TANZANIAN HEALTH SECTOR BUDGET ANALYSIS

2005/06 – 2011/12

November, 2012

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By

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LIST OF ABBREVIATIONS

ADF	Africa Development Forum
AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
CIDA	Canadian International Development Agency
FY	Financial Year
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HSPP	Health Sector Performance Profile
HSSP	Health Sector Strategic Plan
MDAs	Ministries, Departments and Agencies
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
NEPAD	New Partnership for African Development
NSGRP	National Strategy for Growth and Reduction of Poverty
ODA	Official Development Assistance
PMO – RALG	Prime Minister's Office – Regional Administration and Local Government
RAS	Regional Administrative Secretary
SADC	Southern Africa Development Community
TB	Tuberculosis
TDHS	Tanzania District Health Service
TZS	Tanzanian Shilling
WHO	World Health Organization
YoY	Year-on-Year

EXECUTIVE SUMMARY

Tanzania and other African countries ratified the Abuja Declaration (2001), which requires the signatories to allocate 15 percent of the total government budget towards the health sector. Ten years later, Tanzania has not made any progress towards achieving the 15% target. In the fiscal year (FY) 2011/12, the Tanzanian government has only allocated 8.9 percent of its total budget to health. While the international commitment was made to improve the wellbeing of Tanzanian citizens, the government's commitment to refocus its own resources to health have not been put into practice as the local funding to health has been increased at a slower pace compared to foreign funding. The aggregated health sector budget estimates have increased by 176 percent from the FY 2006/07 to 2011/12, of which local and foreign resources grew by 103 percent and 358 percent, respectively. The health sector's dependency on foreign assistance has, thereby, increased from 29 percent in FY 2006/07 to 48 percent in FY 2011/12. This development puts the social wellbeing of Tanzanian citizens at risk as development partners might withdraw their support as they have repeatedly expressed their dissatisfaction about the country's development performance.

The improvement of the citizens' social wellbeing heavily depends on the activities of Local Government Authorities (LGAs). For that reason, our study examined how equitably the resources are distributed among the districts with respect to needs. Tanzania adopted a resource allocation formula in 2004, which uses four criteria to determine the distribution of resources among LGAs. From the total amount of resources, 70 percent are spent with regard to districts' population levels, 10 percent according to their under-5-mortality, 10 percent account for the poverty level and 10 percent are distributed with respect to the mileage covered by medical vehicles. We analyzed the health block grant allocation towards 112 districts from 2005/06 to 2010/11 and found that the formula has not been used during that period.

In order to promote the sustainable social wellbeing of Tanzanian citizen, the government needs to provide sufficient funds and distribute them equitably. Serious political commitment in form of more local resources is necessary to achieve the Abuja target of 15%. To ensure that all citizens receive health service according to their needs, the Ministry of Finance needs to apply an updated resource allocation formula and take the dynamics of the used criteria adequately into account.

1 INTRODUCTION

For the past 6 years, Sikika has been analyzing the health sector budget by giving objective recommendations to the government on areas where it could make improvements and by occasionally commending it for good decisions that improve health services for the Tanzanian citizens. Like in the previous years, budget information has been gathered and analyzed to give advice to the government. The main documents that were used include the budget books volume II – IV, the Medium Term Expenditure Framework (MTEF) of the Ministry of Health and Social Welfare, the Health Sector Strategic Plan, the National Health Policy, the Constitution of United Republic of Tanzania, and local and international health sector reports.

In the year 2012, our analysis addresses two fundamental issues that concern the health services in the country. First, it provides an overview of the resources allocated for health over the duration of the past 10 years with respect to achieving the Abuja target of allocating 15% of the total government budget to health. The second objective is to analyze the distribution of resources to the Local Government Authorities to ensure equity in the provision of services through the use of a resource allocation formula.

Chapter one provides an introduction to the Tanzanian health sector considering the sources and distribution of funding across the government. The analysis and findings will be presented in chapter two and three by focusing on the Abuja declaration and the equitable distribution of resources across districts. Conclusions and recommendations of the study will be presented in chapter four.

Tanzania's Health Sector Service Delivery Structure

The health status of any country is influenced by both demand side and the supply side variables. Our analysis focuses on the supply side and includes the budget allocation, governance of the health sector and policy objectives. The forms and patterns of health financing will determine the effective provision of services and the achievement of policy objectives.

Tanzania's health system is characterized by two levels: the central government which is comprised of Ministries, Departments and Agencies (MDAs) and Local Government Authorities (LGAs). The central government is formed of the appointed officials, politicians and technical administrative personnel who are responsible for formulating the sector's policy, defining priority areas of intervention, preparing the medium term plan, overseeing the sector's development and providing assistance and directives to the Local Government Authorities to ensure the fair provision of quality health services to all citizens.

Actual service delivery is provided by (sub-national) LGAs, which have the responsibility of promoting social development and facilitating service delivery (health,

water, infrastructure development, education, etc.) to the citizen within their areas of jurisdiction. They consist of the elected councillors, service committees and technical administrative personnel. The financing for the services that are rendered by the local councils is done through a top-down distribution of funds which flow from the central government to the local authorities. The Decentralization-by-Devolution policy[1] envisages sustainable development, transparency, commitment and community empowerment by promoting higher participation of the community throughout the budgeting processes. Despite existing achievements in the reform process, most decision-making concerning how money is to be spent still lies within the central government's authority.

The Government Health Block Grant

Tanzania's health sector is financed through a very complex system which is comprised of different sources of funds and transfers from one government level to the other. This study does not discuss the complexity of health care financing. It rather examines the health sector's overall budget allocation and the health block grants that are allocated to the Local Government Authorities (LGAs). However, for the benefit of the reader, the following paragraphs will briefly highlight the health sector's financing modalities.

The spending units in the government receive funds through budgeting votes.[2] With regard to the central level of the health sector, the main spending votes are the Ministry of Health and Social Welfare (MoHSW), which is funded under Vote 52, and the Prime Minister's Office–Regional Administration and Local Government (PMO-RALG), which is funded under Vote 56. The government's budget is categorized by recurrent expenditures, which cover "personnel emoluments" and "other charges", and by development expenditures. Funds are disbursed to the spending votes by the Treasury after the approval of the budget estimates by the Parliament.

There are multiple funding mechanisms for the health sector which are characterized by differing sources of funding and varying modalities of resource flows. At the central level, all Ministries, Departments and Agencies are funded through their votes by government revenues and General Budget Support (GBS) for both their recurrent and development expenditures. In addition, MDAs receive funds directly from development partners which finance projects or programmes in forms of grants, loans or aid. All central service units, such as the Medical Stores Department (MSD) and regional/ national hospitals under the MoHSW are funded through intra-governmental transfers as subsidies. At the central level, the MoHSW is responsible to ensure that health and social welfare services are of high quality, effective, accessible and affordable

1 The policy was adopted in Tanzania in 1990s to strengthen the capacity at the local levels by transferring political, administrative and fiscal responsibility from the central government. It intends to bring decision-making closer to the people. The policy was articulated in the local government reform policy paper in 1998.

2 Budget votes are administrative classification of government expenditures.

(MoHSW, 2011). All regions have their own budgeting votes and funds which are directly disbursed to the regional administrative secretary (RAS) who distributes funds to all spending units within the regional administrative office.

Local government authorities are the key players in the decentralized service delivery. They are funded through their own votes and the funds are disbursed from the Treasury directly to the districts. The PMO-RALG has the mandate to facilitate the empowerment of all Tanzanians through the autonomous local government institutions to efficiently deliver quality services (PMO-RALG, 2011). The Local Government Authorities' health budget is financed through the health sector block grant[3] and health sector basket fund[4]. The government committed itself to use a resource allocation formula for the allocation of the health block grant to the districts in 2004. Extra funding for LGAs can be obtained from the collection of revenues within the districts such as cost sharing mechanisms and community based health insurance schemes like the Community Health Fund (CHF) in rural areas and the "Tiba kwa kadi" (TIKA) in urban centres. Other direct funding to the local authorities is obtained through programmes and projects that are directly funded by the central government or donors.

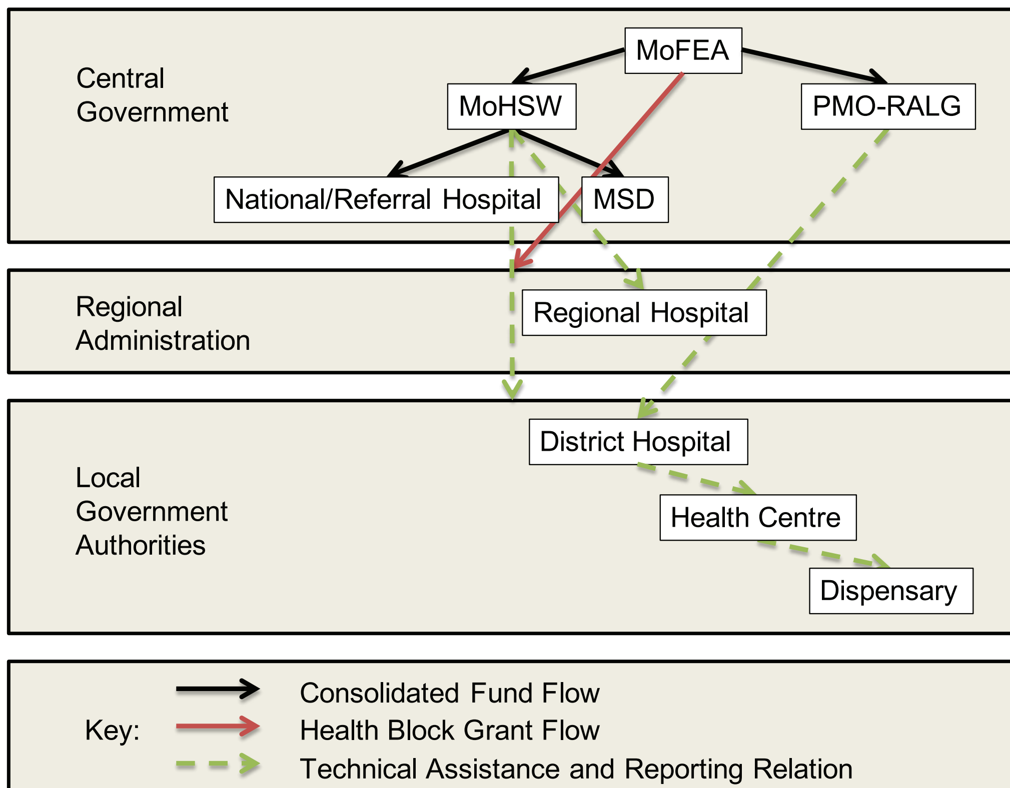
The private sector comprises faith-based organizations, private for profit organizations, training institutions and private insurance companies. The sector is mainly financed through payments that are made by patients. However, poor citizens may face difficulties paying for non-subsidized health services which are provided in the private service provision centres. Furthermore, according to a joint external evaluation in 2007, there have been only little advancements of the strategy to promote Public Private Partnerships (PPP) at the policy level, which could provide a way to make private sector health services more affordable for the poor.

The below figure summarizes how resources flow to the central government units and how health block grants are distributed to the LGAs. Funds are directly disbursed from the Ministry of Finance to the MoHSW which passes intra-governmental transfers to the central service provision units under the Ministry. The PMO-RALG oversees the operation of the Local Government Authorities by offering administrative and technical support, and the LGAs are answerable to the PMO-RALG concerning their daily operations. However, health block grants are directly disbursed from the MoFEA to the district.

3 Government owned funds are disbursed to the district for recurrent spending on the provision of primary health care services. This fund is directly disbursed by the treasury into the local government's accounts.

4 This fund is contributed by multiple bilateral and multilateral donor organizations to support the health sector at all government levels.

Figure 1: Overview of the central government and health sector's block grant funds flow



In the next two chapters, our analysis will discuss how the government has allocated resources to the health sector in general and, in particular, to local government authorities.

2 A DECADE OF ABUJA DECLARATION

The Abuja Declaration and Framework for Action was signed by the African heads of state, including Tanzania, in April 2001 following the Africa Development Forum (ADF) of 2000, which aimed at managing, mitigating and reversing the health epidemics (HIV/AIDS, TB and Malaria) in Africa. At this summit, the heads of state declared health to be a top national priority by setting a target to increase the resource allocation of the health sector to at least 15% of their budget, and they urged the donor countries to fulfil the, yet to be met, target of 0.7% of their Gross National Product (GNP) as Official Development Assistance (ODA) to developing countries.

The commitments that were made at the Abuja 2001 Summit were later reinforced by the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis (TB) and other related infectious diseases (ORID) (2003), the AU/NEPAD Health Strategy (2003) and the AU Assembly Decision on the Interim Report on HIV/AIDS, TB, Malaria and Polio of Abuja (2005). In 2006, in the special summit on HIV/AIDS, TB and Malaria, the AU renewed its commitment to meet the 15% target and, later, the Conference on Poverty of the Southern African Development Community highlighted the increased economic costs of HIV, TB and malaria (SADC, 2008) which require more resources for health. The commitments that have been made at various international forums give evidence that the Abuja declaration forms a widely accepted position for countries which aim at achieving better health services.

In 2008, the Nobel Peace Prize Winner Archbishop Desmond Tutu, Honorary Chair of the Africa Public Health Alliance “15% Now Campaign”, urged African heads of state and governments not to, in any way, revise, drop or further delay the implementation of the Abuja commitments that were made in the year 2001. In his statement, he indicated that the African Union (AU) Abuja 15% pledge is one of the most important commitments African leaders have ever made to health development and financing. He also urged the heads of state to never delay the implementation of this commitment to prevent the loss of millions of lives of Africans, which is unacceptable.

Given the scarcity of resources and the slim chance that the country will have a comprehensive and capable health financing system in the near future, the 15% target seems to be the most feasible strategy to achieve universal health care coverage in Tanzania. Moreover, the 15% target is an indicator for the government’s commitment to improve the health of its citizens. Since donor funds are not sustainable, it is important that the target is met by using mainly domestic resources. Likewise, it means that increased external resources should not result in reduced financing though local funds.

The implementation of the declaration is guided by a Framework for Action that has been agreed on by all heads of state. Our review mainly focuses on the following targets:

- the achievement of 15% government spending on health indicating that equitable resource allocation is more likely where domestic health budgets are increasing.
- The need for substantial additional domestic resources to address the growing health needs associated with HIV/AIDS, TB, malaria and other diseases continues to be a primary motivation.
- Commitment by the government to ensure access to consistent, quality and timely data on health care spending to support the monitoring of progress.

The Abuja Declaration in Plans and Policies

During the implementation of the Health Sector Strategic Plan (HSSP) II, the country experienced a considerable increase in public health expenditure. According to the Tanzania Mainland National Health Accounts 2009/10, health expenditure grew from TZS 774 billion in 2002/03 to TZS 2,333 billion in 2009/10. However, a large portion was due to an increase of foreign funding while domestic funding for health grew only slowly, as will be shown below.

In the HSSP III, the Ministry of Health explicitly committed itself “to advocate for increase funding for the health sector, meeting the Abuja targets (15%) of Government budget, in order to ensure access to health service, equity, and increase in coverage of health promotion, prevention and care.“[5]

Tanzania’s Health Policy of 2007 recognizes the need of sustainable social welfare development indicating that the government of Tanzania should remain the major financier of the health sector. However, the policy did not indicate which proportion of the resources should be committed by the government. Our analysis shows that the trend of health care financing is not in line with that policy objective as indicated by figure 2 below. While locally financed health expenditures have increased in absolute terms, foreign sources have grown at a much higher pace than domestic sources.

5 MoHSW (2009), p. 32.

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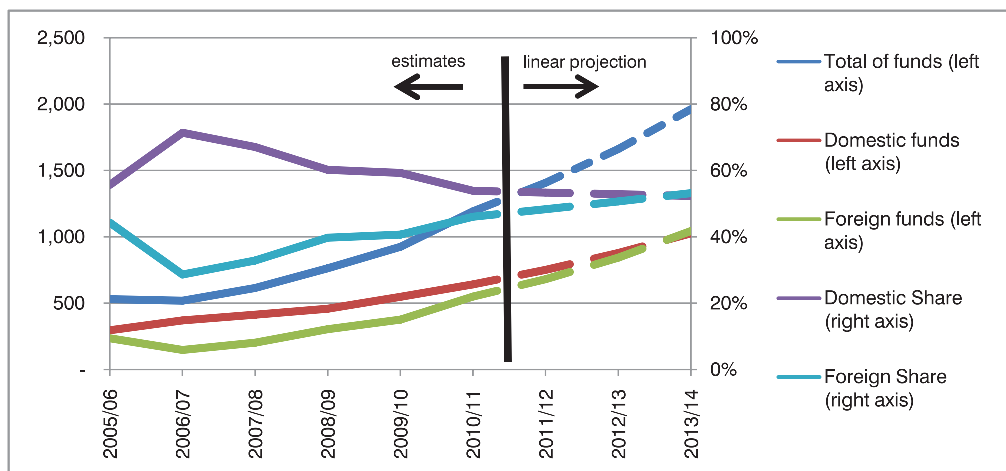
Figure 2: Estimated health sector expenditures, projections and sources of funding (million TZS)



Source: Health Sector PER Updates (2005-2010).

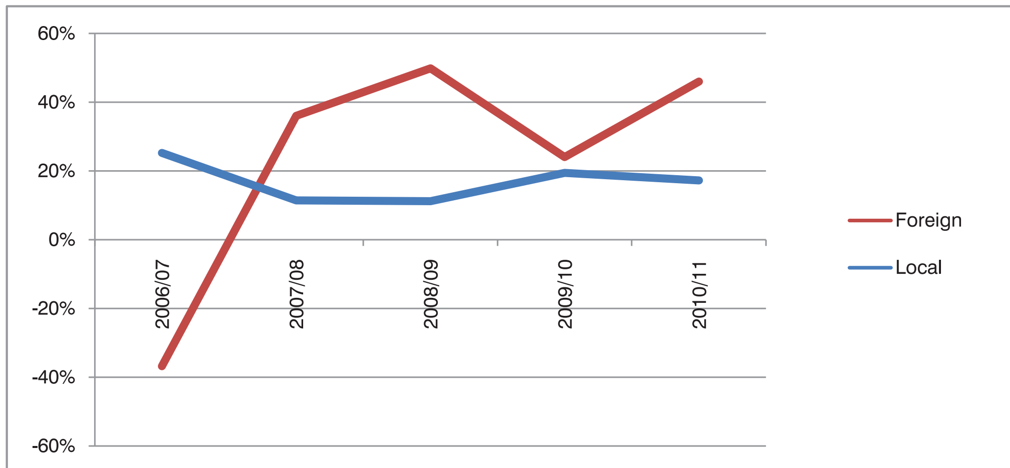
Health Donors are Financing Other Sectors

As indicated above, the government's commitment to the health sector financing has continuously deteriorated as its proportion of the total sector funding has been diminishing of the last years. The declining share of domestic funding and the increasing share of foreign funding to the total health sector budget are indicated by the secondary vertical axis on the right hand side. Such high dependency can be explained by the government's decision to divert financial resources to other sectors by replacing its own funding with development assistance. Thereby, the foreign donors, which intend to finance health sector activities, actually fund other sectors which the government prefers over health. If one projects the development of such a financing strategy for the next three years assuming that the financial growth rates are sustained,[6] the foreign funding share exceeds the domestic funding share for health within the next two years.

Furthermore, we calculated the annual change of domestic and foreign health financing to see if there is any pattern. For the period under review, year-on-year change of domestic financing for health has been moving in the opposite direction of foreign financing. This tactical behaviour made it difficult to achieve the Abuja Target of 15%. The graph below indicates the rate of change of financing for health for both local and foreign funding.

6 The forecast was calculated based on the average growth rate of 17 and 24 percent for domestic and foreign funding, respectively, for the period from FY 2005/06 to 2010/11.

Figure 3: Rate of change of health sector funding for both local and foreign resources

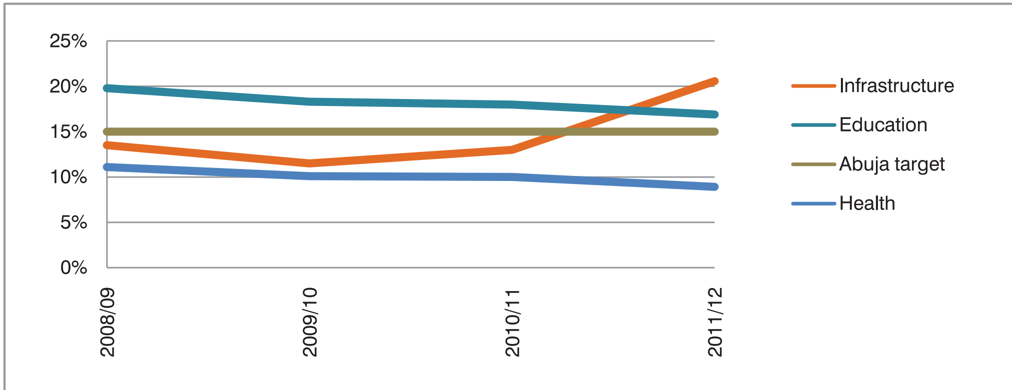


Source: URT (2011, 2012).

The financing trend indicates that the government is shifting resources to other sectors. Every time foreign financing accelerated, the government decided to slow down local financing to the benefit of other sectors and to the disadvantage of the health of its citizens. Thereby, the foreign share of the total health sector funding has increased significantly compared to the domestic share. This also implies that health sector donors are actually funding other sectors. A health sector financing strategy with a fund allocation rule that ensures adequate domestic commitment to health would be an effective instrument to avoid such tradeoffs. For example, if the Tanzanian government was committed to add 3 Shilling for each foreign Shilling, the domestic funding share would slowly converge to 75% of the total health sector budget.

A sector wide analysis was conducted to compare the share of each sector from the total national budget. As indicated in the graph below, the obtained result does not indicate that the health sector is a priority area for the government, despite the need of healthier people for the development of Tanzania's economy.

Figure 4: Percentage share of the total budget by sectors (FY 2007/08 – 2011/12)



Source: URT (2011, 2012).

The phenomenon has significant influence on the achievement of the Abuja declaration. The health sector's share of the total government budget has gone down from 11 percent in 2008/09 to 8.9 percent in the 2011/12 budget. This share includes both local and foreign funding. While infrastructure received relatively more funding, the social sector (health and education) has not been a priority to the government as indicated in the above figure. In the FY 2011/12, health has been the third largest sector; however, with the existing population growth and other phenomena, health is not given the priority it deserves. The Health Sector Performance Profile (HSPP) 2010 update indicates a deteriorating nutrition status of young children at an average of around 3% between 2005 and 2010. Neonatal death remains a significant challenge accounting for 32% of all under five deaths in Tanzania, and other indicators like maternal mortality ratio (MMR), service delivery at facilities, diseases indicators and human resources for health perform all behind expectations.

3 HEALTH SECTOR FINANCING AND EQUITY

Basic Concept

Equity is an ethical concept grounded in the principle of distributive justice. One can generally distinguish between vertical equity (unequal treatment of unequals) and horizontal equity (equal treatment of equals). Braveman and Gruskin (2003) defined (A/N: vertical) equity in health as the absence of systematic disparities in health between groups with different position in the social hierarchy, whereby health inequities worsen those who are disadvantaged. For health care financing, vertical equity refers to the idea that households with greater (lower) ability to pay should pay more (less) to obtain health care. Horizontal equity in health is concerned with the extent to which persons receive equal treatment for equal needs regardless of their income or socio-economic position (Boubon Cisse et al, 2006). Since the concept of fairness and social justice can be defined and interpreted differently, it requires setting clear measuring criteria on the subject of discussion.

Overview of Equity for Health in Tanzania

The HSSP III alludes to equity in the context of "geographic equity for underserved populations and for vulnerable groups who cannot fend for themselves".[7] To promote geographical equity, special attention, in terms of financial and human resource allocation, has to be given to the remote rural and underserved areas. To promote accessibility of health services by vulnerable groups, targeted action plans are to tackle health determinants such as education, poverty, exclusion and stigmatization. Also, exemption mechanisms are to ensure that health services are accessible by the poorest.

The Health Policy 2007 advocates for equity and accessibility to health care by ensuring that all individuals have the right to health care. Health resources are to be allocated equitably based on population, under five mortality (burden of diseases), accessibility (remoteness) and poverty levels.

The Resource Allocation Formula

From an equity perspective, health finances should be utilized to achieve an equitable distribution of resources (including health facilities, human resources, medicines and medical equipment) which, in turn, ensures that services are delivered according to needs.

To promote the equitable allocation of resources, Tanzania commissioned an independent consultant to develop a resource allocation mechanism in 2002. The

7 MoHSW (2008), p.7.

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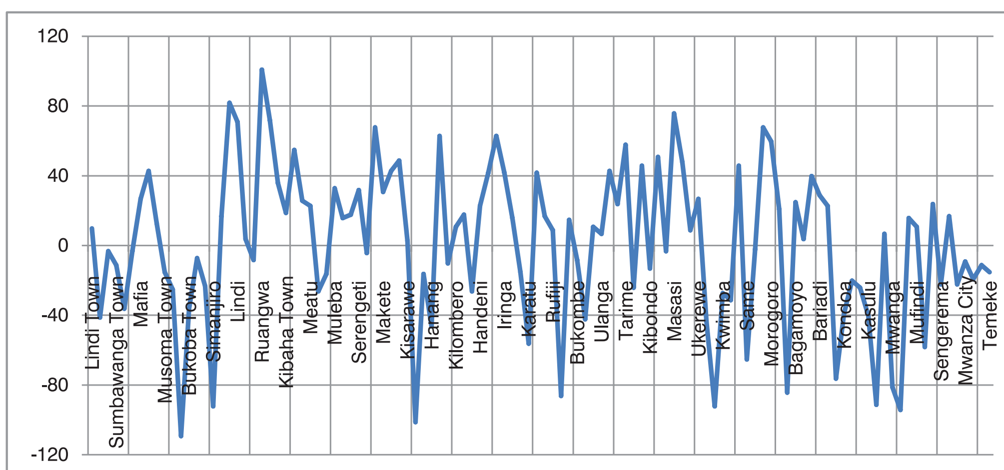
outcome of this process was a formula which determined that financial resources should be distributed according to four, differently weighted, need-based criteria, namely population (70%), percentage of people living below the basic poverty line (10%), district medical vehicle route (10%), and under-five-mortality (10%). The factors and weights were selected on the basis of their importance in determining the quality of health in every district. 'Population' was chosen since citizens are the main recipients of the health services. The three other factors were considered to serve special needs: a) poverty is correlated with other underlying health determinants such as low education or bad housing; b) rural population often lives in hard-to-reach areas due to underdeveloped road infrastructure; c) people living in areas with a higher burden of disease (measured using under-five-mortality (U5M) as the burden of disease profile indicates that U5M takes up to 75% of the total years of life lost) face higher morbidity and mortality risks. The under-five mortality ratio varies by a factor of more than six between districts, as shown in the figure below, which indicates the deviation from the national average of the U5M as of the 2002 census.

Figure 5: District U5M distribution by deviation from the national average



Source: URT (2002).

The aforementioned formula was endorsed with a policy statement (MoH, 2003) which was developed by the Health Sector Reform Secretariat at the Ministry of Health and Social Welfare. The formula was to be applied from the year 2004 to determine the allocation of Health Block Grant and Health Basket Fund across all districts.

Application of the Resource Allocation Formula in Tanzania

Tanzania adopted the resource allocation formula to ensure equity in health care provision. Hence, we analyzed the extent to which financial resources were allocated according to the formula. As mentioned above, the health sector in Tanzania is financed

through multiple channels and at different levels including central, regional and local government authorities. Our analysis focused on the districts (local government authorities) as they are the key level of service delivery, and the resource allocation formula was designed to provide an equitable allocation of resources to the district level.

Districts receive recurrent financial resources that are earmarked for health care through two distributive mechanisms: the health sector block grant, which is composed of local funds, and the health sector basket fund, which receives funding from foreign donors. While the former grant is disbursed by the Treasury, the latter is provided by the MoHSW. Our study will only analyze the distribution of the locally financed health sector block grant. We will review the approved budget estimates for the period of financial year 2005/06 to 2010/11.

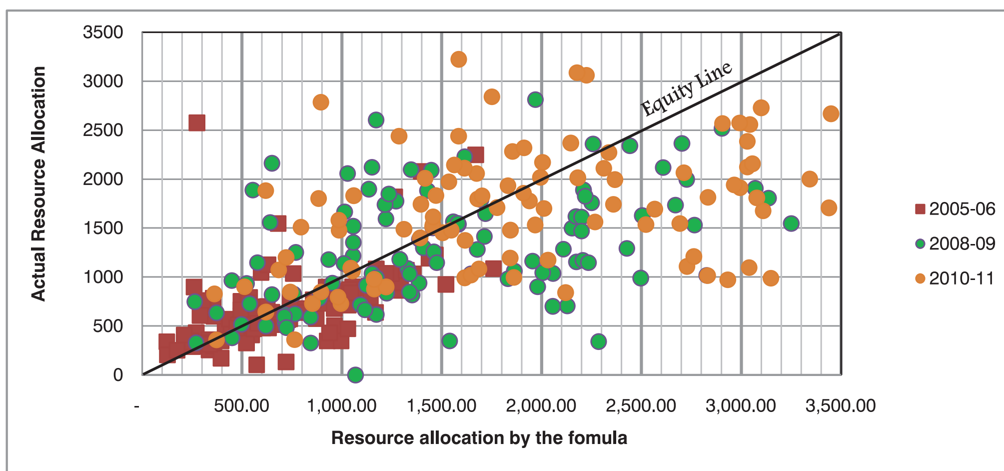
Data

The data of the health block grants that were allocated to individual districts was obtained from the PMO-RALG online database that provides records for the FYs 2005/06, 2007/08 and 2009/10. For a sample of 112 districts, information on four equity criteria, namely population, poverty levels, mileage covered and under-five-mortality was obtained from the Tanzania district health service (TDHS) online database, which provides estimates based on the national census 2002. All administrative districts that were formed during this review period are not included our presentation as information about their population and other health need-criteria does not exist for all years.

Deviation from the Resource Allocation Formula

Using the existing TDHS database, we estimated the grant allocations if the resource allocation formula was used to allocate the total health block grant to the 112 districts, and we compared this with the actual allocations. To visualize deviations, we plotted the actual allocation against the estimated allocation after applying the formula on the total health block grant for 3 different financial years in figure 6.

Figure 6: Relation between actual allocation and allocation by resource allocation formula



Source: PMO-RALG online data base.

The scatter plot shows the relationship between the approved estimates and estimates after the application of the formula. The 'equity line' represents the level at which the budget would have been distributed if the allocation formula had been applied to distribute the grants equitably. The further afar the points are from the equity line, the higher the levels of inequity. Any point above (or below) the equity line indicates higher (or lower) actual budget allocation to the district compared to if the resource allocation formula was used

In this regard, it is confirmed that the allocation of health block grant was not allocated by using the resource allocation formula. The plot indicates a high variance between the allocation that should have been made according to the formula and the actual allocation. Hence, it can be concluded that other criteria must have been used to allocate resources neglecting the equity concept that is embodied in the resource allocation formula which the policy documents are referring to.

The above analysis has shed some light on the question whether the allocation formula has been applied in the past. In the next section, we will show to what extent the actual resource distribution was not equitable.

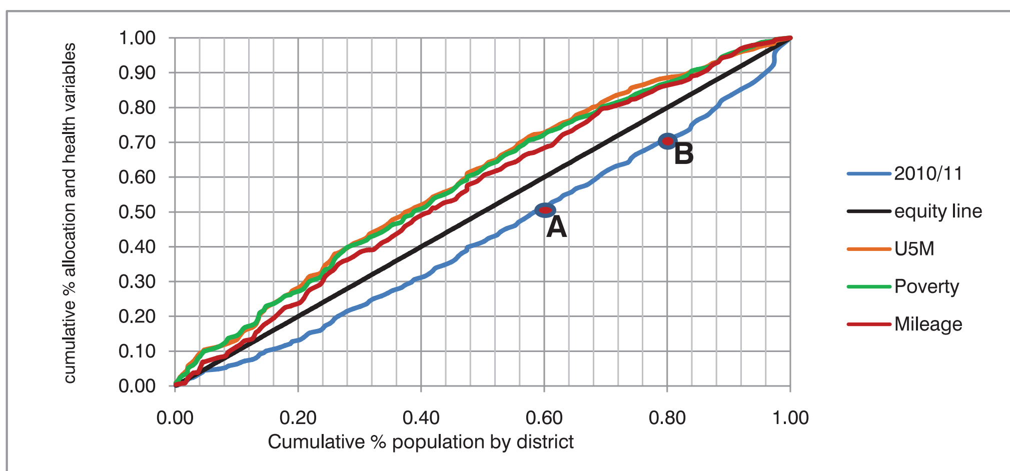
Concentration of Needs and the Allocation of the Health Block Grants

In line with the economics literature, we used a Lorenz curve (we use the term 'allocation curve'), and its associated gini coefficient, and concentration curves (we use the term 'needs curves') to visualize the discrepancy between the varying needs and levels of funding across districts.

The 'allocation curve' is a graphical representation that describes the distribution of resources per population. Each point along the allocation curve indicates the (poorer) bottom X% of the population receiving Y% of the total available resources. The 'need curves' are used to display a share of health variables accounted for by cumulative proportions of individuals in the population ranked by the income they received (compare Kakwani 1977; Kakwani et al. 1977; Wagstaff et al. 1991). For our study, the need curves represent health needs drawn from the resource allocation formula, namely U5M, poverty level and accessibility (measured by the mileage of medical vehicle), which have been ranked by the health block grants that districts received in a selected year.

Both the allocation curve and the need curves have been drawn into the same graph to show the allocation of resources against needs. Since the need curves for all the years could not be drawn on the same graph, we selected the most recent year 2010/11. For all previous years, the need curves and the allocation curve show a similar pattern.

Figure 7: Cumulative needs and resource allocation curve for districts for the FY 2010/11



In the above graph, the orange, green and red need curves indicate the cumulative share of the health needs that are measured using the indicators U5M, poverty level and medical vehicle mileage. The black 45-degree line describes an equal resource distribution in which every district would receive health block grants according to its population size. Since the resource allocation formula assigns 'population' a very large weight (70%), the 45-degree line closely approximates the combination of all needs. For the sake of simplicity, we will refer to the black 45-degree line as the 'equity line'.

The blue allocation curve indicates the cumulative allocation of resources across the districts against the cumulative share of the population ranked from the lowest to highest financed districts. As shown by the graph, most resources are shared amongst very

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few people. For example, point A indicates that the lower 60 percent of the population receive only 50 percent of the total funds allocation. Point B indicates that the upper 20 percent of the population receive 30 percent of the total funds allocated for health. All need curves lie above the equity line implying that the districts with a comparatively high need for health services received comparatively small health grant allocations. Thus, the greater need indicated by higher population size, U5M, poverty levels, and mileage were not adequately matched with greater amounts of financial resources. Our analysis shows that the distribution of resources across districts did not consider the resource allocation criteria that are to promote equity.

As mentioned above, the black equity line is a good proxy to depict the combination of needs that are implied in the resource allocation formula. Therefore, the discrepancy between the allocation and needs (inequity) can be measured using the gini coefficient. The gini coefficient is a measure of inequality, and it takes the values between 0 (perfect equality) and 1 (maximal inequality). We calculated the gini coefficient for all years under review. The results are summarized in the table 2 below.

Figure 8: Gini indices for resource distribution FY 2005/06 – 2010/11

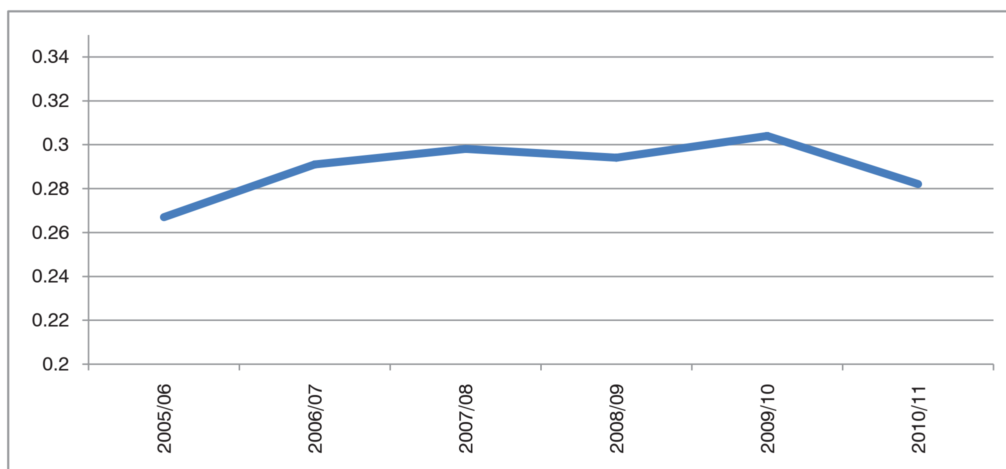

Figure 8 indicates that the level of inequality has remained significant and varied very little (between 27% and 30%) over the entire period under review.

The primary objective of this section was to analyze whether the resource allocation formula has been used to address the equity issues. Our findings do not support the hypothesis that the formula, which is to promote health equity, has been applied so far. However, we should as well keep in mind that the population figures that we used were obtained from the 2002 census. The formula should take into account dynamics such as population growth and interior migration, new infrastructure (i.e. roads), a change of health variables, like U5M, and poverty levels.

3 CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Health is one of the basic social welfare services that the state government is obligated to provide to all of its citizens. For over a decade now, Tanzania has committed itself towards achieving the Abuja target by allocating 15% of its total budget to health. But, like other nations, Tanzania has not managed to achieve this target. Further, the government has continuously increased the nation's dependency on unsustainable foreign aid. Thereby, it is putting the social wellbeing of its poor citizens at risk.

We advocate that the Government increases domestic funding for health and ensure that its commitment to the Abuja declaration is met to ensure sufficient and sustainable health finances.

Health financing must ensure the equitable allocation of available funds to reach all groups of our community. Tanzania adopted a resource allocation formula in 2004 to ensure the equitable allocation of intergovernmental transfers across districts. However, we cannot find evidence that support this policy goal with respect to health block grants. This deprives people's basic right to access quality health services.

The Government should take immediate steps to ensure the equitable distribution of health services as stated in the health policy (2007) and HSSP III.

Recommendations

To ensure that sufficient and sustainable financial resources are allocated to health and then distributed equitably, the government should undertake the following measures:

- The Abuja Target of allocating 15% of the total government budget to health is achievable if the government demonstrates strong political will. Further, the target is part of the HSSP III performance assessment framework. Without stronger political commitment, the government's credibility will suffer and may drive away disappointed donors on which the nation's poor citizens currently rely on.
- The Government needs to revisit its health policy (2007) and take action to be the main financier of the health sector. A renewed commitment should be complemented by a joint financing strategy which ensures that growing local and foreign resources improve the sustainability of health sector financing.
- The Government should demonstrate how it uses the resource allocation formula to ensure that an equitable allocation of resources is achieved. Further, the resource allocation formula needs to be updated to capture the changes in the applied variables.
- The Government has to become more transparent with regard to its methods to allocate domestic and foreign resources across sectors and the local authorities.

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APPENDIX

Recurrent other chargers Health block grant allocation to districts for FY 2005/06 – 2010/11 (Million TZS)

Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Arusha Municipal Council	298,178	1,046.30	1,301.00	1,276.30	1,776.20	2,142.80	2,840.70
Monduli District Council	195,373	752.40	897.00	759.20	1,215.20	1,313.70	1,515.90
Ngorongoro District Council	136,973	515.70	369.00	514.70	783.20	771.20	899.60
Karatu District Council	188,422	551.50	546.90	830.60	1,665.20	1,625.50	1,744.00
Meru District Council	544,934	1,084.40	1,699.10	913.80	1,627.90	1,930.90	2,668.00
Arusha District Council			695.00	898.60	1,411.50	2,508.90	2,240.60
Longido District Council				440.50	658.50	909.00	825.10
Kibaha Town Council	138,964	783.70		838.30	826.20	999.70	1,090.90
Bagamoyo District Council	242,440	640.70	872.70	2,048.30	1,385.90	1,877.10	2,319.10
Mafia District Council	42,943	339.50	527.00	515.80	748.60	981.40	828.00
Kisarawe District Council	100,932	431.00	855.10	1,264.10	1,147.90	1,382.00	1,510.70
Kibaha District Council		293.90	762.50	599.60	514.10	895.70	911.50
Rufiji District Council	213,887	624.60	1,126.00	1,252.00	1,594.20	1,738.50	1,798.80
Mkuranga District Council	197,926	578.80	695.10	1,019.60	1,036.50	1,036.50	3,224.00
Dodoma Municipal Council	341,806	1,511.10	2,247.50	1,431.20	1,566.00	1,920.00	2,369.00

Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Kondoa District Council	453,280	857.20	843.70	1,331.60	1,889.70	2,036.70	2,558.80
Mpwapwa District Council	268,524	1,547.40	776.40	1,460.90	1,502.00	1,832.50	2,171.80
Kongwa District Council	263,287	535.00	673.30	1,189.80	1,087.80	1,361.00	1,932.80
Bahi District Council				685.00	642.90	1,426.20	869.70
Chamwino District Council				932.30	884.50	1,319.50	1,541.40
Iringa Municipal Council	112,630	346.30	541.00	689.40	933.70	1,222.40	1,199.90
Njombe Town Council	443,776	887.10	1,504.00	234.20	341.50	550.70	988.10
Iringa District Council	475,849	639.40	830.00	917.90	989.50	1,542.10	1,707.10
Mufindi District Council	298,668	1,035.60	1,752.30	1,486.20	2,228.20	2,620.80	3,060.90
Njombe District Council				1,485.00	1,445.70	2,782.20	1,250.10
Ludewa District Council	135,695	599.50	778.50	1,180.60	1,252.20	1,528.20	1,831.10
Makete District Council	111,998	361.90	609.00	680.70	531.70	1,150.50	1,477.80
Kilolo District Council			685.00	446.80	751.10	751.10	1,192.10
Kigoma/Ujiji Town Council	152,745	255.70	496.60	468.30	617.40	539.20	1,581.80
Kigoma District Council	518,060	864.60	1,247.60	1,148.80	1,998.60	2,550.10	1,748.20
Kasulu District Council	663,621	1,226.20	1,713.50	2,081.40	1,806.50	2,177.10	2,634.10
Kibondo District Council	438,125	850.50	949.40	1,561.50	1,498.50	2,443.90	1,941.10

Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Moshi Municipal Council	152,260	724.50	1,096.00	1,151.00	1,557.10	1,874.10	1,802.20
Hai District Council	274,171	1,126.00	1,602.00	1,120.10	2,098.40	2,616.00	2,282.70
Moshi District Council	424,986	898.50	1,466.10	1,667.70	2,811.80	2,870.80	2,066.10
Rombo District Council	260,174	790.90	1,143.80	1,621.60	2,120.90	2,709.30	2,439.30
Same District Council	224,196	738.10	1,131.90	1,544.60	1,897.40	1,839.50	2,145.30
Mwanga District Council	121,920	670.70	788.80	1,753.90	2,162.20	2,705.10	2,786.40
Siha District Council				691.30	703.00	821.90	765.70
Lindi Town Council	43,492	204.30	289.50	322.20	327.70	327.70	358.80
Nachingwea District Council	170,975	514.40	730.70	848.80	937.80	1,305.20	1,489.10
Kilwa District Council	181,123	567.50	881.80	1,121.60	915.50	1,384.80	1,477.60
Liwale District Council	79,549	347.90	913.80	474.80	516.70	516.70	1,073.10
Lindi District Council	227,526	480.20	579.70	781.90	817.60	818.70	996.60
Ruangwa District Council	131,306	298.60	417.50	563.00	624.00	944.20	1,063.40
Musoma Town Council	114,202	288.90	516.60	583.30	727.90	368.00	848.90
Bunda District Council	274,166	514.90	931.90	1,404.10	1,299.30	1,836.00	1,778.10
Musoma District Council	349,231	575.30	1,146.00	1,564.70	1,060.80	1,621.00	1,693.90
Serengeti District Council	186,417	421.10	646.60	687.60	718.70	1,287.90	1,453.40

Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Tarime District Council	519,606	940.70	1,434.70	1,379.20	1,530.20	1,698.80	1,906.10
Rorya District Council				460.00	573.00	1,010.40	808.60
Mbeya Municipal Council	281,213	696.40	934.00	1,579.60	1,739.80	1,905.40	2,058.70
Chunya District Council	218,032	467.70	808.90	954.40	992.10	1,432.20	1,375.70
Ileje District Council	116,311	329.40	340.90	624.20	596.20	716.90	795.30
Kyela District Council	184,058	570.50	940.30	1,258.80	1,178.70	2,009.80	2,438.80
Mbeya District Council	269,019	528.70	856.00	915.70	939.20	2,287.50	1,856.60
Mbozi District Council	543,820	1,036.10	1,303.10	1,691.70	1,734.60	2,398.80	3,058.70
Rungwe District Council	324,408	654.60	1,181.00	1,383.70	1,792.10	2,287.50	2,273.10
Mbarali District Council	247,876	700.70	498.70	961.60	1,033.90	1,409.70	1,479.20
Morogoro Municipal Council	241,332	604.40	727.00	923.50	1,353.00	1,518.70	1,614.50
Morogoro District Council	553,095	1,032.80	955.00	1,122.70	2,518.30	1,646.50	2,209.50
Kilosa District Council	516,917	1,818.30	1,950.90	2,256.10	2,364.70	2,940.90	3,505.10
Kilombero District Council	340,535	640.60	976.00	947.90	1,033.50	1,441.80	1,563.70
Ulanga District Council	204,653	518.80	1,260.10	1,242.60	-	1,706.40	1,833.60
Mvomero District Council			1,152.40	949.30	1,517.00	1,849.40	1,318.00
Mtwara/ Mikindani Town Council	97,579	336.30	444.00	498.80	378.80	518.10	643.30

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Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Mtwara District Council	216,170	410.00	535.30	623.10	618.40	984.20	992.10
Newala District Council	194,132	511.10	879.50	1,226.60	2,057.70	1,418.60	2,009.30
Masasi District Council	466,936	905.70	1,360.00	1,440.20	1,292.50	1,532.80	2,000.90
Tandahimba District Council	215,831	327.30	587.40	980.80	665.30	1,553.70	1,973.50
Nanyumbu District Council				128.00	337.10	552.10	777.40
Mwanza City Council	502,610	795.80	1,419.20	2,231.50	2,341.10	2,153.00	4,437.30
Ukerewe District Council	276,178	526.90	1,011.60	980.90	2,091.10	1,909.10	2,018.20
Sengerema District Council	528,354	1,037.00	1,600.00	1,758.20	2,119.10	3,895.30	3,355.80
Geita District Council	750,801	1,087.10	2,158.30	5,057.60	2,083.80	2,141.50	915.10
Kwimba District Council	333,456	640.70	1,001.00	1,315.00	1,282.30	2,127.60	2,110.60
Magu District Council	439,421	901.60	1,405.00	1,819.00	1,758.00	2,419.20	2,728.80
Misungwi District Council	271,204	534.80	972.40	1,494.10	1,883.00	2,039.50	1,532.10
Songea Town Council	351,515	347.90	486.00	844.70	900.20	879.70	1,108.90
Songea District Council	138,560	761.00	974.40	601.40	820.10	764.40	848.40
Tunduru District Council	261,592	619.10	937.50	1,256.80	1,256.80	1,681.80	1,701.10
Mbinga District Council	427,580	838.70	1,361.00	1,824.20	1,619.20	1,997.20	2,573.70
Namtumbo District Council			890.00	890.00	753.40	944.10	950.10

Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Shinyanga Municipal Council	142,438	608.70	411.00	764.30	500.10	512.80	729.10
Shinyanga District Council	546,042	1,068.90	750.80	983.40	1,017.80	1,279.00	1,470.40
Maswa District Council	322,314	677.20	1,334.50	2,050.20	1,647.30	1,549.20	1,995.30
Bariadi District Council	639,121	924.10	1,351.40	2,309.40	1,546.10	2,059.20	2,405.70
Kahama District Council	629,895	1,192.60	1,696.30	1,947.00	1,905.40	2,561.90	3,750.60
Meatu District Council	262,819	515.70	495.70	1,529.50	1,146.40	1,527.90	1,172.90
Bukombe District Council	418,558	504.70	815.20	1,812.30	1,037.10	1,653.20	1,814.80
Kishapu District Council			660.00	1,299.10	973.00	1,021.90	927.30
Singida Town Council	423,936	348.30	424.80	581.30	704.60	807.00	972.30
Singida District Council	388,633	847.30	1,214.10	1,115.70	1,154.90	2,316.70	1,911.80
Iramba District Council	121,611	898.90	1,182.50	1,672.70	1,888.50	1,888.50	360.90
Manyoni District Council	216,514	480.10	917.00	962.20	1,180.10	1,664.70	1,709.90
Tabora Municipal Council	297,641	490.90	698.50	946.10	847.00	1,138.30	1,195.00
Igunga District Council	343,164	641.20	1,043.70	1,260.30	1,414.70	1,632.60	1,742.70
Nzega District Council	439,634	839.90	1,429.00	1,503.40	1,284.10	2,671.80	2,568.30
Uyui / Tabora District Council	199,067	471.70	645.30	743.40	882.50	1,052.60	1,021.00
Urambo District Council	391,061	732.00	1,015.60	1,210.40	1,162.80	1,369.10	1,546.40
Sikonge District Council	140,543	171.60	362.90	384.50	326.80	811.80	877.60

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Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Tanga Municipal Council		792.60	1,172.00	1,297.70	1,921.60	2,559.00	2,060.90
Korogwe Town Council	275,551	132.70	180.00	242.80	347.40	760.10	841.80
Muheza District Council	294,787	751.50	877.80	715.20	1,539.40	2,357.80	2,014.00
Pangani District Council	46,505	408.60	837.50	760.80	964.90	1,279.10	1,882.50
Korogwe District Council	256,918	632.50	1,316.50	1,324.40	2,604.30	3,871.70	2,112.00
Handeni District Council	415,515	873.30	510.70	1,498.90	2,359.70	4,086.20	1,676.10
Lushoto District Council	443,286	871.10	1,399.00	1,405.50	1,826.50	3,082.00	2,157.20
Kilindi District Council			433.00	701.80	548.00	964.90	534.80
Mkinga District Council				401.20	484.40	1,279.70	1,068.60
Bukoba Town Council	85,626	251.90	375.00	426.20	634.80	736.10	901.30
Karagwe District Council	449,252	769.00	1,044.90	1,377.10	1,612.20	1,954.10	2,385.40
Biharamulo District Council	433,478	679.40	1,155.20	659.40	701.40	849.60	1,014.20
Muleba District Council	407,848	429.90	769.00	829.20	1,045.40	1,134.70	1,209.40
Bukoba District Council	417,205	714.70	1,103.00	799.10	1,171.10	1,066.60	1,096.30
Ngara District Council	354,086	769.00	828.00	839.50	983.40	1,655.80	1,537.10
Chato District Council				629.80	725.70	940.60	1,085.70
Misenyi District Council				366.60	542.90	642.70	1,053.30

Council	Population (in 2002)	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11
Ilala Municipal Council	672,284	2,079.70	2,786.70	3,756.60	5,248.10	11,385.80	7,307.60
Kinondoni Municipal Council	114,691	2,575.60	2,734.90	6,611.50	5,925.90	5,966.30	8,181.20
Temeke Municipal Council	813,667	2,248.50	3,125.50	4,083.40	5,277.80	7,304.60	8,302.90
Dar es Salaam City Council		108.20	120.20	259.60	273.20	273.20	339.10
Sumbawanga Town Council	155,482	314.10	397.00	481.00	484.50	969.50	728.20
Mpanda Town Council		817.20	1,039.00	175.70	230.90	248.40	335.10
Mpanda District Council	434,603			1,314.80	1,146.70	1,499.80	1,808.90
Sumbawanga District Council	393,623	839.40	1,286.00	1,480.60	1,469.80	1,888.70	2,123.30
Nkasi District Council	219,509	471.90	659.40	873.10	835.00	1,090.00	1,083.70
Babati Town Council		104.10	135.80	171.10	337.00	1,018.20	1,129.00
Babati District Council	320,038	572.80	1,252.50	1,108.50	1,548.90	1,486.80	3,087.20
Hanang District Council	216,682	666.60	816.50	1,462.30	1,519.40	1,288.60	1,533.10
Kiteto District Council	161,258	480.50	486.20	842.60	1,138.00	1,273.10	1,399.70
Mbulu District Council	251,242	527.00	759.60	848.10	1,848.60	1,774.80	1,828.60
Simanjiro District Council	149,441	349.50	412.00	670.70	591.50	830.00	976.70
Total	**33,933,092**	**81,087.60**	**118,079.70**	**155,597.10**	**173,317.20**	**228,523.30**	**238,732.00**

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Sikika works to ensure equitable and affordable quality health care services through health systems and social accountability at all levels of government.

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