 19: Timeliness and completeness of cumulative health resource transfers to LGAs (As a % age of annual allocation)

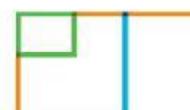
Budget item	2010/11					2011/12				
	Q1	Q2	Q3	Q4	% total budget	Q1	Q2	Q3	Q4	% total budget
Health recurrent block grant	29.7	43	61.5	87.5	87.5	n.d	37.1	35.1	63.5	63.5
Health basket fund	35.3	43.2	67.2	87.4	87.4	n.d	46.7	68.9	93.9	93.9
Health sector development grant	14.5	38.9	66.3	89.4	89.4	n.d	16.4	24.9	36.1	36.1

Source: MoF (2013), Authors n.d=no data available

Although Table 19 shows quarterly amounts, in practice block grants are disbursed to LGAs on a monthly basis. No transfers were recorded during quarter one of FY 2011-12 even though this is highly unlikely since PE would still have needed to be paid. As displayed in Table 19, the patterns in actual transfers of the recurrent block funds remained unpredictable over the period under review. However, in comparison, the transfers in the health basket funds were more predictable, achieving a performance of 93.9% in FY2011-12. On the other hand, transfers of development grant were very poor, especially in FY2011-12 (36.1%), implying planned development activities in LGAs could not be implemented or stalled for lack of funding. Another observation is that development expenditure by its nature requires a relatively longer lead time as dictated by the project being funded. As such, if funds are not available early in a fiscal year, projects start late and this would inevitably result in large “carry over” to the following year. In addition, this usually leads to cost escalations due to inflation, penalties for delays or changes in various inputs.

Discussions with relevant officials during the field study indicate that there are several reasons for delays in the transfer of funds. Some of these are:

- Disbursements in most of the quarters were way below budget allocations, implying that some of these activities were underfunded.
- The current set-up of the budgetary relationship between LGAs and Regional Secretariats (RSs) has also been a cause of delays. The RS is the budget-holder for the regional vote that includes LGAs in the region. In that capacity the RS receives details of funds transferred to all LGAs in the region and passes on details to each LGA; although funds are transmitted directly to the LGAs. This arrangement often results in information disconnect between RS and LGAs, where funds may be in the LGA bank account ahead of details of what the funds are to be used for. Without such details LGAs are unable to utilise funds, thus resulting in considerable delays.
- There are delays associated with the Government or Development Partners releasing funds into the Bank of Tanzania (BoT) Holding Account due to non-



fulfilment of some conditionality in the agreements, such as carryovers, or inadequate reporting.

- The current set-up of the budgetary relationship between LGAs and RSs has also been a cause of delays. The RS is the budget-holder for the regional vote that includes LGAs in the region. In that capacity, the RS receives details of funds transferred to all LGAs in the region and passes on details to each LGA, even though funds are transmitted directly to the LGAs. This arrangement often results in an information disconnect between RS and LGAs, where funds may be in the LGA bank account ahead of details of what the funds are to be used for. Without such details LGAs are unable to use funds, thus resulting in considerable delays.
- The cash budget system used by the GoT means that if there has not been sufficient mobilization of revenue, budgetary allocations will be delayed.

6.6.3.3 TRANSPARENCY AND CREDIBILITY OF THE FUNDS TRANSFER SYSTEM

An analysis of the system of transfers indicates that it is overly complex, consisting of numerous different grants with different allocation criteria of variable transparency. Although elements of the transfer system have been designed with the intention of allocating resources to LGAs in an objective, fair and transparent way through the use of a formula-based approach³⁵, these no longer appear to be working as intended with the formulas not always being applied in a consistent and transparent way. The problems have been recognised by the MoF and a Mapping Exercise on Transfer of Funds to LGAs has been completed (MoF, 2013). The mapping exercise seeks to harmonize the multiple transfers and making the system work in a way that adheres more closely to the principles of the formula funding that is currently in place.

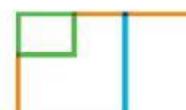
An Inception report (MoF, 2013b) submitted to the MoF on 'Mapping Exercise on Funds Transfers to LGAs' discusses the issue of transfer system transparency and credibility by observing that:

'Not only does the current approach mix local resources for different sectors within the same budget votes, but these votes also mix regional and local resources. Thus it is difficult to separate out the share of the central government budget that is transferred to the local government level. Furthermore, the budget voted on by Parliament only includes transfer amounts that are aggregated across all LGAs within each region. Therefore, Parliament never actually votes on the exact formula-based allocations for each council, which eliminates any legal backing for the formula-based allocation of resources'.³⁶

Thus, for the resource transfer to work more efficiently and transparently, there is a need to review the entire system in tandem with the formula-based allocation to eliminate the observed anomalies.

³⁵ 70% by population, 10% by Number of poorer residents 10% by Council medical vehicle route, and 10% by Under-five Mortality. The allocations by LGA were subjected to the assessment results (100% for Very Good, 80% for Good, 50% for Poor and 50% for Failed).

³⁶ Inception Report for Mapping Exercise on Funds Transfers to LGAs, February 2013.



Recommendations:

- Communication between the MoF, RAS and LGAs should be improved so that as soon as funds are released, the information goes to the RAS as well as the LGA.
- MoF should endeavor to release funds in a timely manner and communicate delays to the RAS and LGA for their own cash flow planning.
- LGAs should aggressively plan for and use the unspent CHF funds.
- LGAs should develop systems for claiming and collecting from the NHIF.
- LGAs need to be knowledgeable of all procurement regulations and be able to do proper project and cash flow planning in order to minimize the unspent balances in their books.

6.6.4 REVENUE MANAGEMENT – OWN SOURCES

LGAs collect revenue from various sources, including local taxes, fines, licenses, user fees, CHF premiums and matching grants, and NHIF reimbursements. Revenues that are directly targeted at improving health services are the CHF (including TIKA) and NHIF reimbursements. These revenues constitute only a small fraction of total health funding for LGAs. In FY2010-11, actual revenue realized accounted for only 4.5%, with CHF and NHIF accounting for 1.2%³⁷. Revenue collections have tended to be quite close to what the councils budget for (below 3% variance from FY2007-08 to FY2010-11, but 20% below target in FY2011-12), but the CAG has expressed doubts about the accuracy of these budgets³⁸. The team is not aware of any studies by councils to determine the real potential for local revenue collection. Discussions with the Hospital Reform Team at the MOHSW also indicated that hospitals and health centers do not monitor their revenue collections against the volume of services. It is possible that there is under-collection of health cost sharing fees and NHIF reimbursement.

Recommendation:

- LGAs should establish simple systems for monitoring revenue from hospitals and health centers, but should set targets based on expected volume of services, and adjust for non-chargeable services (e.g. services for children under five) and waivers of fees for the poor, and facility staff should be trained to follow these procedures.
- Health Facility Governing Committees should be trained to provide appropriate oversight over revenue collection and use.

6.4.1.1 COMMUNITY HEALTH FUND

CHF was established in 1997 as a major health related financing strategy to encourage communities to participate in cost sharing in the health sector in Tanzania. Collections and use of the Funds is clearly stated in Circular No. 2 of 1997 issued by the MOHSW, which directed that the funds will be used for various approved activities. These activities include cost of medicine, drugs, hospital equipment, minor building repairs,

³⁷ PER 2011

³⁸ CAG General Report on LGAs 2011/2012



fuel and night out allowance. The circular also requires procurement of medicines and medical equipment to be made from approved suppliers. During FY2011-12, CAG noted the following issues on CHF financial management.

During FY2011-12, a review of 38 Councils was made on the management of CHF operations. The review found that these Councils had unspent balances of TShs.1,709,747,559, which was mainly caused by not opening and operating separate accounts in respect of CHF and delays in release of the matching grants. This implies that the targeted communities have been denied health services accruing from the planned activities of CHF.

Recommendation:

- Councils should acquaint themselves with the regulations governing the operations of the CHF, including banking and spending rules.

6.6.4.2 NATIONAL HEALTH INSURANCE FUND

The NHIF reimburses hospitals for services rendered to its members. Membership is open to those in formal employment. The fund has been in operation since 2001. Members receive services free of charge at accredited health facilities. Government health facilities constitute 80% of all accredited facilities, the rest being faith based organizations or privately owned for profit entities.

The performance of public hospitals in claiming from the NHIF has been poor. Records from 2012 indicate that public hospitals accounted for only 30% of the value of all claims from the NHIF, the rest going to FBOs and private for profit hospitals. This is a cause for concern and requires urgent investigation to determine whether public hospitals are losing money by not claiming, or whether there is indeed a valid reason for this disparity. Some potential reasons for the higher claiming by non-public health facilities have been identified: they tend to be located in urban centers where they are easily accessible to members; they provide higher quality services; or simply that the government hospitals are not efficient in filing their claims³⁹. As Table 20 below indicates, failure to submit claims is a problem in some councils.

A test check on management and operations of CHF revealed that there were outstanding claims in respect of ten Councils shown below, which amounted to TShs.321, 247,691. These claims were not paid by the NHIF as compensation for the health services provided to various members of the CHF who are also members of the NHIF. Table 20 provides a summary of the outstanding claims not remitted to the NHIF.

³⁹ MOHSW, 2013. Mid Term Review of the Health Sector Strategic Plan III 2009 – 2015, Health Care. Financing, Technical Report, Ministry of Health and Social Welfare, United Republic of Tanzania.



Table 20: List of councils with outstanding claims not remitted to NHIF

S/N	Name of council	Outstanding amount (TShs)
1	Kibondo DC	36,756,500
2	Kilimbero DC	1,507,443
3	Kilosa DC	14,272,611
4	Kyella DC	43,089,695
5	Chunya DC	26,347,900
6	Singida DC	1,945,398
7	Kahama DC	24,170,998
8	Maswa DC	16,482,864
9	Iramba DC	148,266,000
10	Meatu DC	8,408,372
	Total	321,247,691

Source: Controller and Auditor General (CAG) General Report on LGAs 2011/2012

Recommendation:

- Council management should develop a clear system for processing claims and following up to receive reimbursement from the NHIF.

6.7 Financial control and reporting

LGAs are required to prepare and submit two key reports to PMO-RALG: the Council Financial Report (CFR) and the Council Development Report (CDR). These two, and especially the CFR, are the main deliverables expected of councils every quarter to enable PMO-RALG to monitor financial activities at the LGA level. The reports are prepared and submitted electronically. The CFR and CDR both provide a standardized reporting format intended to enhance the transparency of local government finances.

The CFR is submitted electronically to PMO-RALG where it is downloaded for analysis and posted on the PMO-RALG website. Some councils complete the CFR in Excel using a template, and email it PMORALG. Others are able to prepare it straight from Epicor, while the remaining prepare it from other systems. The plan is that in the future, all financial reports are produced from Epicor. However, the reports often have to be sent back because the information does not make sense or is not reliable.

There are challenges in the way that the current reporting is completed, which bypasses the respective council committees responsible for finances. It is thus recommended that to enhance transparency and accountability, the Quarterly Financial Report should be presented to the Council committee responsible for finance each quarter along with the regular income and expenditure statement. The financial reports should be shared with the MoF and an appropriate (user friendly) summary should be disseminated to the ward and village through public notices. Since PMO-RALG hosts a website, it should ensure that quarterly CFRs are posted in a timely manner to enhance transparency and use of public resources.

The CFR electronic copy is forwarded to all key high level staff who deal with finances, including the Director of Policy and Planning and deputies. Specific areas in the report that need MOHSW action are highlighted by the head of DHS and forwarded to the attention of the relevant MOHSW staff. There is no follow-up to see if any action has been taken (partly it seems for LGAs the DHS head is the only 'staff' and she is not able



to follow up everything). Nobody in the MOHSW monitors health spending at the LGA's level (the opinion is that monitoring systems have been put in place by POM-RALG and they are the ones that makes follow up with the help of CAG).

Recommendations:

- The CFR and CDR should be reviewed by the council finance committee before submission to PMO-RALG to ensure that information contained therein is accurate.
- CFR and CDR should be shared in a user-friendly format with the public for added accountability.
- The MOHSW should take a more active interest in health spending at the LGA level and monitor it more frequently than during the annual PER.

6.8 Use of integrated financial management systems

6.8.1 OVERVIEW

LGAs and the central government use IFMIS (Epicor) for financial management. Since 2000, the Government has been rolling out the IFMIS in LGAs. By 2011, about 100 LGAs were covered. However, despite much effort by POM-RALG to put in place a functional financial management system through provision of training, guiding manuals, equipment and close supervision, the IFMIS system is still largely underutilized.

The NAO commissioned review also observed that there had not been sufficient buy-in by users to the system, and that a change in culture in government would be required to achieve the necessary buy-in. In particular, there was a lack of effective IT and general controls. Application controls were only moderately effective and disaster recovery procedures were missing. In response to the observed weaknesses, PMO-RALG developed plans for improvement of the IFMIS and in 2012, the system was upgraded to Epicor 9.05. This has improved its functionality and addressed some of the concerns identified in the preceding paragraph. Epicor 9.05 version currently covers all Ministries, Departments and Agencies (MDAs), the 22 sub-treasuries and the regional administrations; as well as 133 LGAs. Recent creation of new districts has brought the number of LGAs to 167, of which 34 remain unconnected. Plans are currently underway to get these on board as well as soon as the necessary infrastructure is in place.

The functionality embedded in Epicor includes budget management and core accounting modules such as general ledger, accounts payable and accounts receivable. The 2012 upgrade includes improved reporting tools and internet connectivity. The system is also designed to support expenditure controls. Before the upgrade, there was no functioning commitment control within Epicor at the LGA level. If the commitment control system were used consistently to register all procurements, it would be an effective way of controlling the accumulation of payment arrears. The failure of the expenditure commitment control system to prevent accumulation of arrears has been highlighted in



the recent evaluation of the General Budget Support (GBS⁴⁰) as an important weakness that will need to be rectified.

6.8.2 IFMIS CHALLENGES

Despite many improvements made to the IFMIS from previous versions, there are several challenges that have to be overcome to advance financial management and control. Foremost is an observed lack of human capacity to operate the IFMIS to its full potential. This problem was also noted by USAID assessment⁴¹ which observed:

'A common theme found throughout this assessment that may indirectly pose a financial risk to USAID/Tanzania directly supporting project development is the fact that there is a shortage of qualified and trained personnel throughout the local government authorities. Accounting department staffs are oftentimes only large enough to handle routine transactions but do not have the capacity to spend extra time needed to perform detailed account analysis. In several cases there were not adequate staffs to handle the internal audit function. The Assessment Team noted a general lack of continuous staff training at all levels. For example, some individuals had been trained on Epicor while others had not received as much, if any, training. LGA staff may receive some training but it is often random, piecemeal and inappropriate for their particular job. Continuous professional training for management and operational functions does not occur.'(USAID, 2012).

Thus, in order to achieve value for money and full functionality of the IFMIS, it is important to undertake continuous professional staff training of LGA staff for management and operational functions.

The second challenge is the observed inconsistencies in the allocation of responsibilities that constrain the efficient working of Epicor. Some of these inconsistencies result from differences in the provisions of the relevant legislation. The Epicor system is managed by the District Treasurer, whereas Procurement Management Units are, according to the Public Procurement Act, supposed to issue LPOs after validation of the availability of funds. To further complicate things, the (earlier) Local Government Financial Memorandum contradicts the Public Procurement Act, by requiring heads of department to issue LPOs. These delays make an already slow procurement process, especially for development projects (e.g. under the health sector development program), even slower and contribute to the unspent balances that councils carry over from one year to another.

6.8.3 UNALIGNED IT SYSTEMS

At both the central and local government level, there are multiple IT systems for planning, accounting and reporting that are not aligned to each other, making financial management and control weak. For example, the budget planning software (SBAS at central government level and PLANREP at local government level) does not have a standardised interface for data exchange with the Epicor system used for budget execution. Thus, currently, budget plans are exported to Excel files and then input into the IFMS for budget finalization and execution purposes. This is inefficient because of duplication of data entry, and leads to potential inaccuracies. Implementation of an

⁴⁰ 'Independent Evaluation of Budget Support to Tanzania, 2006-2011' Draft Final Report, January 2013

⁴¹ Summary Report on the Tanzania Management Risk Assessment: Stage II' USAID, January 2012



interface between the two systems is feasible and is being planned by the government. Another challenge is that the systems for payroll management and human resource management have no electronic interface with the IFMS. Furthermore, there is also no electronic interface with the annual procurement plan, which makes the systems in place less efficient for financial control purposes.

The Government is aware of the weaknesses of having unaligned systems and associated inefficiencies. As a first step to resolving the issue, the MoF has commissioned a mapping study of all financial management systems and sub systems with the aim of harmonizing and fostering system integration so as to allow government financial data to flow smoothly from one system to another while maintaining data consistency and integrity.

Recommendations:

- Further streamlining of organizational arrangements and the legislative framework is needed to make the IFMS achieve more fully its goals
- The Epicor system should be used to register all commitments including both multi-annual and annual contracts. However, this requires that the funds are first released to the relevant budget lines in order to be controlled through Epicor.
- All relevant LGA staff (e.g. District Treasurer; Internal Auditor; accounts staff; PMU staff) should be trained in the workings of Epicor so that they know how to make the best use of it for monitoring and financial control.

6.8.4 INTERNAL AND EXTERNAL AUDIT PERFORMANCE

The Local Government Finances Act No. 9 of 1982 requires that the accounts of every District Council, and of every urban authority be audited by an internal auditor employed by the authority concerned. An external auditor for each of those authorities should be the Controller and Auditor-General⁴². The ongoing PFMRP IV has KRA No. 4 “Budget Control and Oversight” whose objective is “improved adherence and enforcing of MDAs and LGAs to financial internal controls, rules, laws, regulations and audit recommendations by June 2016.” The expected outputs under this area include: increased coverage and quality of the internal audit functions by 2016; strengthened External audit functions by 2016; and improved transparency on audit reports (central, local and parastatal levels) to strengthen scrutiny and accountability.

6.8.4.1 EXTERNAL AUDIT

In recent years, the number of LGAs that received a clean audit opinion has improved from 54% (72 out of 133 councils) to 78% (104 out of 134 councils) in FY2011-12. The continued poor performance by some LGAs is partly due to changes in accounting standards adopted by the GoT. Since FY2009, all LGAs are required to adhere to IPSAS. This requirement has exerted pressure on the weak human capacity in LGAs to fulfil the conditions of the IPSAS. In addition, only limited training has been provided to staff to implement accrual based accounting required by the IPSAS. LGAs have struggled to achieve minimal standards and basic procedures, such as bank reconciliation, remains an area of concern.

⁴² United Republic of Tanzania. Local Government Finances Act No. 9 of 1982. Section 45. Dar Es Salaam. 2000



Between FY2010-11 and FY2011-12, there was a 24% improvement in the number of LGAs receiving clean audit reports. Despite the improved overall audit performance, the year's audit still included the following serious issues:

- Improper preparation and presentation of financial statements: financial statements are not directly generated from the IFMS as they are supposed to be.
- Deficiencies in Internal Control Systems: As noted in previous years' reports, the internal control systems in some of the LGAs are not adequate owing to use of manual accounting system, ineffective internal audit units and poor performance of the Audit Committee.
- Weaknesses in revenue management from own sources resulted in TSh 18.6 billion of uncollected revenue as presented in Table 21.

Table 21: LGAs own uncollected revenue in FY 2011-12

Revenue source	Uncollected revenue Tsh
Collecting agents	4,466,028,478
Other own sources	8,008,669,844
Property taxes	4,345,570,497
Produce Cess	1,797,972,949
Total	18,618,241,768
LGA total budget (Recurrent)	2,723,595,000,000
% of uncollected to total budget	0.7%

Source: CAG report 2012

- Internal controls and internal audit: This is a major area of concern and as discussed above, requires urgent action to train and employ an adequate number of staff in all LGAs to instil greater financial control and accountability of public resources.
- LGAs for FY2011-12 state that a fraud assessment of 68 LGAs was carried out in FY2011/12: This assessment disclosed that LGA management has not documented or put in place fraud prevention plans. There is also no process for management to monitor "red flags" that could alert them to the symptoms of fraud. Due to this, CAG has concluded that there is a high risk of concealing management or operational level fraud in LGAs – an area that warrants urgent review and rectification in all LGAs.
- Procurement Compliance: In the audit report on LGAs for FY2011-12, CAG has expressed concern at the low level of compliance with procurement procedures; laxity in control over contract payments; poor supervision of LGA projects; procurements being made without Tender Board approval; and missing documentation in LGAs relating to procurement and the manner in which several of the assessed LGAs ordered and paid for goods that were not delivered. Since this is not an accountable manner of using public funds, stricter measures are needed to hold any officials engaged in malpractice responsible.

An assessment conducted in 2010 for the Local Government Development Grant (LGDG), observed that 16% or 21 LGAs had the General Fund Accounts overdrawn during the period July 2008 to June 2009, while 19.7% or 26 LGAs had other accounts



overdrawn during the same period. About 6.8% or 9 LGAs had both the General Fund and other accounts overdrawn during the period. The recent MOF directive to LGAs to reduce the number of bank accounts to six⁴³ at the local level could result in the emergence of additional fiduciary risks. LGAs could face greater difficulties in tracking payments into and expenditures from these six accounts. The amendment to the Public Finance Act of 2010 created the office of the Assistant Accountant General for Local Governments, and for the first time, brought the accounting function of LGAs under the technical purview of the Accountant General of Tanzania. This is a positive change that will foster systems integration and improved financial management and accountability.

Other external evaluators have also expressed concern at the poor financial audit performance of LGAs. The World Bank Fiduciary Assessment points out that weak internal audit and internal controls are “a major area of concern”. The value for money study carried out by PPRA audited 91 LGA projects with a value of Tsh 91 billion. The main finding of the study was that 68% of the audited projects (53% by value) were of unsatisfactory quality. Malpractice was noted in most LGAs.

6.8.4.2 SYSTEMS AUDIT

According to head of LGA Finance Section at PMORALG, the NAO has 8-10 resident staff in all regions and they carry out audits of regional offices and LGA's. He also expects a special audit of accounting systems in PMORALG later this year, which will take account of the functioning of the Epicor installation.

6.8.4.3 INTERNAL AUDIT

According to Section 45 of the Local Government Finances Act No.9 of 1982, accounts of every LGA have to be audited by an internal auditor employed by the authority concerned. Furthermore, Order No. 13 of the Local Authorities Financial Memorandum of 2009 requires each LGA to employ its own Internal Auditors who works closely with the Heads of Departments and reports directly to the Accounting Officer.

The internal audit function has been the subject of criticism from the CAG and other evaluators as being ineffective. According to the World Bank Fiduciary Assessment, this is a major area of concern. CAGs audit report for FY2011 stated that internal audit is ineffective in 90% of LGAs, that the IT control environment is inadequate in 83% of LGAs, that Audit Committees are largely ineffective in 73% of LGAs and that there is no risk management framework in 53% LGAs.⁴⁴ The Dege report on the Health Sector Development Grant observed similar weaknesses, as to the functionality of the internal audit in LGAs, including the fact that they did not audit the HSDG.⁴⁵

The World Bank report notes that there have been some improvements. An amendment to the Public Finance Act in 2010 created the Office of the Internal Auditor General for Tanzania and he/she will have responsibility over internal auditors working in Local Governments. This should help improve their independence, professionalism and technical competence.⁴⁶ Internal Audit strengthening activities conducted by the USAID-

⁴³ These accounts are as follows: Own Sources Revenue Collection A/C, Other Charges A/C, Miscellaneous Deposit A/C, Development A/C, and Road Fund A/c

⁴⁴ World Bank Fiduciary Assessment

⁴⁵ Dege Consult. 2013. Evaluation of LGSP support for the Local Government Development Grant system

⁴⁶ World Bank Fiduciary Assessment



funded Wajibika project in collaboration with the Institute of Internal Auditors (IIA) Tanzania, focused on updating skills in risk-based auditing; procurement regulations; use of Epicor software; and current international practices in internal audit under the International Professional Practices Framework. Wajibika assisted the internal auditors to register with the IIA and encouraged them to complete professional courses that would lead to the award of the Certified Internal Auditor certificate.

An important challenge is that the IAG does not have formal authority over LGA internal auditors and the relationship is currently one of cooperation only, with communications channeled through PMO-RALG. Internal audit units produce quarterly reports and most, but not all, of these reports are copied to the IAG⁴⁷. The IAG is less successful in obtaining copies of annual audit plans, with only 39% of plans being received in FY2011-12.

Another challenge is the inadequate number of internal auditors in the LGAs. A recent USAID risk assessment of local government has highlighted internal audit as a major risk with shortage of qualified staff being a major handicap:

*'Understaffing of Internal Audit Department at the local level remains a serious problem for local authorities. They are unable to complete their work as is evidenced by the lack of comprehensive follow-up on serious issues identified in several districts...'*⁴⁸

Discussions with IAG staff completed as part of this assignment show that some LGAs have only one qualified internal auditor and inadequate support staff. Training and deployment of a larger number of internal auditors is necessary, but IAG can only offer advice to LGAs on increasing staffing levels because internal auditors are employed by the LGA itself⁴⁹ and the IAG has no direct influence over appointments. It is therefore important for PMO-RALG to work more closely with IAG to address the weaknesses in LGAs' internal audit as a way of improving financial control and accountability.

Recommendations:

- Formalize the relationship and the flow of information between LGAs and the IAG. This may require an amendment to the Local Government Finance Act to give the IAG more authority over local internal audit units.
- LGAs should be encouraged to fill any vacant Internal Auditor positions with adequately qualified staff
- LGAs need to strengthen their internal control systems, including the internal audit function.
- Every effort should be made to collect Own Revenue that goes uncollected every year due to poor LGA systems for planning and monitoring of revenue collection.
- All LGAs should have a risk assessment and fraud prevention plan in place.

⁴⁷ 103 districts reported in 2011/12

⁴⁸ 'Summary Report on the Tanzania Management Risk Assessment: Stage II', USAID, 2012

⁴⁹ Central government internal auditors are employed through the Government Employment Secretariat.



- LGA procurement management units need to be strengthened with training on all procurement regulations. Training should also be extended to the Councilors so that they are not a bottleneck to the approval process.

6.9 Human resources for financial management

This section provides a summary of the human resources for financial management at the PMO-RALG, regional and local government level. Overall, comparing the resource gap with requirements, there is a shortage in human resources for financial management in the order of 23.5% at the POM-RALG; 18% at the regional level and 32.7% at the local government level as the figures below illustrates. It is important for these positions to be filled in order to improve financial management and accountability at the local level.

6.9.1 PMORALG CENTRAL

The Department of Local Government at PMORALG has three sections: Local Government Finance; Local Government Human Resource Management; and Governance and Service Delivery. The health team are located in Governance and Service Delivery department.

The Local Government Finance section is headed by an Assistant Director Local Government (Finance). He works with a team of seven whose task is to evaluate financial management of the LGAs and support them to achieve better results. They are also responsible for ensuring that LGA planning and budgeting follows guidelines and ensuring that budgets are posted correctly in the accounting system. His team includes one person dedicated to finance reporting, another dedicated to planning and budget, and another dedicated to audit follow-up. He also has a staff member who monitors borrowing from commercial banks.

Table 22: PMO-RALG human resource for financial management at the 'Help Desk Support'⁵⁰

Position	Number required	Filled positions	Gap
Technical Support	5	5	-
Application Support	12	8	4
Total	17	13	4

Source: PMO-RALG

Table 23: Regional level human resources for financial management

Position	Number required	Filled positions	Gap
Technical Support(CSA)	25	23	2
Application Support(FMO)	25	18	7
Total	50	41	9

Source: PMO-RALG

The Financial Management Officer (FMO) in the RS is responsible for supervising councils and advising on all matters to do with financial management. However, these FMOs are usually junior staff who do not carry much weight with the council treasurers

⁵⁰ Financial management help related to Epicor and PlanRep

due to their inexperience. Under LGRP2, there were Regional Technical Advisors (RTA) with financial management skills at all regions. However, after the program was discontinued due to problems and a "negative audit report" (authors could not get details of this) the role of RTAs has ended. The RTAs were attached to Local Government Management Services reporting to the RAS, and were in post until 30th June, 2013. It is impossible for his team to visit all of the LGAs. Now that the RTAs have gone there are only Financial Management Officers (FMOs) but they are relatively junior and often graduates fresh from college.

Table 24: LGAs human resources for financial management

Position	Number required	Filled positions	Gap
Council Treasurers	167	133	34
Accountants⁵¹	835	532	303
ICT staff	164	120	44
Total	1,166	785	381

Source: PMO-RALG

Some of the new councils do not yet have council treasurers. This is a critical position that needs to be filled quickly in all councils. All council treasurers have not been trained in Epicor 9.05. Since they are responsible for guiding the implementation of the system in their council, they should be given priority in training.

Recommendations:

- Restore the RTAs (or something similar position) staffed with people who have financial management skills and demonstrated experience.
- Include qualified accountants in the design of Epicor in the ICT team to advise on the most appropriate reports and other features to be included in the on-going customization of the software.
- Fill all council treasurers and other senior staff positions that are currently vacant.

⁵¹ Each LGA is required to have a minimum of 5 accountants. Most of the shortage in accountants is in the newly created LGAs – about 34 in the past 4 years.



7. Financial management systems at the district hospitals

7.1 Financial management framework

District Hospital financial management is under the control of the Council Treasurer. He seconds account staff to the hospital to carry out bookkeeping tasks. The hospitals operate the Epicor software in line with other Council departments though transactions are entered into the system only at the Council accounts offices. Since the hospitals do not have direct connectivity to the network, hospitals are subject to the same internal and external processes as the described earlier. They are not distinguished from other departments of the council.

This report does not cover the DDH, but only the public ones – e.g. publicly funded and managed. However, some well-managed DDHs could serve as learning centers to the public ones to demonstrate the benefit of good management practices. In Box 4 below, Sengerema DDH is presented as an example of a hospital that has made improvements in its HMIS and improved its quality of care for patients as well as its revenues.

7.1.1 PLANNING

Planning at the regional hospital is guided by the RHMT, while at the district hospitals and lower facilities this is the responsibility of the CHMT. District hospital plans are part of the CCHP and are the responsibility of the DMO and CHMT. The hospitals prepare their plan in PlanRep3 and submit them to the District Planning Officer who incorporates this into the CCHP.

Individual initiative from hospital management and support from partners can make a significant difference to a hospital's financial management. The same applies to other hospitals, district and regional in that the quality of management determines the quality of systems that are developed or how existing, government regulations are implemented. A key issue that comes up in hospital plans is the need for training in financial management for the hospital managers as well as the supervisors, e.g. RHMT and CHMT.



Box 4: Introducing the HMIS: The case of Sengerema hospital, a Designated District Hospital

Sengerema District Hospital has increased its financial management efficiency thanks to a digital hospital management system. Patients are quickly assisted and know rates for services and obtain early results. This program is supported by the International Institute for Communication and Development (IICD) and Cordaid as part of the Connect4Change consortium.

During the first phase of implementation, with the support of IICD, some key staff in the hospital were trained and computers already being used in the administration offices to create schedules for nurses and computers were placed in an Internet café in the hospital. This allowed staff to become familiar with computers. Then, about two months before introducing the HMIS, 40 staff members were trained for two weeks in basic ICT skills. The benefits of HMIS in the hospital can be summarized as follows:

- Reduced patient waiting time due to expedited file retrieval.
- Patients understand what they pay for. Now Pharmacists have a general price list and do not need to rely on estimated prices as they did in the past. With the digital system, errors are virtually impossible to make in billing. All products are priced in the system and patients now receive digital receipts.
- The digital system has improved financial management and administration. Before the introduction of the digital system, the hospital had to deal with patients not paying for their treatment and or medications due to poor communication between the registering office, the laboratory, the pharmacy and the billing departments. The hospital lost a significant amount of money every day. Now, it is not possible for a patient to walk out without paying for services.

Since the first day of the digital system introduction, the system has proved its value. The hospital has increased its daily revenue from less than half a million Tsh. per day (about US\$ 340) to Tsh. 1.2 million per day (US\$ 800). This additional money can be used for new hospital equipment, supplies, maintenance and to further improve the hospital's general financial sustainability.

Future: Nurses-to-be and other students also learn to use the system

The Sengerema district hospital is also the home of a nursing college and a clinical officer's college. In the future, the nurses and clinical officer students will be able to learn to work with a HMIS before they graduate so that they can apply the same skills to their new jobs.

IICD and Cordaid provide operational and financial support for this project through the Connect4Change consortium.

7.2 Staffing for financial management

Financial management staff at hospitals are confronted with similar challenges as the LGA. A common complaint at both the LGA and Regional level was the low capacity for financial management with poorly trained Internal Auditors (many had not yet been trained in Epicor). In addition, CHMT and RHMT also did not have the skills to supervise financial management functions, especially planning and budgeting. Professionally qualified accountants are normally not assigned to hospitals. Although, in the hospitals visited, some of the heads of finance had a bachelor's degree.



The inconsistent availability of Council Health Services Boards at the Councils and Hospital Governing Boards at the regional level further weaken the financial management oversight. Hospitals rely to a large extent on the irregular internal audits (if they happen at all) or the external audit by the CAG.

7.3 Financial resources and utilization

Hospitals have regular meetings of their senior management (usually weekly). However, there was no clear indication from any of the hospitals the team visited that they complete analysis of financial or health data to inform their decision-making. For example, in Temeke Hospital, the HMT holds weekly, monthly, and semi-annual financial management reviews that include the hospital management, accounting staff, and heads of department to review income and expenditures. However, these meetings do not review efficiency reports to examine how the hospital is using its resources.

Some hospitals do use their Therapeutic Committee to monitor the use of pharmaceuticals, but this appears to be at the discretion of each hospital management team and is not a requirement enforced by PMO-RALG or by MOHSW.

User fees charged to patients are monitored weekly or monthly by the HMT by comparing revenues as recorded by the Cashiers with the amounts recorded in the departments that rendered services. From time to time, internal Auditors also perform audits of revenue collections.

7.4 Use of integrated financial management systems

Hospitals are using the Epicor and PlanRep3 tools and experience similar challenges as the Councils.

Recommendations:

- Identify well-managed hospitals (DDH or public) and use these as learning centers where other hospital managers can observe financial management systems that work.
- Hospitals are not sufficiently analyzing revenues and expenditures to assess their efficiency. Some basic analysis, for example, of revenue collections against volume of patients can be easily completed with minimal skills. The Hospital Reform Team should look into developing a simple analysis templates that hospitals can apply on a regular basis to improve revenue collections, as well as review key expenditure items.



8. Regional Health Management

8.1 Overview

The management of health services at the regional level is the responsibility of the Regional Medical Officer (RMO) who heads the Health and Social Welfare Section and reports to the Regional Administrative Secretary (RAS). The LGA Management Services Section is relevant to the financial management at the regional level and is responsible to, among other things: “advise and facilitate proper use of public finances in LGAs; build capacity and promote good governance in LGAs; take part in routine inspection of LGA performance...; assist LGA budget preparation and expenditure.”⁵² The FAU and the Internal Audit Unit are also directly involved in LGA financial management.

8.2 Health funding

The sources of funding for health at the region are:

- The Recurrent budget of the RAS.
- Health Basket for RHMT.
- Funds held at MSD. The RMO is notified by MSD (by e-mail) when funds arrive. MOHSW does not notify the RMO in advance to know what to expect, though according to an RMO interviewed, this would be helpful. The RHMT agrees with Hospital director on how to spend the MSD funds.
- Cost Sharing. This is controlled by the Hospital/RHMT and is in two parts: the NHIF and Direct Fees. The money is banked in the Sub-Treasury account. It is controlled by the RMO and can be spent from there at his discretion, although there is a general agreement from the RAS on how it should be spent.

8.3 Regional hospitals

The regional hospital is managed by a Hospital Director who reports to the RMO. A Hospital Governing Board provides further oversight. However, these boards are not always functional.

8.3.1 PLANNING

Planning at the regional hospital is the responsibility of the RHMT, under the supervision of the RMO. Regional Hospitals prepare an annual Comprehensive Hospital Operational Plan that forms part of the tools for implementing the five-year health strategic plan for the region. Regional hospitals visited during this study had their

⁵² The functions and organization structure of the Regional Secretariats (approved by the President on 3rd June, 2011).



FY2011-12 CHOPs available. The CHOP includes what (on paper at least) is a serious effort to prioritize interventions according to laid down criteria. The Comprehensive Hospital Operating Plans for Kilimanjaro Region (Mawenzi Regional Hospital) followed the following criteria to decide what should be funded: magnitude, severity/danger, feasibility, cost of intervention and political expediency.

8.3.2 FUNDING

The sources of funding for health at the region are:

- Funds held at MSD. The RMO is notified promptly by MSD (by e-mail) when funds arrive. However, the MOHSW does not notify the region of the funds that have been allocated in advance, though this would be helpful so that they know what to expect. The RHMT agrees with Hospital director on how to spend the funds. The funds are never sufficient for the hospital's needs and are always used by the end of the period.
- Cost Sharing. This is controlled by the Hospital and the RHMT and is in two parts – the NHIF and Direct Fees. The money is banked in the Sub-Treasury account. It is controlled by the RMO and can be spent from there at his discretion, although there is a general agreement from the RAS on how it should be spent. Reports on collections and balance available are obtainable from Epicor.
- Project funding: There are some Projects, including USAID HIV/AIDS Care and support and Tunajali, which reimburse certain expenditures after they are made by Hospital.

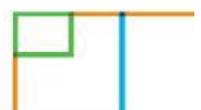
8.3.3 HUMAN RESOURCES FOR FINANCIAL MANAGEMENT

An Accountant seconded from the ACCGEN Common Service serves the RMO and the Hospital. The accountant has a team of four according, including three accountants and an accounts assistant. Most of the team are graduates and at varying stages on their studies for the Certified Public Accountant (CPA) qualification.

8.3.4 FINANCIAL REPORTING

The hospital receives reports from Epicor but the accountant does not have direct access to the system. In Dodoma Hospital, if the accountant wanted reports she had to go to the main ICT Department in another building, and they printed the reports for her. While she did not consider this to be a major inconvenience, it would be very helpful if she had report reading/printing Epicor access in her office. The main reports produced include: the itemized commitments and expenditure report by fund category, which shows, against each Bank Account, cost centers and line item; budgets; commitments; expenditures; budget balance; and funds (cash) balance.

Due to the limitations of the reporting module in Epicor, coupled with lack of direct access to the system, accountants also use Excel spreadsheets to manage transactions from day to day. This also helps to keep track of balances even when the Epicor system is down, especially due to network bandwidth problems.



8.3.5 OVERSIGHT

The inconsistent functioning of Hospital Governing Boards at the regional level weakens financial management oversight. Hospitals rely to a large extent on the irregular internal audits or the external audit by the CAG.

Recommendations:

- Regional Accountant should have access to the Epicor system with authority to access the printing functions to avoid wasting time going back and forth between the hospital and the ICT department for reports.



9. Sector Institutional Framework and Coordination of Resource Management

9.1 Institutional Framework

The major difficulties in financial management and in financial reporting do not stem from the institutional framework itself, although it may be a minor player. They stem primarily from the cash rationing system; the limitations of computer systems; the insufficient capacity or skill set of employees; dysfunctional environments (for instance LGAs with no electricity or Internet); and poor communication

At the subnational level, the structure of financial reporting and financial management is sufficient. The district hospital reports through the LGA; the LGA receives funds from the Region and provide financial reports and implementation reports to the Region; and the Region reports to PMORALG. The central government Ministry has the mandate to receive and coordinate all such reports. This process is complicated by the multiple income streams received by LGAs, but they arise from parallel structures and projects that characterize the world of aid rather than the specific institutional framework of the health sector.

At MOHSW, the institutional framework is not a major culprit of poor performance. It is sensible for both recurrent and development revenues and expenditures to be reported through Ministry structures, and for the Ministry to take an interest in the activities, revenues and expenditures of those institutions that it supports financially (such as MSD and the central hospitals). Certain institutional issues within the Ministry serve as bottlenecks, such as communication between the FAU and DPP or the role of the DHS, but again the problems are not a result of the institutional framework itself. Similarly reported difficulties of the reporting relationship between MOHSW and PMORALG seem to be issues of overlapping mandates or poor communication (to the extent that MOHSW does not receive all the financial information on health available to PMORALG). Recent efforts to strengthen PMORALG with the posting of the former CMO to serve as DPS Health, will improve communication and the needs of the health sector for stronger financial flows and more performance information.

It would be an overreach to suggest changes to the institutional framework based upon the challenges that we find in financial management and financial reporting, which represents one part of the whole. Assessment and modification of the institutional framework will require an extended analysis and a multi-disciplinary approach.



9.2 Monitoring and evaluation of revenues and spending

Monitoring and evaluation of revenues and spending of health resources is carried out at many levels and in all health institutions, including the central MOHSW and PMORALG central, regional and district hospitals, executive agencies such as MSD and TFDA, and the LGAs. Many of these reporting mechanisms are referred to elsewhere in this paper, but they include:

- At an operational level, the day-to-day monitoring of revenues and expenditures through ad hoc reports for managerial purposes, such as the weekly reporting of revenues at hospital management meetings, or the production of itemized reports of expenditure from Epicor to establish the day-to-day budget position.
- At a slightly more formal level, the Accountant General produces “Flash Reports” from the Epicor IFMS within two weeks of the month end.⁵³ The flash reports provide expenditure information for each vote (i.e. Vote 52), but not by sub-vote or economic classification. They are mainly for cash management purposes.
- Almost all health institutions are understood to produce quarterly financial reports, including both revenue and expenditure. This was certainly the case for the central institutions visited by the team (MOHSW, MSD and Muhimbili Hospital). The LGAs are also required to produce quarterly financial reports (although some fail to comply) as are the development projects.
- In addition to the quarterly financial report, MOHSW produces a quarterly implementation report showing expenditures against activities set out in the MTEF.
- Further monitoring of revenues and expenditures and the underlying systems is carried out through the internal audit activity described above.
- All health institutions produce annual financial reports with both revenue and expenditure that are in turn audited by the CAG. Procurement is also audited under the auspices of the PPRA.
- Global Fund projects are monitored through Global Fund financial reporting procedures on the standard Project Update and Disbursement Report (PUDR), which is in turn monitored by the Local Fund Agent (LFA) of the Global Fund. In addition to any audit by the CAG, Global Fund spending is also audited by the Global Fund’s own Office of the Inspector General.
- The various Audit Reports and their recommendations are monitored by the Audit Committee of the relevant institution (the Audit Committee of the MOHSW met three times in FY2012-13) and also by the Health Basket Audit Sub-

⁵³ Flash reports capture the original approved budget (or revised budget), cumulative exchequer issues (authority to spend), cumulative funds allocation (commitments), balance of unallocated funds (exchequer releases less funds allocated) and actual expenditure incurred to date and in the previous month. The balance of unallocated funds (the ‘free’ balance) represents the scope for managing the budget for the remainder of the year.



Figure 7: Health financing and financial management

committee. They are also monitored by the Public Accounts Committee of Parliament.

- There is no real possibility for public monitoring of health sector spending or revenues since these data are not displayed on any Ministry website nor made public. The annual PER conducted by MOHSW could be used more effectively for monitoring health spending and making the public more aware of the use of health resources.
- Every year a PER of the health sector is completed and produces information on health financing in standard categories: health spending as a percentage of total government spending; budget and spending by economic classification; budget and spending by program; budget and spending in recurrent and development; budget and spending by region; and budget execution rates. It is a very useful document but could usefully be extended to:
 - Provide greater analysis of third party spending under the recurrent budget.
 - Explicitly present the Recurrent Budget execution analysis as budgetary execution (percentage of budget released) and financial execution (percentage of releases spent).
 - Include an analysis of value for money, similar to the 2010 health PER conducted by the World Bank.

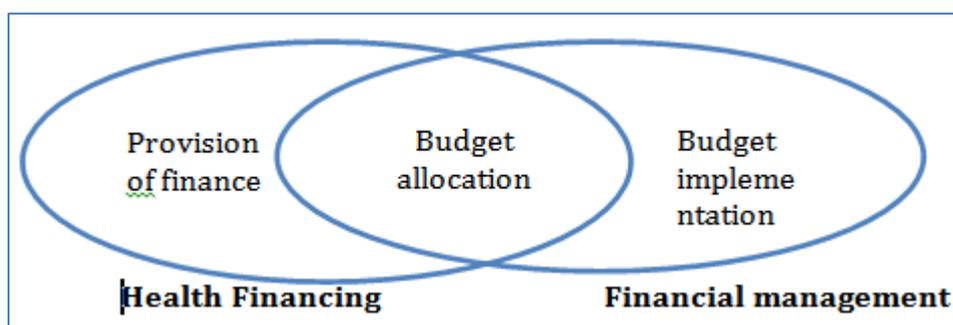
The challenge confronted in Tanzania is not so much the absence of reports but the distribution of reports and data (both on the public website but also internally to relevant stakeholders), and a lack of customization of the reports to country specific needs (e.g. some small changes to the Council Financial reports might ensure a more complete summary of financial data for the health sector).

9.3 Monitoring of financial management in HSSP and Annual Plans

Financial management and reporting are included in the HSSP in Section 4.5 as Strategy 5L Health Care Financing. There is logic in including health sector financial management and reporting as part of health care financing. However, in practice they are distinct but overlapping areas, each of considerable importance in its own right. Health financing is concerned with the effective *provision* of health finance. This is not limited to the identification, quantification and analysis of sources of finance. It extends to the allocation process, exploring the financing of the separate components of health sector activity, commenting on resource allocation systems and formulas.

For our purposes we may distinguish financial management from macroeconomic management, and consider it to cover both areas of *allocative* and *operational* efficiency. Thus there is an overlap as shown in Figure 7.





In general, Health sector financial management is given minimal attention in the HSSP. There are 5 health financing strategies:

1. Reduce the budget gap by mobilizing adequate and sustainable financial resources.
2. Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015.
3. Improve equity of access to health services.
4. Improve management of complementary funds raised at local level.
5. Increase efficiency and effectiveness in use of financial resources.

Of these five strategies, only two relate directly to financial management as described above, and one of these (number 4) relates to the management of a very specific and relatively small area of funding. Increasing efficiency and effectiveness in use of financial resources is a huge undertaking that could have much more prominence within the HSSP. In the two pages of text that accompany Strategy 5, there is only one line that addresses this fifth strategic point at the foot of page 32:

"Budgeting, accounting and auditing processes will be strengthened in coordination with PMO-RALG and MOFEA, leading to transparency in health care financing."

There is only one indicator for this component: the percentage of MDAs and LGAs with clean auditing reports. We applaud the use of audit reports as a measure. It has some clear advantages such as simplicity and ease of accessibility of data, but this particular variation of the indicator has difficulties as well:

- It does not reflect the disposition of health sector funds, because it is completely unweighted, with MOHSW accounting for something in the region of $\frac{1}{2}$ of one percent of the outcome. This is in spite of the fact that MOHSW manages more than 50% of the resources.
- Audit qualifications in LGAs may arise from issues unrelated to the health sector.
- It does not take account of the role of other elements of government in health sector financial management.



- In practice, it is interpreted simply as the percentage of LGAs with clean audit reports and thus reinforces the relative neglect of central financial management issues.

Recommendations:

- A revised audit report indicator that separates out MOHSW, MSD, Central Hospitals (weighted percentage) and LGAs (unweighted percentage). This would separate the "pure" health institutions from the LGAs. It might then be possible to develop an overall weighted indicator based on the expenditures of each institution, using total health expenditures of LGAs for their weighting.
- A procurement indicator based upon PPRA reviews and appropriately weighted.
- Rates of financial execution (that is to say, spending as a percentage of resources received). This is more appropriate than the percentage of budget spent, since budget is not always released. However, this may still be affected adversely by factors outside health sector control, such as the late release of funds.
- Some important areas of financial management do not lend themselves to indicators and should be monitored qualitatively. These include follow up of audit recommendations and improvements in financial reporting. Indicators could be developed to be followed up at a lower level than the HSSP itself, such as within a Health Sector Financial Management Improvement Plan.



10. Value for Money

Value for money is central to health policy and the delivery of healthcare. The MOHSW recognizes the need to monitor it as part of its accountability to stakeholders for investments in the health sector. Value for money seeks to ensure that resources available to the health sector are procured, managed, and used in a manner that leads to the efficient achievement of health goals. Specifically, value for money looks at:

- **Economy:** inputs have been procured at the lowest cost for the best available quality.
- **Efficiency:** inputs are used to achieve maximum value of outputs.
- **Effectiveness:** the best program outcomes are achieved in relation to the total cost of inputs,

Based on the areas that have been assessed in this paper, we highlight the key value for money issues.

10.1 Economy in procurement

A Midterm Review conducted in the Dodoma region in 2012 showed that there were no common guidelines for procurement; that it was difficult to comprehensively trace alternative procurements from the council level; that prices were higher than those of MSD and not-for profit suppliers; and that performance of pre-qualified suppliers varied in terms of quality assurance, availability and supply lead time (MTR 2013). The Midterm Review notes the need to continue to strengthen procurement capacity of the decentralized levels. This is a mutual responsibility of MOHSW (providing technical support) and PMO-RALG. However, local governments are ultimately accountable for pharmaceutical management in their jurisdiction.

10.2 Efficiency in service delivery

Many Ministries of Health are familiar with financial audits (both internal and external) of their transactions. They use financial audits to ensure that their spending complies with government regulations. However, financial auditing does not look at the nature of a transaction in light of the goals and objectives of the organization that makes the expenditure in order to establish a greater level of accountability that goes beyond compliance with procurement regulations. Performance auditing serves this function by examining how a financial transaction contributes to the goals and objectives that the organization is working towards. It aims at checking the economy, efficiency and effectiveness of spending as an organization tries to accomplish its goals.

According to the published reports of the NAO, performance audits have been conducted twice in the health sector for primary health care and maternal health care.



The purpose of the primary health care performance audit⁵⁴ was to review whether health centers are managed efficiently and whether their performance is appropriately considered when allocating the available resources. The audit also focused on the performance of LGAs that are responsible for all matters pertaining to primary health care services. A key value for money finding was that health centers are not efficiently managed and are funded without proper consideration of service demands and performance. For example, out of 30 health centres reviewed, patient workload varied significantly. Workload varied from 1 to 23 patient visits per day per full time working staff. Only six health centers (20%) accounted for almost 50% of the total outpatient visits. Eighty percent of health centers had less than ten visitors per full time staff per day. This means that staff in these facilities were underutilized and hence financial and human resources were not used efficiently.

Similar findings were noted by the Service Delivery Indicators study where, among dispensaries, 14 (10%) delivered half the outpatient visits, whilst the 57 lowest output dispensaries (39%) managed only 5 % of the outpatient visits.

Quality of care as measured by the ability of clinicians to arrive at the correct diagnosis and treatment is also a cause for concern. Poor quality results in higher than necessary use of resources. For example, when patients have to suffer repeat visits to the health facility, they use staff time, diagnostic tests and drugs. In the service delivery indicators survey⁵⁵, clinicians in Tanzania's primary health care facilities reached the correct diagnosis, in an average of 57% of the cases. The share of clinicians who made the correct diagnosis for malaria with anemia was only 27%; for diarrhea with severe dehydration it was 29%. Inability to correctly diagnose some of the common causes of morbidity undermines value for money in service delivery. Similar studies were not available for higher level facilities. A similar study would be valuable to guide efficient use of resources in hospitals.

10.3 Efficiency in resource allocation

Planning and budgeting was covered in section 6.2. Using planning tools to ensure that resources are matched with burden of disease data in each council is a persistent challenge. Failure to plan and allocate resources to priority areas impacts the ability of the MOHSW to accomplish its goals because resources are not going to the most cost effective interventions.

Recommendations:

- The MOHSW should institute a regular review of performance of health facilities country-wide to assess value for money in service delivery, with particular emphasis on staff productivity using a few quality of care indicators (e.g. accuracy of diagnosis; prescribing patterns; availability of key pharmaceuticals).
- PMO-RALG, through the Regional secretariats should put more emphasis on performance issues in their monitoring of primary health care activities at the council level. This will call for the design of appropriate guidelines and training of members of the RHMT and CHMT.

⁵⁴ A performance audit on the management of primary health care: A case study of health centers. A report of the Auditor General of the United Republic of Tanzania. Dar Es Salaam. 2008.

⁵⁵ Service delivery indicators, Tanzania. International Bank for Reconstruction/Development World Bank. Washington DC. 2013



- The practice of performance audits should be conducted periodically to assess key program areas of the MOHSW and to determine how resource allocation and spending in those areas align with goals and objectives. Performance audits can be completed by the CAG as well as additional staff and external technical advisors with expertise in program evaluation.



11. Conclusions and Recommendations for improving financial management and reporting in the health sector

The GoT has made progress to initiate major PFM reforms which, if fully implemented, will create a reliable system for internal as well as external users. To date, Tanzania continues to face many challenges. The key areas that merit urgent attention are presented below:

11.1 Recommendations for MOHSW

11.1.1 FINANCIAL MANAGEMENT ENVIRONMENT

The environment for financial management and budgetary activity is a major factor in its effectiveness. This includes the quality of office space and the availability of filing space, as well as the availability of computer hardware, software, Internet, and e-mail. The offices of the FAU are sometimes cramped with three or four people working in a small space, and corridors and gangways are used for filing and storage. Some of this is undoubtedly inevitable, but reorganization and disposal of old documents may create a better working environment.

Recommendations:

- The FAU together with the DPP and Budgeting Section (and more widely MOHSW) should prioritize the development of an electronic office space using modern technology fully including:
 - Computer numbers/specifications to be assessed and where necessary replaced.
 - FAU staff and Budget Officers to have extensive training in Excel based upon a system whereby those who embrace it more completely can be selected for more advanced courses.
 - FAU staff and Budget Officers to have training in use of email as well as use of email storage software, and be assisted to establish email addresses where they do not already have them. The use of email storage software would compensate in part for erratic internet or limited connectivity since it would make it possible to read and write mails offline.
 - Finally, the establishment of group or departmental Dropboxes could make file sharing easier.



11.1.2 MAJOR TRANSFERS TO HEALTH INSTITUTIONS

Grants and transfers comprise 68% of the recurrent budget for FY2013-14, or 57% if transfers to health facility accounts at MSD are excluded. The top three items – Muhimbili, DDHs and Voluntary Agency Hospitals account for 60% of the FY2011-12 total.

Recommendations:

- The MOHSW engage a consultant to work with senior staff to determine the existing accountability arrangements in place for this large component of the recurrent budget. The review should cover at least the top eight recipient organizations that would represent over 90% of the transfers. The review should propose a process for ensuring strong accountability going forward, indicating the roles and responsibilities of key players including the Permanent Secretary, Director of Policy and Planning, the Chief Accountant and others.
- Explore the possibility of developing Service Agreements between the Ministry and these agencies, and ensure that there is adequate capacity for subsequent monitoring. Some agencies that receive grants from MOHSW, especially hospitals, also receive revenues and some may not be maximising their revenue possibilities.

11.1.3 DEVELOPMENT BUDGET

The development budget is dominated by external funds, especially the Global Fund and the Health Basket. Effective financial management initiatives can use this information to focus reform and value for money initiatives on major areas of spending.

In view of the huge sums of money flowing through donor-funded projects, a more detailed review of the management of development projects is needed to introduce a more formal process of financial scrutiny to highlight slow implementation, or to ensure that the resources are in place to enable implementation, and to clarify project financial management responsibilities.

Recommendations:

- For donor funded projects, all financial reports on Development Projects should be signed off by the Chief Accountant prior to release. The Chief Accountant should assure that all necessary reconciliations and verifications have been carried out.
- In terms of the development budget for central and regional hospitals, enhance revenue by having an Internal Audit examine central and regional hospital revenue collection patterns in relation to certain significant statistics, such as catchment area population; number of beds; number of outpatients or inpatients. The results should be graphed and examined for outliers.

11.1.4 ADEQUACY OF IFMS

The Epicor IFMS has significantly strengthened financial management in line ministries. However several weaknesses have been observed. First, IFMS is unable to record arrears because it only allows commitments for spending that has been authorized during the period. Second, it includes the recurrent budget in its entirety on a day-to-



day basis, but only part of the development budget, which comprised 49% of spending in FY2012-13. The Health Basket (9% of the Development Budget) is recorded fully on IFMS, but larger projects such as Global Fund make numerous payments off IFMS and record them on Excel spreadsheets. Third, the standard suite of reports for the Accountant General that aim to control and centralize reporting do not take into account the internal management requirements of line ministries. Furthermore, there is no flexibility to generate a customized report. Lastly, bank reconciliations cannot be performed on the IFMS.

Recommendations:

- Develop a transition plan to start using the web-based systems "thin client" to minimize bandwidth requirements and to extend usage privileges.
- Budget office in DPP should have access to IFMS so that they can produce their own reports. The lack of access may be a licensing issue. KPMG reported in the 2010 review of IFMS that there were "a total of 225 IFMS licenses installed at ACCGEN. However for the current year ACCGEN has paid for 554 licenses."
- Extend access to Epicor so that users can view reports. This would obviate the need for users to maintain duplicative Excel Cash Books.
- Due to the large number of Epicor users, propose the establishment of an Epicor Users Forum.

11.1.5 HUMAN RESOURCES FOR FINANCIAL MANAGEMENT

The current PFM structure of the GoT does not give adequate weight to financial management that is always managed by a "Unit." Even though the Chief Accountant has director status and is fully engaged in the management of the day-to-day requirements of the accounting process, the perception is that financial management is a less critical activity and the Chief Accountant a less critical player. Furthermore, there is no strategic view of financial management in the health sector – there is only a strategic view of health financing in the DPP.

Recommendations:

- Create a position of Director of Finance with responsibility for a Finance Department that would have responsibility for all the functions of the current FAU, but also for a strategic view of financial management, including sector inputs to financial management reforms. It is acknowledged that since this is a national structure there is little that the Ministry can do on its own.
- Group the DPP budgeting and FAU accounting functions relating to MOH's own funds (e.g. vote 52 under a Finance Director role), as is done in the private sector, in parastatal organizations, and in government departments in other countries.
- Give another DPP unit (e.g. the current policy unit, building on its current PER and NHA responsibility for the wider sector budgetary planning, value for money and expenditure efficiency tracking, supported by a strong data management and analysis unit.



- Fill the senior vacancies as soon as possible.
- Expand the role of the International Technical Assistant in Finance who is based in the Ministry and financed by Danida. His current contract will continue until 2014.

11.1.6 DEVELOPMENT BUDGET

The development budget has become increasingly important over time and the overall budget has expanded significantly. Actual spending on development managed by MOHSW has expanded from TShs. 56 billion in FY2006-07 to TShs. 186 billion in FY2010-11. In FY2013-14 the budget is TShs 471 billion.

Recommendations:

- A structure of Director of Finance supported by Chief Accountant (recurrent) and Chief Accountant (development) is easily justified. However, this may prove difficult to carry out in the present structure of government. In that circumstance, the option should be to have at least a Principal Accountant (recurrent) and a Principal Accountant (development) reporting to the Chief, with other sections reporting to them.
- In view of the recent and significant increases in the health budget, especially in the area of development, a review of staffing needs in the FAU would be timely.

11.1.7 EXTERNAL AUDIT

The Management Letter, which accompanied the financial statements for the year ending 30 June 2012, shows recommendations from previous years have not been dealt with, totaling TShs.71.2 billion. This is an important matter and the items identified require urgent resolution.

Recommendations:

- Prioritize and implement CAG recommendations. Ensure that the issues raised are correctly interpreted by stakeholders and that their significance is correctly assessed.
- Consider allocating a mid-level staff person to the resolution of audit queries to release the Senior Accountant Expenditure for her routine duties.

11.1.8 PUBLIC FINANCIAL MANAGEMENT REFORMS

Budget section responds to the MoF on budget and MTEF reform and FAU responds to ACCGEN on issues concerning the IFMS and IPSAS. The reforms are monitored by the Deputy Director Budget or by the Chief Accountant. PFM reforms at the sub-national level are managed by PMORALG. Whilst the Ministry may take an interest because such reforms may improve the information flow or strengthen budget execution for health, it is primarily an observer.

This lack of central coordination results in a missed opportunity to look at the financial management needs of similar institutions in the health sector, but differ from others



within a district (e.g. hospitals are likely to have more similarities to other hospitals across district boundaries than to schools within a district).

Although the Ministry is no longer a component of the central PFM reform program, there are many steps to strengthen PFM at the sector. The FAU could consider drawing together a summary of reforms, audit issues, staffing requirements, computer capacity reviews, trainings, etc. and bring them all into one annual PFM improvement plan under a focal staff member.

Recommendations:

- MOHSW, through FAU, needs to develop a PFM improvement plan that reaches throughout the sector and is consistent with PFMRP IV, but wider to embrace internal management objectives and follow up on audit recommendations.

11.2 Medical Stores Department

The Permanent Secretary of MOHSW is the Accounting Officer for MSD, and under the Public Financial Management Act has responsibility for the effectiveness of its accounting systems and internal controls.

There is one financial professional on the MSD Board, Mrs Monica Mwamunyange (MSD Financial Statements FY2011-12) with skills in finance and economics. Importantly, she chairs the meetings of the Audit and Risk Management Committee and attended four of their five meetings in FY2011-12, including all Extraordinary Meetings. However, the Finance and Administration Committee of the Board, which is responsible for oversight of financial management, human resources and administration does not have any member skilled in financial management.

There are three specific financial management issues adversely affecting the functionality of MSD. The first is the disbursement process, which tends to provide the health facility accounts at MSD with too little funding too late in the year. The second is the failure to reimburse MSD for the costs associated with the clearance, storage and distribution of goods received in-kind. The third is the absence of a strategy to prevent the erosion of working capital, which has undermined the ability of MSD to perform according to its mandate.

Recommendations:

- Implement the recommendations of the Special Audit report of 2012, the Plan of Action, and the Financing recommendations of the Strategic Review, especially:
 - Inclusion of the vertical programme handling charges in full in the MTEF and budget; paying the debt in full and putting in place procedures to ensure that future charges are paid within 90 days.
 - Ensuring that MSD has sufficient working capital, and carrying out a recapitalisation review.
- Strengthen the financial management representation on the Board with a professionally qualified accountant knowledgeable in financial management strategies for wholesaling and distribution operations.



- Financial analysis and business planning should form part of the Terms of Reference for the upcoming Danida-financed consultancy in support of MSD's new five year Medium Term Strategic Plan 2013-2018.
- In mature economies medicines are distributed to health facilities through private sector channels, and it is not known whether the GoT is planning such changes in the medium-term. In the meantime, and for as long as it is the central delivery vehicle, the MSD should be a strong and growing organization.

11.3 Muhimbili Hospital

On the whole, it appears that financial management at the MNH is strong with sufficient controls for revenues and expenditures. The CAG issued a clean audit report in FY2011-12, which is a positive indicator of adherence to government financial regulations.

In their preamble to the financial statements for FY2011-12, the Trustees of the Board note that the operating losses in the year and in the previous year result from shortfalls in subventions received against the budgeted amount. These losses have taken their toll on the liquidity of the hospital. MNH is aiming to maximize its revenues from hospital income and therefore monitors it closely. Possibilities to minimize losses are limited since 40% of patients are exempted under national regulations and prices have not been increased since 2009. It is understood that there is an Internal Audit report on revenue collection at MHN and that there has subsequently been a review of revenue management by PriceWaterhouse Coopers.

Recommendations:

- Findings of the internal audit and the PriceWaterhouse Coopers review should be processed by management and the Board. A monitorable and time bound Action Plan should then be developed (this may well be underway).

11.4.1 BUDGET EXECUTION – INABILITY TO SPENT BUDGETARY AND OTHER ALLOCATIONS

A major challenge at both the central and LGA levels is lack of capacity to use funds. The limited capacity to spend may be due to a combination of factors such as the late disbursement of funds, mostly in the third and fourth quarter of the fiscal year that derails effective implementation of plans; over-stretching staff that cannot implement extra activities; poorly supervision of employees; weak ICT systems; and inadequate familiarity with rules and procedures for the disbursement of funds thus delaying disbursement and expenditures.

During FY2011-12, a review of 38 Councils was made on the management of CHF operations. The assessment found that these Councils had unspent balances of TShs.1,709,747,559 which was mainly caused by not opening and operating separate accounts in respect of CHF and delays in release of the matching grants.



Recommendations:

- Councils should acquaint themselves with the regulations governing the operations of the CHF, including banking and spending rules.

11.4.2 PRIMARY HEALTH SERVICES DEVELOPMENT GRANTS

A test check by CAG on the financial performance and use of PHSDP funds received by Councils for improving accessibility and quality of the health service noted unspent balances of TShs. 2,586,057,984 in respect of thirty two Councils as of 30th June, 2012.

Recommendations:

- This is areas warrants close attention by all LGAs and follow up by MOHSW as well as PMO-RALG to ensure that the limited health resources are being used to achieve intended health outcomes.
- Supportive supervision by the RHMT should include primary health sector development grants in their menu of interventions during their supervisory visits.

11.4.3 TRANSFERS OF FUNDS

An analysis of the system of transfers indicates that it is overly complex, consisting of numerous different grants with different allocation criteria of variable transparency. Although elements of the transfer system have been designed with the intention of allocating resources to LGAs in an objective, fair and transparent way through the use of a formula-based approach,⁵⁶ these no longer appear to be working as intended. The formulas have not always being applied in a consistent and transparent way. The problems have been recognised by the MoF and a Mapping Exercise on Transfer of Funds to LGAs has been completed (MoF, 2013). The mapping exercise seeks to harmonize the multiple transfers and to make the system work in a way that adheres more closely to the principles of the formula funding that is currently in place.

Recommendations:

- Communication between the MoF, RAS and LGAs should be improved so that when funds are released, the information goes to the RAS as well as the LGA.
- MoF should aim to release funds in a timely manner and communicate delays to the RAS and LGA for their own cash flow planning.
- LGAs should aggressively follow up to plan for and use their unspent CHF funds.
- LGAs should develop systems for claiming and collecting from the NHIF.

⁵⁶ 70% by population, 10% by Number of poorer residents 10% by Council medical vehicle route, and 10% by Under-five Mortality. The allocations by LGA were subjected to the assessment results (100% for Very Good, 80% for Good, 50% for Poor and 50% for Failed).



- LGAs need to understand all procurement regulations and be able to do proper project and cash flow planning in order to minimize the unspent balances in their books.

11.4.4 EXTERNAL AND INTERNAL AUDIT FOR LGAS

In recent years, the number of LGAs that received a clean audit opinion has improved from 54% (72 out of 133 councils) to 78% (104 out of 134 councils) in FY2011-12. The continued poor performance by some LGAs is partly due to changes in accounting standards adopted by the GoT. Since FY 2009, all LGAs are required to adhere to the IPSAS. This requirement has exerted pressure on the weak human capacity in LGAs to fulfill the conditions of the IPSAS. In addition, only limited training has been provided to staff to implement accrual based accounting required by the IPSAS. LGAs have struggled to achieve minimal standards and basic procedures. For example, bank reconciliation remains an area of concern.

Despite the improved overall audit performance, the year's audit still included the following serious issues:

- Financial statements are not directly generated from the IFMS as they are supposed to be, resulting in the improper preparation and presentation of financial statements.
- Deficiencies in Internal Control Systems: As noted in previous years' reports, the internal control systems in some of the LGAs are not adequate owing to use of manual accounting system, ineffective internal audit units, and poor performance of the Audit Committee.
- Weaknesses in revenue management from own sources resulted in TSh 18.6 billion of uncollected revenue.
- In the audit report on LGAs for FY2011-12, CAG has expressed concern regarding the low level of compliance with procurement procedures, laxity in control over contract payments, poor supervision of LGA projects, procurements being made without Tender Board approval, the missing documentation in LGAs relating to procurement, and the manner in which several of the assessed LGAs ordered and paid for goods that were not delivered.

Recommendations:

- Formalize the relationship and the flow of information between LGAs and the Internal Auditor General (IAG). This may require an amendment to the Local Government Finance Act to give the IAG more authority over local internal audit units.
- LGAs need to strengthen their internal control systems, including the internal audit function.
- Every effort should be made to collect Own Revenue that goes uncollected every year due to poor LGA systems for planning and monitoring revenue collection.
- All LGAs should have a risk assessment and fraud prevention plan in place.



- LGA Procurement Management Units (PMU) need to be strengthened with training on all procurement regulations. Training should also be extended to heads of department as well as Councilors so that the councilors are not a bottleneck to the approval process.

11.4.5 INTEGRATED FINANCIAL MANAGEMENT SYSTEMS AND OTHER IT SYSTEMS

PMO-RALG has developed plans for improvement of the IFMIS. In 2012, the system was upgraded to Epicor 9.05. This has improved its functionality and addressed some of the concerns identified by the NAO and other evaluators. Epicor version 9.05 currently covers all Ministries, Departments and Agencies (MDAs), the 22 sub-treasuries and the regional administrations; as well as 133 LGAs. Recent creation of new districts has brought the number of LGAs to 167, of which 34 remain unconnected.

Despite much improvement of the IFMIS from previous versions, there are several challenges that have to be overcome to improve further financial management and control:

- Lack of human capacity to operate the IFMIS to its full potential.
- Inconsistencies in the allocation of responsibilities that constrain the efficient working of Epicor. Some of these inconsistencies result from differences in the provisions of the relevant legislation. The Epicor system is managed by the District Treasurer; Procurement Management Units are, according to the Public Procurement Act, supposed to issue LPOs after validation of the availability of funds, but most of them do not have access to Epicor.

Recommendations:

- Streamline organizational arrangements and the legislative framework to enable the IFMS to more fully achieve its goals.
- Use the Epicor system to register all commitments, including both multi-annual and annual contracts.
- Train all relevant LGA staff (e.g. District Treasurer; Internal Auditor; accounts staff; PMU staff) to use Epicor so that they can better manage and control finances.

11.4.6 FINANCIAL REPORTING

LGAs are required to prepare and submit the Council Financial Report (CFR) to the PMO-RALG on a quarterly basis. This report is also distributed to the MOHSW, but it appears that no action is taken to monitor spending on health. The CFRs have also tended to be of variable quality from one LGA to another and reliability of the information reported has been an issue partly because they are not reviewed by the council finance committee before submission.



Recommendations:

- The council finance committee should review the CFR and CDR before submitting to PMO-RALG to ensure that information contained therein is accurate.
- Share CFR and CDR with the public in a user-friendly format for added accountability.
- MOHSW should take a more active interest in health spending at LGA level and monitor it more frequently than during the annual PER.

11.4.7 HUMAN RESOURCES FOR PFM IN PMO-RALG, REGIONS AND LGAS

The Local Government Finance section is headed by an Assistant Director Local Government (Finance). He works with a team of seven whose task is to evaluate financial management at the LGAs and support them to achieve better results. The team is also responsible for ensuring that LGA planning and budgeting follows guidelines, and ensuring that budgets are posted correctly in the accounting system. The ICT team is responsible for the design and application of the Epicor software. However, design of the software does not currently include qualified accountants.

At the regional level, Financial Management Officers (FMO) are responsible for supervising LGA financial management. These FMOs are fairly junior and in many cases inexperienced. Until June 2013, there was a position of Regional Technical Advisor attached to Local Government Management Services reporting to the RAS, but this position was discontinued despite being one of the key support mechanisms for council PFM. In the council, council treasurers oversee financial management activities and are also responsible for developing capacity in the Epicor application with assistance from PMO-RALG ICT staff in Dodoma. Staffing at the regional and local government levels require strengthening, as there are some serious gaps.

Recommendations:

- Restore the Regional Technical Adviser (or a similar) position staffed with people who have financial management skills and demonstrated experience.
- Include qualified accountants in the design of Epicor in the ICT team to advise on the most appropriate reports and other features to be included in the on-going customization of the software.
- Fill all council treasurer and other senior staff positions that are currently vacant.

11.5 Regional and district hospitals

District hospitals are affected by the same financial management weaknesses presented above under the LGA. Regional hospitals reveal the need for management training for staff, as well as the RHMT that are supposed to supervise them.



Recommendations:

- Build management skills of hospital senior management. Particular attention should be placed on use of IFMS and the health information systems in decision-making, and especially in the control over resources and revenue collection.
- Identify well-managed hospitals (DDH or public) and use these as learning centers where other hospital managers can observe how financial management systems function and can be implemented.

11.6 Monitoring and evaluation

The systems of DPP and FAU in MOHSW, PMORALG and their equivalents in MSD, and hospitals constantly monitor financial management indicators; audits are the institutionalized evaluation process. This report outlines ways to strengthen these systems.

The MOHSW conducts annual PER and National Health Account estimations approximately every two years. National AIDS Spending Assessments (NASA) are produced periodically by TACAIDS. This is a laudable success that has not been accomplished by many countries in Africa. A plan for institutionalizing the production of these resource tracking activities is in place, though it needs to be updated and costed. To avoid conflicting messages, the MOHSW should adopt a more thorough definition of expenditures.

Recommendations:

- Use PFM data in strategic planning documents. Revise indicators to include financial management more fully. Options include:
 - A revised audit report indicator to separated "pure" health institutions from the LGAs. For example, MoHSW; MSD; Central Hospitals (weighted percentage); and LGAs (unweighted percentage).
 - An appropriately weighted procurement indicator based upon PPRA reviews.
 - Rates of financial execution (that is to say, spending as a percentage of resources received).
- Develop qualitative financial management indicators in addition to quantitative indicators. For example, provide audit recommendations and improvements in financial reporting. Indicators could be developed for the second of these to be followed up at a lower level than the HSSP itself, such as within a Health Sector Financial Management Improvement Plan.
- Update the MOHSW's resource tracking institutionalization plan to include clear definitions of expenditure indicators and possible data sources.

11.7 Conclusion

While many issues need to be addressed, PFM in the MOHSW and LGAs is in a process of improvement. The Ministry of Finance, MOHSW and PMO-RALG have been informed of the many challenges through evidence emerging from stakeholder studies and evaluations. To further improve PFM, the MOHSW needs to make consistent steps to



implement these recommendations, the most important of which are repeated in this document. In addition, the MOHSW needs to come to agreement with stakeholders on a clear plan to strengthen PFM. PFM is a cross-sectoral issue involving the MOF and PMO-RALG as well as development partners.



Annex 1: Terms of Reference

Financial management and reporting

1. Background

Tanzania is entering a new phase of health financing reforms based on those undertaken since the early 1990's. The first phase of reforms moved the Tanzanian health financing system from a purely budget financed system to a mixed financing model with the hope of increasing availability and quality of care. In this first phase, user-fees (in 1993), Community Health Funds (CHF's - from 1997 onwards) and the NHIF - in 1999 were introduced in order to leverage additional funds, build community ownership and create stronger accountability of service providers. The system now has countrywide coverage, albeit with low population coverage.

At the same time, Tanzania has gone through a period of decentralization with profound effects on the way budget financing works. Management and (partly) financing of social services, including primary and first level referral health care, moved to LGAs and a system of central-local intergovernmental transfers (Block Grants) was introduced, together with a pooled funding mechanism for donor funding (the Health Basket Fund).

A third development has been the overall increase in health expenditure. Total Health Expenditure (THE) increased from US\$734 million in 2002/03 to US\$1.75 billion in 2009/10 (NHA 2009/10). Per capita expenditure doubled from US\$21 to US\$41. A strong influence on this has been the large increase in donor funding, which grew from US\$200 million per year to nearly US\$700m per year (while the share of donor funding increased from 27% to 40%).

While these developments have helped to achieve very significant health gains by containing the HIV/AIDS epidemic, reducing Malaria and child mortality, and other successes, challenges remain. There is a large body of evidence that shows that spending from public sources, especially domestic, is still too low to finance a package of essential health services, user-fees are a barrier to access when coverage of pre-payment schemes is low, funding is not distributed equitably between and within districts, and the limited funds available are not used efficiently to achieve the maximum effect. Accountability and transparency can also still be improved.

In order to meet these challenges in an environment in which citizens demand more and better services, and in which development aid is declining, Tanzania is now embarking on a new round of health financing reforms that will build on the foundations of previous reforms, strengthen existing systems, and develop new approaches where needed.

In 2007, the Government of Tanzania adopted a *Health Policy* with the policy vision "to improve the health and well being of all Tanzanians with a focus on those most at risk [...]". This vision remains still valid, and the GOT is committed to moving towards *Universal Health Coverage* and to ensure that all citizens have access to quality services and be protected from financial risk. As part of *the Health Sector Strategic Plan III*, a decision was taken to develop a Health Financing Strategy (HFS) to ensure that this vision would become reality.



Oversight for the development of the Strategy has been given to the Inter-ministerial Steering Committee (ISC), comprising of key ministries and departments, to ensure that the proposed reforms are comprehensive, accepted and supported by all stakeholders, and implemented with the support of all stakeholders. To achieve this aim, the ISC has identified key areas for reforms and requested several reports to inform the development of the Strategy. These are:

1. Minimum Benefit Package(s): options to sustainably structure access to benefits;
2. Insurance Market Structure: options for the Social and Private Health Insurance architecture;
3. Performance financing: options for linking allocations to performance of service providers;
4. Equity-based financing: options for improving the equity targeting of (esp. budget) resources;
5. Inclusion of poor & vulnerable: options for identification and financing of services for this group;
6. CHF reforms: options for the re-design of the CHF system;
7. Private sector resources: options strengthening equitable funding from the private sector;
8. Financial management: options for improving accountability and timely availability of funds;
9. Innovative financing and fiscal space: options for increasing public financing for health;

Terms of Reference (TOR) have been developed and approved by the ISC for each focus area. This set of TOR guides the assignment in the area of **Financial Management and Reporting**.

2. Status of focus area

Tanzania has made large strides in financial management and reporting at both the national and local level through implementation of integrated financial management systems. In the mid nineties, the government embarked on undertaking Public Financial Management Reforms in which central payment system and cash budgeting was introduced. Consequently Epicor - *(a two-tier architecture computerized accounting system)* Integrated Financial Management System (IFMS) was introduced to capture approved budgets and track expenditure transactions both at Central and Local Governments. At the local level PLANREP was introduced. This is a planning and reporting Database which assists local authorities in: planning, budgeting, projecting revenue from all sources, tracking funds received, physical implementation and expenditure, and reporting.

While computerization of the financial management and reporting systems has improved resource management and accountability, the mingling of Basket funds, Block grant funds and funds from other sources has proved to be a big management challenge for all Councils. Planning has been guided by the central level through guidelines such as the Comprehensive Council Health Plan Guidelines, and autonomy in terms of priority setting is limited. Accounting and planning systems are still not sufficiently linked, and often accountants managing the health funds at the Council are not consistent with financial coding to appropriately account for the funds. Audit and other reports continue to identify weaknesses in a number of Councils' financial management and reporting, including: inappropriate allocation of resources, inefficient revenue systems, inequity and inefficiency in the use of health resources as well as weak delivery of vital public health care services. The central and local government with support from Development Partners are trying to address these weaknesses, including updating of management and reporting tools (Example from Platinum to Epicor which now has been



updated to version 9.05; Planrep 1 to the current Planrep3, introduction of Strategic Budget Allocation System (SBAS), etc). Overall, the system and institutional framework for management and reporting of health funds is improving, although much remains to be done to ensure cost effective, efficient and accountable management of resources.

3. Steering & Oversight

The assignment is aimed at informing the ISC, which will have the final say in all issues related to the process, assisted and supported by the ISC Secretariat and the TWG HF. The TWG HF will develop TOR, pre-select consultants and pre-approve reports for submission to the ISC. The ISC will give final approval of TOR, consultants and report. The financing organization will ensure that contracting and compliance with contractual obligations from both sides will be fulfilled. The ISC Secretariat will support on these issues.

4. Scope

The main focus of this consultancy will be to look at improved mechanisms for the management of health financial resources at both the central and local level, emphasizing particularly planning, budgeting, accounting and reporting at local government level and defining roles of stakeholders and implementers in both, management and oversight of health service delivery. In undertaking this assignment, the consultant(s) will focus largely on assessing processes and tools for management and reporting of health resources, including human resources thereof, and the improvements that may be needed to achieve greater efficiency, cost effectiveness and more responsible use and delivery of health resources.

5. Objectives and tasks

The overall objective of this assignment is to develop comprehensive, adequate and feasible reform strategies / options for the focus area on **Financial Management and Reporting** to be presented to the ISC for feeding into the Tanzanian Health Financing Strategy.

The specific objectives and tasks are as follows:

1. Review the processes and tools in place at central and local government for allocation, planning, budgeting, accounting and reporting of health resources, including identifying strengths, weaknesses and suggestions for strengthening management and reporting of health resources.
2. Analyse the institutional framework for managing and reporting health resources, identifying strengths, weaknesses and ways and means of improving the institutional framework. In this regard, clearly delineate the roles and responsibilities of various stakeholders, indicating where the gaps are and showing how the identified issues can be resolved to strengthen the system.
3. Review the health system financial resources coordination mechanism at central and local government levels, clearly identifying the main stakeholders. Undertake mapping of the health financing providers and suggest tools for future use.
4. Analyse issues related to health resource use efficiency and effectiveness (value-for-money) at the central and local level, clearly indicating how efficiency, and cost effectiveness, can be monitored given current information and how transparency and accountability can be improved.



5. Review in detail the information and communication technology (ICT) tools in use (Planrep, Epicor, etc) at the local government level for managing and reporting health resources from all sources; clearly indicating how the tools are working and gaps that have to be addressed (For example, it is alleged that there is no direct link between the planning tool (Planrep3) and budgeting tool (Epicor9), which reduces systems' efficiency).

6. Review human resources capacity for effectively managing and reporting of health resources at both the central and local government levels; clearly identifying strengths, weaknesses and ways and means of addressing the gaps identified. Issues related to equity in human resource allocation between districts should also be analysed because 'underserved' districts tends to exhibit weak planning and financial management outcomes.

9. Analyse financial management systems at the district and regional hospitals, identifying strengths, weaknesses and gaps that will need to be addressed to improve cost effectiveness and efficiency of service delivery.

10. Discuss the management and evaluation (M&E) system in place for monitoring revenue, spending and reporting of health resources, clearly delineating areas for better alignment, integration and improvement.

11. Provide a brief summary of three (3) to five (5) pages of the findings which may be included in the Health Financing Strategy.

6. Methodology

Field work to collect primary data will not be necessary for this assignment. The report will rely on literature reviews and key stakeholder interviews on financial management and reporting. The literature review will include Tanzania and other selected countries (to be proposed in the inception report).

The consultant should consider reviewing international best practices and experiences in the management and reporting of health resources.

7. Timeframe and Deliverables

The suggested timeframe for this assignment is February to mid-April, based on the assumption that the selection of consultants/firms takes place before Christmas 2012. The following table shows the timing at which deliverables are expected:

#	Deliverable	Weeks after signing contract
1	Inception report incl. report outline	2 weeks
2	Draft report	7 weeks
3	Presentation to ISC	10 weeks
4	Final report incl. executive summary	12 weeks



8. Professional requirements

At least two consultants are required for this assignment. There will be one international-level lead consultant with significant practical experience in financial management and one national health financing specialist. This team may be composed of two individually contracted consultants (in which case the lead consultant will approve the national consultant for contracting, and clear his/her contributions for payment by contractors or by a consultancy firm.

Lead consultant	
Profile	<ul style="list-style-type: none"> • Masters degree in a relevant field (Health Systems, Financing, or Economics; Public Health or Medical degree with a relevant financial management specialization). • A minimum of 10 years of work experience in health financing and management work. • Work experience on health financing reform in several low- and/or middle income countries, especially in Sub-Saharan Africa. • Familiarity with the Tanzanian health financing system is a strong asset. • Excellent analytical skills • Excellent report writing skills.
Tasks	<ul style="list-style-type: none"> • Report to the ISC and the contracting party and take responsibility for work outcomes. • Coordinate the report writing and present to the ISC. • Manage and coordinate the specialist consultant. • Clear specialist consultants' contributions for payment by contractor.
National consultant Health Financing	
Profile	<ul style="list-style-type: none"> • Masters degree in a relevant field (Health financing, economics, public health with relevant specialization). • A minimum of 5 years of work experience in a relevant field (including health resource management, MoHSW, health systems and health financing research) • Excellent knowledge of the Tanzanian health financing and resources management system and recent reforms. • Connectedness in the Tanzanian financial management ministries, departments and agencies (MDAs), especially MoHSW, Ministry of Finance, PMO-RALG). • Good organizational skills. • Good report writing skills. • Excellent command of English and Kiswahili, written and spoken.
Tasks	<ul style="list-style-type: none"> • Report to the lead consultant. • Assist the lead consultant in planning, managing and implementing



	<p>activities, especially during interviews and stakeholder consultations.</p> <ul style="list-style-type: none"> • Collect all relevant health financing, management and reporting documents. • Provide written inputs for the report in the field of specialisation.
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9. Relevant materials

Relevant materials include:

- NHA 2009/10 (MOHSW 2011)
- Health Sector PER – various editions (MOHSW 2011)
- Tanzania Health Systems Assessment (MOHSW with HS2020, 2011)
- (Draft) Health Financing System Analysis (TWG HF 2012)
- Making Health Financing Work for the Poor (World Bank 2011)
- SHIELD reports (IHI, various years)

Relevant materials for the focus area include:

- Ministry of Finance: 'Public Financial Management Reform Programme Strategic Plan (PFMRP), June 2008
- PMO-RALG: 'The road map implementation of integrated financial management information system – Epicor in local government authorities, March 2011
- PMO-RALG: 'Change management material for Epicor 9.0'
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- Local Government Finances and *Financial Management in Tanzania: Empirical Evidence of Trends 2000 – 2007*' Special Paper 10/2, Dar es Salaam, (REPOA)
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