Tanzania Health Policy Note: Reasons and Consequences of Low Budget Execution

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This is the second in a series of health policy notes that address critical health finance related questions in Tanzania. They are issued as part of a larger public expenditure review exercise. The audience is government, civil society and the development partner community with the aim to initiate a dialogue around key health finance issues and present recommendations to government. This policy note raises budget execution in health as a problem and discusses reasons behind low rates and the consequences for service delivery.

Key Findings and Recommendations

Main Finding: Budget credibility in Tanzania is poor and has been deteriorating. There is a 15-20% deviation between budgeted spending and actual spending in part due to poor revenue forecasts. This affects all sectors including health. While budget allocations for personnel has largely been protected, the investment and non-wage recurrent budget have seen significant cuts during implementation. The consequences include an opportunistic budget process that prevents strategic planning, unreliable funding at the local government level that undermines an output orientation for facility budgets, a significant accumulation of arrears and supplier price increases, as well as inefficiencies in the sector that stem from insufficient budget provisions for operational expenditure items to enable health staff to work. Lastly, it has undermined the maintenance budget thereby gradually eroding the capital stock in the sector.

Recommendation 1: Advocate for a more predictable resource envelope to the Ministry of Finance. This can be done through communicating the consequences of low budget execution on service delivery.

Recommendation 2: Bolster the effect of fluctuations through reducing service providers' dependency on government other charges budget provisions. This could be done by strengthening a unified payment system toward which other sources (such as donor financing and complimentary financing) contribute.

Recommendation 3: Strengthen budget controls. As budget releases were not made, spending units accumulated arrears to continue their activities. This leads to arrears and inefficiencies and should be discouraged. Therefore, budgetary and commitment controls should be strengthened at point of budget execution to prevent commitments without available resources. In addition, an effort should be made to clear outstanding arrears.

Recommendation 4: Work closer with the donor community to channel a greater share of donor support through the budget and ensure that commitments are honored.

Budget credibility in Tanzania is problematic and deteriorating. At the aggregate level expenditure outturn has decreased significantly since 2010. Budgeted and actual expenditures have increasingly fluctuated in part because of worsening revenue estimates, and an underestimation of resource needs for other priority sectors such as infrastructure. Unreliable revenue and expenditure estimates at the macro level have trickled down to the sectors as is clearly visible in the scores by government function and even economic classification (with scores of a D and C respectively). A separate PEFA assessment at local government level finds a similar trend, which follows unreliable fiscal transfers from central level.

Table 1 An Overview of Government Budget Credibility

PEFA Assessment		Aggregate expenditure outturn	Expenditure composition outturn	...by government function	…by economic type
General govt	General government (2010)	A	D	n/a	n/a
	General government (2013)	B	D	n/a	n/a
	General government (2017)	C	D+	D	C
Local government	Linid (2016)	C	D+	n/a	n/a
	Rorya (2016)	D	D+	n/a	n/a
	Mwanza (2016)	C	D+	n/a	n/a
	Longido (2016)	A	D+	n/a	n/a
	Sengerema (2016)	D	D+	n/a	n/a
	Kigoma (2016)	D	D+	n/a	n/a
	Mvomero (2016)	D	D+	n/a	n/a
	Mtwara (2016)	D	D+	n/a	n/a
	Korogwe (2016)	D	D+	n/a	n/a
	Mwanga (2016)	C	D+	n/a	n/a
	Bunda (2016)	D	D+	n/a	n/a
	Kasulu (2016)	A	B+	n/a	n/a

Source: Various PEFA Assessments.

While the growth of health budget allocations has not been commensurate to its potential (see previous policy note on health prioritization), the promised budgetary allocations were often not met with adequate releases. This has resulted in low budget execution. Total budget execution for 2017 in the health sector was 82 percent, which is low but compares favorably to other sectors such as the water, agriculture, or energy sector who executed 34, 54, and 70 percent of their budget respectively. Responsible for the inadequate budget execution rates are unrealistic revenue projections that lead to appropriations in the budget that cannot be met. As revenue inflows fall below projections there is cash rationing. Budgets for statutory payments such as wages and debt payments have to be made first and other expenditures items such as development expenditures and goods and services then bear the brunt of the burden.

Table 2 Budget Execution Rates by Sector and Expenditure Type, 2017

Sector	Total	Recurrent	Wages	Goods and services	Grants	Development
Security	93%	95%	96%	81%	100%	29%
Defense	89%	94%	94%	82%	54%	60%
Education	88%	95%	91%	54%	90%	63%
Health	*82%*	*89%*	*96%*	*70%*	*80%*	*70%*
Judiciary	75%	96%	96%	66%	64%	37%
Infrastructure	71%	83%	89%	27%	71%	70%
Energy	70%	120%	88%	122%	66%	66%
Agriculture	54%	76%	86%	53%	66%	26%
Water	34%	71%	90%	32%	34%	32%

Source: FMIS and Boost.

Government health services are in part also financed through on-budget donor support. These on budget external sources of financing for health have however been declining in recent years in terms of absolute numbers and also as a proportion of total financing for health. This trend is likely to continue given the general decline in budget support and programmatic and basket fund support at the macro level. Similar tends are also observed in other countries in the region. This diverging trend is shown in table 3 below.

Table 3 The role of unrealized donor commitments in budget execution

	2010	2011	2012	2013	2014	2015	2016	2017
Domestic	93%	100%	93%	90%	87%	90%	94%	80%
Foreign	66%	61%	96%	89%	86%	95%	38%	87%

Source: FMIS and Boost.

In the health sector budget execution has historically not always been problematic. There were episodes such as in FY2012, 2013 or 2015 were close to the full budget was executed including that for goods and services. The budget release for goods and services and the development budget was particularly problematic in 2016 where less than 40 percent were executed. An overview over time for the health sector budget execution is provided in table 3 below.

Table 4 Budget Execution in the Health Sector

	2010	2011	2012	2013	2014	2015	2016	2017
Total	81%	81%	94%	90%	87%	91%	76%	82%
Recurrent	93%	102%	94%	92%	91%	94%	94%	89%
Wages	95%	130%	98%	98%	98%	97%	97%	96%
Goods and Services	69%	57%	97%	91%	95%	95%	35%	70%
Grants	91%	98%	91%	88%	88%	91%	86%	80%
Development	67%	61%	94%	87%	81%	85%	38%	70%

Source: FMIS and Boost.

The implications of an inadequate budget release is that not all planned health expenditures can be implemented and as such budget adjustment will happen during the implementation. Thus, even as the legislative may approve a budgetary increase for health, this may not translate into reality during implementation if the executive doesn't release the necessary funds and reprioritizes away to other sectors. Furthermore, this has led to the accumulation of arrears. As budget allotments are made and facilities need to spend to be able to provide services they may be put into a situation where they have to commit to suppliers to pay at a later date when the budget will become available. The amount of arrears accumulated have become significant, and whilst the stock of arrears is being paid off, new arrears accumulate. As a share of total arrears, the health sector is estimated to make up about 10 percent. Putting this into perspective of total health spending, the stock of health sector arrears approximated the entire sector spending in 2016 and 2017. Inroads appear to have been made since 2016, when the stock of arrears was significantly reduced. An overview of outstanding liabilities from central MOH is provided in table 4. This bears considerable inefficiencies as suppliers build in risk premiums into their prices and the budget becomes opportunistic rather than strategic. Allowing for the buildup also undermines basic PFM processes as current systems and procedures are subverted and internal budgetary and commitment controls not utilized.

Table 5 Overview of health sector arrears

	2014	2015	2016	2017
Central MOH arrears	484,013 M	629,546 M	585,466 M	360,606 M
Total GOT arrears	4,415,294 M	6,644,613 M	8,363,920 M	9,529,519 M
MOH share of total arrears	11%	9%	7%	4%
Stock of arrears as proportion of total MOH spending	61%	84%	93%	44%

Source: MOF.

Discussion and Conclusion

There are budget execution issues in the health sector that inhibit the efficient delivery of services. This is in part driven by poor revenue projections and expenditure reallocations at the macro level, but also in part due to inadequate donor contributions that didn't honor commitments. Both of these need to be addressed in order to foster a more efficient and enabling environment for health service delivery.