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Health Financing in Transition:
Toward a Unified and Output-Oriented Provider Payment System in Tanzania

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Overview

The health sector in Tanzania has traditionally been input oriented and financed against a historical budget. Council health management teams were responsible for the implementation of activities at the district level, including what was needed at lower level facilities. This situation is changing rapidly: there are ongoing budget reforms that are changing the structure of the budget toward a program based classification; Tanzania is piloting a results-based financing initiative where facilities are being paid against service outputs; and the health basket fund is being further decentralized to the facility level, giving them increasingly more financial autonomy.

Such changes in the financing system experimented through donor funds present both opportunities and challenges for the sector to move towards an output-based payment system in a coherent manner, enhance accountability to results and increase value of money.

This note provides an overview of the current health financing situation (including features of different financing streams), and discusses what has been achieved already, and remaining issues that require attention.

Table 1: Reforming health facility financing: what is necessary, what has already been done, and what issues remain?

Necessary steps	**Progress in Tanzania**	**Remaining agenda**
Facilities need to be able to receive funds directly	Dedicated cost centers have been established for all facilities, and facilities are recognized as separate administrative entities in the LG chart of accounts.	Government needs to start using facility cost centers to allocate recurrent budget.
Access to banking services	Government bank accounts were set up for facility budget management. Facility accounts host funds for all sources other than government	Government funds are still managed at the council level and thus do not make use of facility accounts. Devolution of government budgets to the facility level will necessitate financial management processes including banking services.
Bottom up planning	Facilities plan against all funding sources on an annual basis. Facility health plans are integrated at the council level and form the basis for the comprehensive council health plan. All plans are developed using Planrep.	No additional work required.
Use of plans to determine annual budgets	Facility health plans form basis for facility budgets from DFF basket allocations. The link between facility health plans and budgets for government and RBF	There is a need to better align facility plans with facility budgets, especially for government funds and RBF.

	budgets are more tenuous as budgets for government funds are given to the council and RBF budgets are revisited in-year and conditional on performance measures.	
Fragmented funding sources	There are a number of financing sources at the facility level, including the government budget, RBF funds, basket fund allocations, user fees, and insurance reimbursements. These come with separate protocols, which need to be considered during the planning / budgeting stage. Planning and budgeting across sources has been facilitated through the use of integrated information systems.	Pooling funding sources at a higher level that use a common set of guidelines could entail considerable efficiency gains through consolidating the provider payment system. This could include a base tranche and a performance tranche.
Executing the budget	Systems for facility expenditure management have been set up to mimic processes at the council level. FFARS has robust commitment and budgetary controls, that all funds routed through it are subjected to.	RBF is not routed through the FFARS and is managed separately. The reform focus in budget execution should focus on full FFARS coverage, including RBF.
Flexibility in execution	Facilities have a lot of discretion with regards to spending of RBF funds, which deviates from the rigid controls used for government budget and basket funds.	In the medium term it is desirable to give facilities increased discretion for government budget and DFF funds. However, this comes at a reputational risk as it increases the chances of misuse. Flexibility should be given once capacity for accountability is evidenced.
Accounting and reporting	Accounting and reporting processes are done through different tools (Epicor and FFARS) at the council and facility level, but the fundamental functionality is the same. As planning, payment and reporting functionalities are integrated in FFARS and Epicor, this provides a strong basis for accountability and integrity of financial reports. RBF funds are not fully integrated into these	RBF funds do not make full use of government internal accounting and reporting checks and balances. The reform agenda could focus on alignment of these processes.

	processes, and employs alternative mechanisms to strengthen accountability.	
Budget evaluation	Government budget and basket fund allocations are subject to standard review of recurrent expenditures by the national audit office. RBF funds are audited separately on RBF compliance.	It remains difficult to do performance audits if not all funds are audited on the same basis. Integration would however require alignment of RBF with the government recurrent budget.

Acronyms

CCHP	comprehensive council health plan
DFF	direct facility financing
DMO	District Medical Officer
FFARS	facility financial accounting and reporting system
FMIS	financial management information system
HFP	health facility plan
IPSAS	international public-sector accounting standards
LGA	local government authority
MOF	Ministry of Finance
MOH	Ministry of Health
MSD	Medical Stores Department
PORALG	President's Office of Regional Affairs and Local Governance
RBF	results based financing

Introduction

In Tanzania, financing for salaries and wages is provided directly from central level with little discretionary room at district or facility level. For non-salary recurrent expenditure, districts and facilities receive funds through a number of avenues in Tanzania. Government funds are channeled to the council, which manages the funds on behalf of facilities. Basket fund allocations used to follow general government to the council level, but are sent directly to facilities since January 2018, following the direct facility financing reform initiative. Facilities already have some experience with managing funds directly from other sources: user fees are collected, retained, and managed at the facility level; the national health insurance fund reimburses some facilities directly on a fee for service basis; and facilities under the results based financing pilot receive funds and are accountable for the management and funds. An overview of the various fund sources and their recipient is provided in the table below.

Table 2: Funds receipt by source

	Government			Development partners	
	Salaries	Other charges-general purpose	Capital development grant	Basket fund	RBF
LGA	✓	✓	✓	✓ (prior to 2017)	✓
Facility				✓ (after 2017)	✓

Note: This table is a simplification as some RBF as well as basket fund allocations also go to the council level for various purposes. Also, some insurance funds reimburse LGAs.
Source: Author.

These streams follow different administrative processes across the spectrum of public financial management, potentially fragmenting incentives and diminishing their effectiveness. This note discusses and compares these processes, and assesses the alignment of the funding flows with one another. Based on this assessment, the note discusses potential reforms that would streamline financing mechanisms and make the health system more output oriented as a critical enabling strep to realize the long-term vision of a single national health insurance fund.

The current health financing arrangement

This section provides a brief overview of the three main channels through which funds arrive at the council and facilities: (i) the government budget; (ii) through results based financing; and (iii) through the basket fund in terms of direct facility financing.

Funds from the government budget

Tanzania has a two-tier government structure revolving around central and local government. Local government authorities (LGAs) carry an important role in the delivery of public services at the decentralized level, most notably with regards to primary care. Funds are channeled via the Ministry of Finance directly to the districts, which have the mandate to execute these funds. The President's Office of Regional Affairs and Local Government (PORALG), oversees the process and holds a critical stewardship role. Financing for salaries and wages is provided directly from central level with little discretionary room at district or facility level against predetermined establishment control. Budgets for other recurrent expenditures such as goods and services are provided to the district level against the approved budget. Districts follow the central government budget calendar and are guided by the public finance and local government finance act. Councils are the recipient of government budgets and execute on behalf of facilities who provide the services. Funds for other charges however usually make up a small share of the overall budget envelope (see ODI 2014), and are used for mostly administrative tasks. Support to facilities through this avenue is in terms of in-kind transfers, with councils maintaining overall accountability for the use of funds. Similarly, district capital development grants are managed through the district level and are subject to government budget rules and regulations. Facilities provide input through bottom up planning processes, but ultimately districts execute funds and are held accountable. Districts receive a virtual allocation for drugs, against which they can place requests from the medical stores department (MSD). The MSD gets funded directly from the treasury and the NHIF, and upon delivery of drugs, the allowance for councils and facilities gets deducted. All these transactions are routed through the government financial management information system (Epicor) at the district level.

Health basket fund through direct facility financing

Recurrent expenditures to facilitate service delivery are supported by a basket fund, which is donor financed. Until recently, the health basket fund was earmarked to support CCHPs and was disbursed to the council health account, which would manage and oversee expenditures and be held accountable for the use of funds. Processes were closely aligned to funds in the general government recurrent budget. The direct facility financing initiative is a recent departure from this model in that funds are sent directly to facilities instead. As such, facilities are responsible directly for budgetary management and have access to banking services, while councils take more of an oversight and reporting role. Facilities are expected to issue an elaborate facility health plan, against which they spend, and a facility governing committee approves this plan and provides regular oversight of the implementation. Performance elements were introduced at the council level and national level to supplement the base allocation.

Basket fund grants are sent directly from the MOF to facility bank accounts, thus bypassing the council level or lowest level cost center. The council is notified of the amount sent, and makes the release entry in Epicor. Facilities are responsible for accounting for the use of funds and

report on the use of funds with the associated documentation to the council periodically, which completes the transaction process in the Epicor system. To ease the expected additional workload, strengthen capacity at the facility level, the government is rolling out the facility financial accounting and reporting system (FFARS), which is intended to streamline accounting and reporting processes of facilities, and allow for ex-post posting of facility level financial information to the council level FMIS.

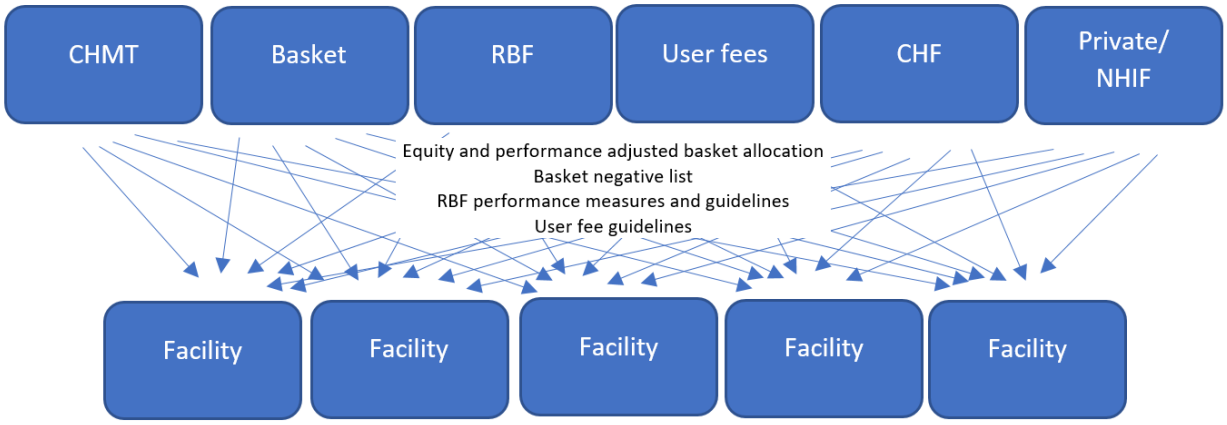
Results based financing

A results based financing pilot was initiated in 2015 in the Shinyanga, Mwanza, Pwani, Simiyu and Tabora regions. This was the first effort of providing financing to facilities directly. Facilities receive funding from a project co-financed by WB and USAID based on predetermined unit prices of services and quantity of services provided which are measured by a number of indicators as follows. To that end rigorous monitoring and oversight mechanisms were established to ensure integrity in the process. Further, the RBF introduced flexibility on the use of funds, including bonus payments to civil servants. Rather than following the annual budget cycle, RBF funds are guided by quarterly business plans. An effort was made to integrate these funds into the budget and a dedicated budget line was introduced to capture these flows under the development budget starting in 2017, though not at the same level of granularity as is for activities in the government other charges budget.

Alignment of funding flows

There is high fragmentation across funding sources to facilities. Funding sources include in-kind contributions from the council health management team, funds provided to districts through the basket fund, which has two tranches, RBF funds where facilities are more directly paid against outputs, user fees that are retained by facilities and subject to their own guidelines, as well as NHIF funds and CHF funds. This arrangement is shown in the figure below:

Figure 1: Current financing arrangement for facilities



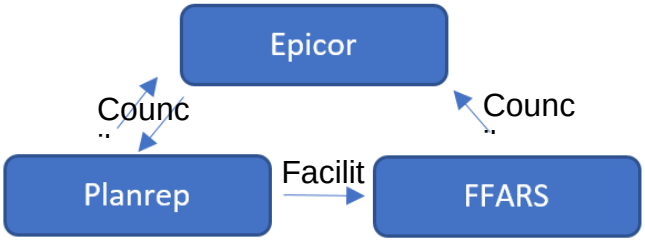
Source: Author.

Fragmented funding sources have own spending protocols, which makes optimal planning difficult. Even though systems are becoming more integrated, and facilities have one facility

health plan, facilities are still required to plan activities against funding source and ensure compliance to spending protocols for that particular funding source. Planning to optimize outputs against six different guidelines and funding projections against these guidelines becomes a very difficult task, especially given the unpredictable nature of the sector. What this has meant in practice for facilities is that the negative list for basket funds (e.g. capital expenditures) needs to be honored during the plans. Basket fund resources are thus used for recurrent expenditures. RBF funds have more flexibility for the use of funds with a formula of 25/75 percent bonus and other expenditures having to be applied. Anecdotal evidence suggests that facilities usually use the 25 percent for bonus payments, and much of the remaining 75 percent of allocations for capital investments, as they cannot use basket fund payments for that. The fragmentation is particularly of concern given the tight expenditure control. An unforeseen shortfall of funds in one category cannot easily be substituted by another, and a crucial activity that was planned for under one source may not be implementable while there is funding available for other less important or urgent tasks.

The integration of management information system has strengthened processes significantly. All plans at the district and facility level are developed in Planrep, regardless of source. This forms the basis of the budget, and the consolidation of plans across sources has led to increased stewardship at the facility level. Plans from Planrep are loaded into Epicor at the council level and FFARS at the facility level, which ensures that funds are spent against these plans. Expenditure information is then posted back into Planrep to enable reporting against various objectives or programs. FFARS spending information is exported into Epicor periodically, which is used as the principal government financial management information system, from which financial reports are drawn. The integration of various tools is displayed in the figure below. While RBF funds are disbursed to the facility level, they are not making use of the full FFARS functionality and are not subject to the same level of controls.

Figure 2: Communication of planning and reporting systems



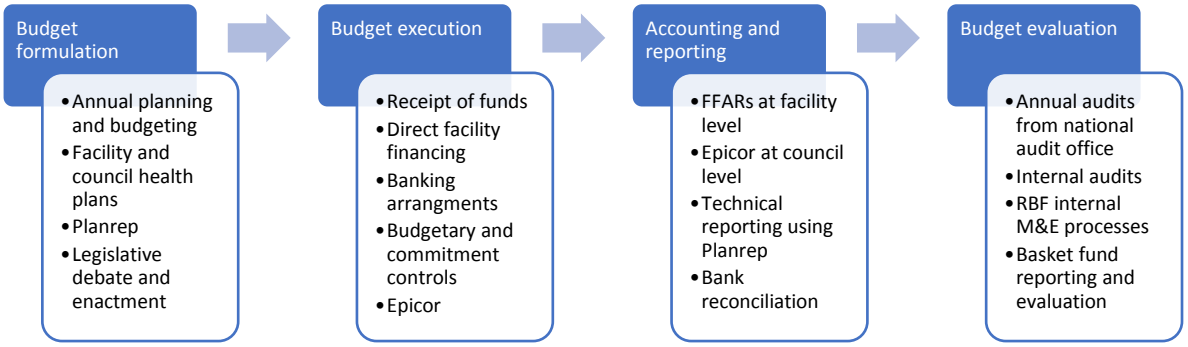
Source: Author.

The introduction and integration of various tools at the facility and council level has increased the stewardship function of facilities significantly. However, this only partially addresses the problem of fragmentation as long as expenditure protocols vary by funding source. A more foundational reform would require the pooling of funds at a higher level, and developing a common provider payment mechanism against which facilities are reimbursed.

All LGAs in Tanzania follow the country-wide PFM cycle. The budget formulation stage is underpinned by strategic budgeting, where high-level policy directives are translated into functional expenditure ceilings, and budget preparation, the mechanistic preparation and

finalization of the annual budget that is submitted to the legislative. This is conducted against a budget circular issued to assist the engagement between the LGAs preparing the budget proposal and various counterparts. This proposal is then submitted to the legislative (full council for LGAs) for scrutiny and approval. This then becomes the annual budget law, and the LGAs have the mandate to execute it. Execution should be done against the budget approval. In this process, some flexibility exists as virement within a vote and budget categories does not require in-year amendments with full council approval[1]. Internal control and audit processes accompany budget execution to ensure compliance with established rules. Internal control is enforced through the government financial management information system, which is decentralized to the district level and accommodates for government financial accounting and reporting. External oversight is provided by the national audit office on an annual basis through mainly financial audits. These various stages of the budget cycle are summarized in figure 1. This chapters discuss the various financing streams in further detail and the extent to which they are aligned with one another.

Figure 3: The Tanzania budget cycle



Source: Author.

Budget formulation

Formulation of the government budget. The government budget consists of recurrent personal emoluments, recurrent other charges, and development expenditures. These are all managed at the council level and not the facility level. Recent devolution efforts through direct facility financing applies to donor financed basket funds only. The provider payment mechanism for government funds is in terms of in-kind contributions from the council level only. The DMOs supported by the CHMTs are responsible for producing a comprehensive council health plan (CCHP). Though these are based on facility health plans, for government funds they are consolidated at the council level, who is the recipient of these funds and eventually also charged with the execution of funds. Facilities are consulted, but play a lesser role as final decisions are taken by the council and activities are conducted at the aggregate level making it difficult to monitor which facility is expected to benefit from which activity. The plans are produced in Planrep and integrated into Epicor. Plans are intended to be comprehensive of all sources, on and off budget alike and include expected user fees. CCHPs are submitted to the regional level and

[1] Full council approval is not required where (i) virements are between items within the same vote provided these items were part of the original budget, (ii) there are no virements from other charges to personal emoluments, and (iii) the overall budget amounts do not change (LGFM Para 18 (3)).

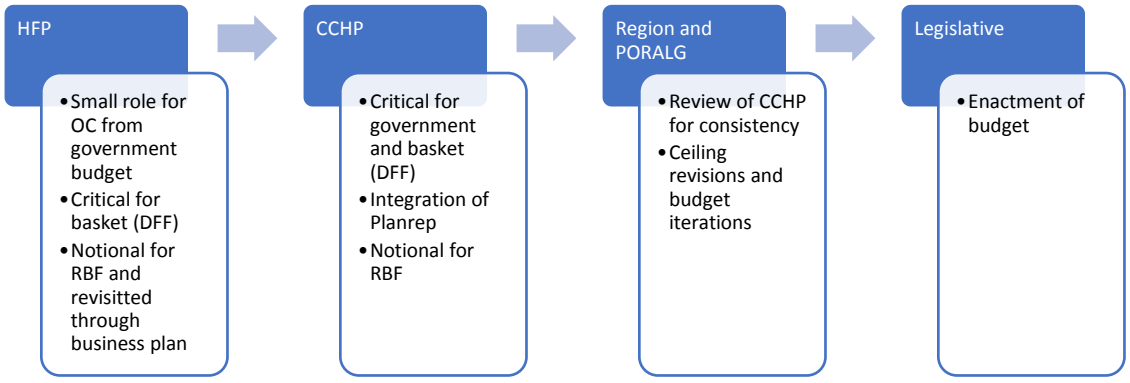
PORALG, for quality control and compliance, are consolidated and then further submitted to the legislative. In the development of the CCHPs no formal budget ceilings are set and the direction given is to use the previous years' budget as an indicative ceiling. In practice, plans for activities reflect 'need' rather than budget ceiling expectations. CCHPs are submitted to the region, reviewed for consistency and subsequently to PORALG, which consolidates and passes them on the MOF as the budget proposal. At this point the MOF decides on an aggregate budget ceiling, which may deviate from the submitted proposal (World Bank 2016; PEFA 2017). The submitted budget proposal will then have to be revisited at the council level and undergo the above-mentioned processes to meet the actual ceiling. Budgets are binding and developed on an annual basis.

Formulation of the basket fund budget through DFF. Devolving financing responsibility to the facility level also entails devolving the planning responsibility. A bottom up approach is taken, and facility health plans are given more prominence. Facilities prepare an annual plan based on estimated needs, which is submitted to the respective DMOs, who (supported by the CHMT) collate them and prepare the CCHP. CCHPs are submitted to the regional level and PORALG where they are consolidated, and passed on to the legislative. The basket is funded from external sources and the ceiling is set accordingly through the development budget. The provider payment modality for this funding source is largely input based reflecting standard government budgeting processes, based on a pre-agreed formula on the distribution of funds. This however includes two important performance adjustments. Of the agreed amount a 70 percent base payment is provided adjusted for equity, (distance from council HQ), need (population), and utilization (outpatient visits as a proxy for performance). The 30 percent tranche is determined by the performance against a set of indicators. Providers are thus paid from this funding source largely on an input basis. All plans are developed on an annual basis by the facility in Planrep against ceilings, are integrated into the CCHP, and undergo the same approval and scrutiny process as regular government funds. Facilities need to project expected revenue from the basket fund, such that they can execute against the plans during the year.

Formulation of the RBF budget. The health facility management team develops a health facility plan, that feeds into the CCHP. As with the basket fund DFF model, these CCHPs are submitted to the regional and PORALG level from where they are subject to legislative scrutiny. They too are presented in the development budget. An important difference is that RBF requires the development and submission of clear business plan, as a precondition for receiving RBF funds. Facility health plans and CCHPs give an overall budget envelop estimate and are indicative of the activities expected to be pursued with RBF funds, but are not binding. Quarterly business plans reflect on performance to update ceilings, and allow for a revision of planned activities. The business plan specifies the strategies to be implemented to increase performance and indicate the essential resources (human, material and financial) required in achieving the business plan objectives.

Alignment of budget formulation. There are important differences in the budget formulation process across the various funding sources. An overview of the budget formulation process and associated issues is provided in figure 2 below.

Figure 4: Key issues in the budget formulation process



Source: Authors.

Health facility plans play a more prominent role in determining basket fund budgets than government or RBF budgets. Health facilities receive a budget directly against available funding from the basket and facility plans. In contrast, for the government budget, they contribute to the CCHP (and are annexed to the CCHP), but are only an input for the council, where revisions are made. As funds from government sources are executed at the council level on behalf of the facilities the relationship between what facilities hope to receive through their facility plans and what the council receives and executes on their behalf can be tenuous. RBF make use of facility health plans, but inputs are revised on a quarterly basis in their business plans. The relationship between annual facility plans and actual RBF budgets can thus also be tenuous. Substantial revisions to plans for government budget require virement and need to be resubmitted. There is an opportunity to do so usually every 6 months. (LG PEFA 2017)

Budget ceilings are determined differently across sources. Budget ceilings for government funds are determined relatively late in the planning process. Plans are developed against need and a notional budget in November/December and submitted to PORALG. Once ceilings from MOF become available in April/May plans need to be revised accordingly. This is in contrast to basket fund budget ceilings, which are a function of donor contributions and performance at the facility and council level. The budgets facilities receive through RBF are not predetermined by the annual plan, but rather a function of the facility performance. The actual budget available to the facility is given for each quarter based on the performance reported against the given set of indicators and targets.

The use of Planrep is critical in the assignment of government and basket fund budget allocations, but less so for RBF. Facility health plans and CCHPs get loaded into Planrep for formal budget submission. Planrep budgets are subsequently loaded into Epicor and FFARS, the budget execution systems. Planrep is key for government funds and basket funds, as spending units (councils for government budget and facilities for DFF) cannot request funds without the budgetary allotment in the execution system. Planrep plays a less important role for RBF funds, as activities do not get executed against the Epicor/FFARS loaded budget and plans are periodically revisited.

The legislative plays a more important role for government and basket funds than RBF. The legislative reviews budget proposals that are produced from the various CCHPs. All government funds are subjected to rigorous compliance control before submission. As basket funds are comprehensively included in the CCHPs, activities proposed from this funding sources is subject to the same oversight and approval process. RBF funds are included notionally at an aggregate level. They are however not subject to the same level of detail of review.

Concluding remarks. Health facility plans and CCHPs are comprehensive plans inclusive of all sources of funding. Prior to DFF, these plans only remain relevant in theory, facilities are not accountable for whatever is planned in CCHP because funds from government and basket fund are budgeted and executed at the council level on behalf of facilities, there is no mechanism to ensure the consistency between facility level-planning and council-level execution. However, after the DFF, facilities are expected to be more accountable to what is planned for basket fund as there is now a closer link between the planning and execution.

As of RBF, it is attached to CCHP, but again, what really matters is the quarterly business plan. And there is no mechanism to ensure consistency between these quarterly business plans and annual CCHP.

Budget execution

Government budget. There are four stages in the Tanzania budget execution process: (i) allocations of appropriations and release of funds to spending units; (ii) commitment; (iii) acquisition/verification; and (iv) payment. Funds are released by the MOF to the spending units / councils by notifying them of the cash limits. Funds are transferred to their respective accounts depending on purpose. At the commitment stage, future obligations to pay are incurred. Commitments are placed against the budget and appropriations. This includes placing an order or awarding a contract for goods or services to be received or works to be completed. The commitment entails an obligation to pay, but payment will only occur once the other party has complied with the provisions of the order or contract. At the acquisition/verification stage the goods are delivered and/or services are rendered and their conformity with the order or contract is verified. Payment happens after goods have been received and verified. Payment can happen through a variety of instruments including cash, checks, electronic transfers, and vouchers. These individual processes are guided by Epicor, that provides budgetary and commitment control as well as integration of payment and reporting functions. Checks and vouchers are only issued if there is budget availability, and are produced automatically by the system. The budget is executed at the council level, which is the lowest level of Epicor. The council executes the budget in all sectors and prioritizes activities as funds come in. As such these are fungible within their category. Once funds have been released into the district treasury sub-account the district can execute an activity in the budget.

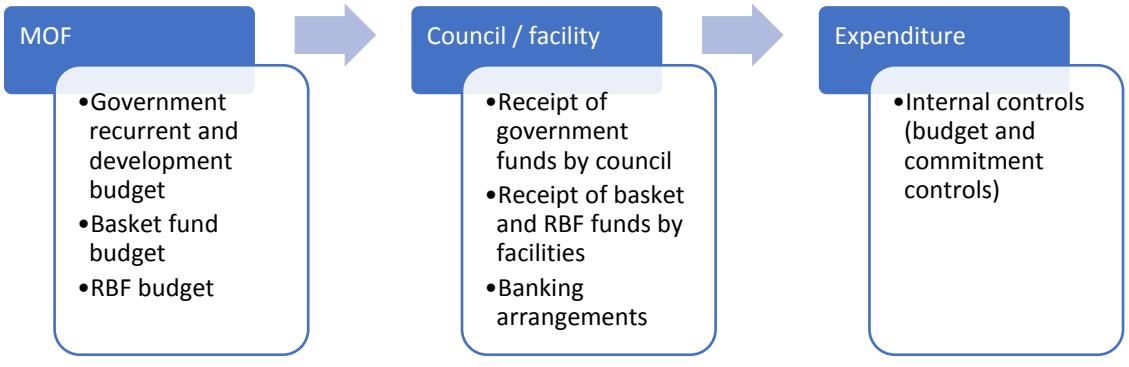
Basket funding with DFF. With the introduction of DFF, lower level facilities receive funds directly and need to execute and account for these funds. Dedicated bank accounts have been set up at facility level for this purpose. Dedicated cost centers have recently been set up at the facility, and processes at the facility level mimic those at the council level. Facilities use FFARS to execute the budget, which checks for budget availability and also has commitment control integrated, and thus is similar to Epicor in its fundamental functionality. FFARS is fully rolled

out across all councils, but an offline version is used in remote councils with limited or unreliable electricity and IT access meaning that system internal controls are manually applied.

With RBF. The budget execution process differs significantly from that of the government and basket funds. An effort is made to use existing systems including Planrep and FFARS, and actual expenditure is subsequently posted into Epicor. However, execution rules cannot follow appropriations the way they do for government and basket funds, as quarterly business plans change the layout of annual plans, and Planrep is locked at the beginning of the year. To integrate the change into Planrep a supplementary budget would have to be submitted, which is not feasible. Thus, with RBF, facilities retain the flexibility to use funds as required within certain guidelines (e.g. cap on staff bonuses, procurement, etc…) and follow the implementation of the quarterly business plans. Prior to the utilization of RBF funds, it is required to obtain consent from the health facility governance committee (HFGC), to ensure adherence to RBF guidelines. Once funds are spent, they are reported against the chart of accounts and accounted for at the district level with Epicor, which is in alignment with other funding streams.

Alignment in the execution of funds across sources. The execution process and alignment questions across funding sources is outlined in the flowchart below (figure 3). Government funds at the council level and basket funds at the facility level undergo similar execution processes and are subject to similar internal ex-ante controls. Epicor, the treasury system is used in all councils and subjects payments to budgetary control as well as ex-ante commitment control. In other words, the system checks whether funds are available for an activity, and whether there is an appropriation. These internal controls are rigid at the line item level. FFARS is used at the facility level and also subjects payments to these controls. However, more flexibility is granted as facilities can adjust line item inputs without virement. For RBF the process has been manual and payments are not subjected to this level of control giving facilities greater flexibility in terms of use of funds and deviations of plans. These need to be approved through internal processes (facility governance committee), but do not require virement. Quarterly review of business plans, also give facility mangers the opportunity to revisit plans for RBF funds, to adjust them to unanticipated need. Discussions on the integration of RBF funds into Planrep and subjecting payments to FFARS will make the flexible nature of funding and execution more challenging going forward.

Figure 5: Alignment of execution processes



Source: Authors.

Banking arrangements are an integral part of the execution process. At the LGA level, districts use government bank accounts under the purview of the treasury. Facilities often maintained separate accounts for various donor sources or to deposit user fees. The introduction of results based financing necessitated the opening of bank accounts – if facilities did not have them already - as facilities were given greater financial autonomy. Similarly, routing basket fund grants to facilities directly also means that banking services are necessary for operational tasks. The DFF reform agenda includes a clause that a single account inclusive of all sources should be opened to provide more clarity on the cash position. Accounting and reporting is intended to be streamlined through the use of the FFARS. Upon the receipt of funds, facility management records this into the FFARS software, which enables budgetary control and allows for subsequent requests against these funds for activities in the plan. Thus, while funds are managed in one account, they are not pooled at the facility level but remain separate for their individual intended purposes.

Accounting and reporting

Government accounting and reporting. All financial transactions are executed through the FMIS at the district level. The budget is loaded in the FMIS, and checks and vouchers are issued directly from the system against the budget after a set of ex-ante budgetary controls are applied. Thereby the system integrates the planning, budgeting, spending, and recording processes, which ensures that the data has integrity. The system includes reporting modules that allows users to generate pre-assigned budget execution reports at various levels of aggregation. Given that the system operates live, at any point in time reports scan be pulled, giving the exact financial position of the spending unit. The available reports from Epicor are however fixed and have been developed a long time ago. There is limited scope for on demand customization, and user report development capabilities are low. Further, there is limited evidence that a data-warehouse has been implemented and integrated with a business intelligence interface, which would give users the ability to formulate queries against the system database in order to produce a variety of fiscal, budget execution, and other analytical reports. On the upside, the National Audit Office has direct access to the FMIS database, can draw specialized reports, and use these to investigate.

Basket fund accounting and reporting. The nature of accounting is similar to that of government processes despite using a different system and being decentralized at the facility level. Financial management processes have also been integrated through FFARS, and are similar to those in Epicor. Commitment control in FFARS ensures that expenditures are reported against budgets. Further, the system produces cheques and vouchers thereby integrating the transactions and reporting functions, which gives confidence that reports have integrity and are auditable.

RBF accounting and reporting. RBF funds are not fully integrated into Planrep and FFARS as this would limit the flexibility on the use of funds. Though RBF funds do use FFARS for accounting and reporting, funds are not subject to full FFARS functionality. For government and basket funds, once the budget is loaded into FFARS in the beginning of the fiscal year, the program is locked, and the budget executed against it. With RBF and the use of quarterly business plans it is necessary to periodically update plans and budgets which cannot be done if FFARS is locked. Flexibility for RBF requires that these essential control features in FFARS are overridden. This means also that the financial management processes at the facility level are not integrated across all sources. For example, checks and vouchers are not issued from the system

against the budget and subsequently retired in the system. Rather they are issued on a manual basis, and transactions are recorded in the manual ledger after they have occurred. This does not guarantee that the utilization of funds is actually reflected as such in the ledgers unless rigorous ex-post audits are frequently conducted. Secondly, it is not possible to obtain accurate information on the actual expenditures incurred at a given point in time since the manual data entry are only uploaded periodically to the FMIS. On the upside however, rigorous monitoring has been institutionalized, which provides further guarantees of the integrity of the reporting information. Further, performance indicators are set up that reward facilities against good financial management and reporting. Financial reports are required on a quarterly basis and are a prerequisite for the subsequent release of funds. The internal audit department is given the mandate to carefully review these for inaccuracies.

Budget evaluation

Government budget. Districts are required to send their annual financial reports to the national audit office for external audit and accountability processes that conclude each budget cycle. The main role of the NAO is to examine whether government financial activities were carried out in compliance with the original budget law, and respecting all other rules and procedures. In addition, it ought to perform technical and value for money assessments of public spending (looking, for instance, at what kinds of services were purchased with public money). Their reports and findings are used by legislative bodies to raise issues and concerns with the executive as a whole (given audits of annual financial statements, for instance), and with executive agencies individually (given the value for money audits, for instance). Government officials have to appear in front of specialized committees to respond to concerns about spending, and have to respond by detailing the corrective actions they intend to take.

Budget evaluation of basket funds. As a cost center has been established at the facility level and facilities document expenditures through FFARS and post them to Epicor similar processes as for the government budget apply. The NAO will be able to access expenditure statements and conduct audits as necessary on an annual basis.

Budget evaluation for RBF funds. For RBF payments that do not use the FFARS, as the primary accounting tool, audit may become more difficult as the transactions do not happen at the cost center where they are stored. Further, transactions will be recorded per line item in the chart of accounts for the district as a whole, but not by the various facilities as they do not have cost centers. As such it will be difficult to hold districts accountable to funds that are recorded in one line item and for which ledgers are kept in facilities. A forensic exercise would be necessary to determine whether the total amount recorded by line item in the FMIS at district level indeed matches the aggregates accumulated from facilities. This may however be prohibitively expensive and time consuming.

An overview of the alignment of the various stages and funding sources is given in the matrix below:

	Government budget	***Basket fund after DFF***	***Results based financing***

Budget formulation	CCHPs produced at district level; facilities consulted; authority on allocation by district; budget derived from district plans; ceilings set at MOF level; adjustments made without sufficient consultation	Produced by facilities; collated by districts; budget derived from facility plans; ceilings set at MOF level; adjustments made without sufficient consultation	RBF funds planned against in CCHP; RBF business plan integrated into CCHP; budget is determined on a quarterly basis and a function of facilities' performance.
Budget execution	Budget executed in Epicor against line items	Use of FFARS; budgetary and commitment controls maintained. Control at activity level, providing more flexibility.	Execution process happens manually; more flexibility re use of funds. Use of facility governance committees
Accounting and reporting	Real time reporting possible through FMIS; integrity of reports should be guaranteed	Real time reporting possible through FFARS; use of government accounting systems and protocols	Actuals reported to district level FMIS from where financial reporting is done; has implications on integrity of data and timely availability of reports; additional guarantees given through close monitoring of FM processes
Budget evaluation	National audit office conducts financial and technical audits of transactions at the district level	National audit office conducts financial and technical audits of transactions at the facility level	Financial and technical audits may be difficult to do given misalignment in accounting and reporting

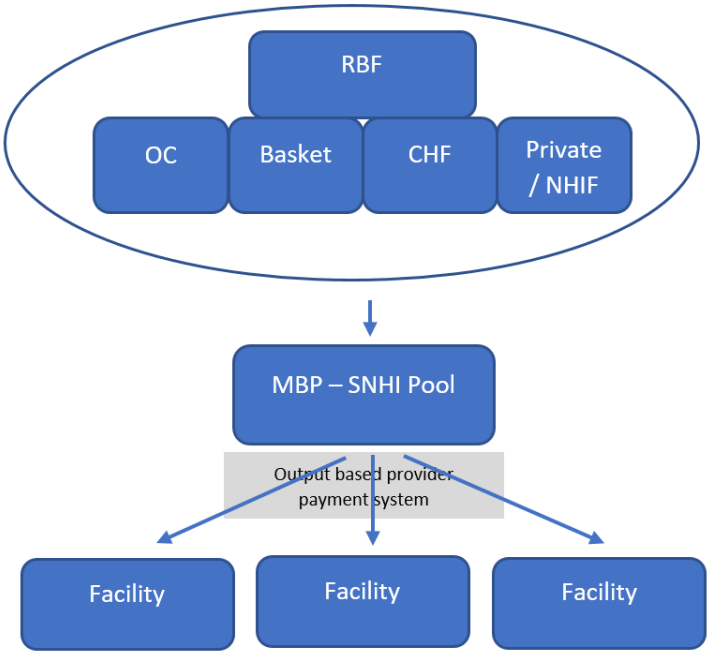
Toward an output-based system: what will it take?

The various purchasing modalities outlined above are not conductive for an efficient health system as not a strategic approach is taken. Incentives can be conflicting, processes prone to duplication, and effective planning difficult.

This note suggests reforming the purchasing modalities to fold together the various funding sources and take a more overall strategic approach that would lend itself to greater government ownership and has the potential to foster efficiency gains. A scenario where all sources are combined is outlined in Figure 6, where the government budget (through other charges), the donor basket fund, and the community health fund are pooled and topped up with a performance portion from the RBF funds. This pool of funds could then be drawn upon to purchase a minimum set of services (or benefits package) from facilities and the modality through which purchasing happens can be a strategic combination of equity adjusted capitation and fee for service or output/performance orientation. Such an approach is not a drastic deviation of the current status quo, as many of these elements are already reflected through the fragmented

financing modalities. Pooling funds together would however institutionalize the process and ensure greater alignment and a more strategic direction and ownership from government.

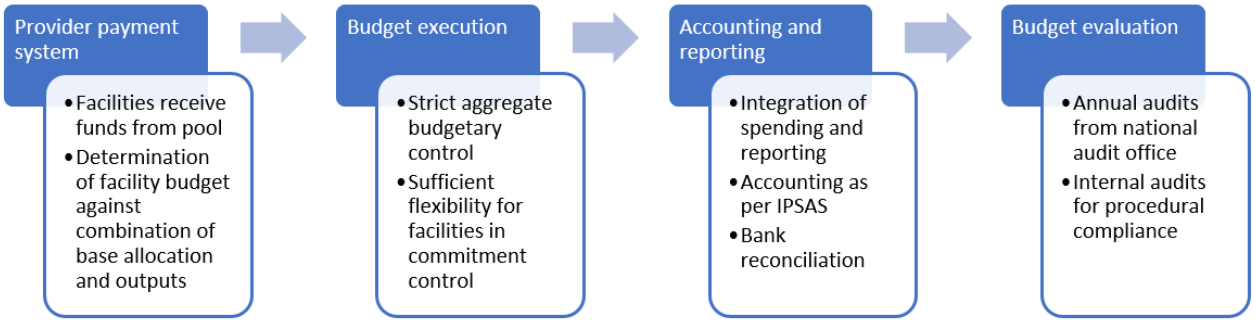
Figure 6: Pooling funding sources to enable an effective provider payment system



Source: Author.

Shifting toward an output-based system using current health financing modalities. If government budget modalities are a credible interim modality, how can these become better integrated and more output oriented. A lot of experience has been generated through piloting RBF and DFF, and mainstreaming some of some of these concepts hold a lot of promise. A lot of groundwork has already been laid fundamentals such as facilities having their dedicated cost centers and access to banking services are provided. It would subsequently be critical that facilities also have sufficient autonomy during the budget execution stage, which will require a departure from the current status quo, where there is strict line item control at the council level, and strict activity control and the facility level. RBF funds already use a more flexible system, which has shown to be subject to minimal accountability concerns. The chart of accounts also already accommodates for an output-based budget structure, and it will be necessary to elevate the controls to that level to make the budget effective and allow facilities to execute activities according to need rather than according to line items. This will require an adjustment of the systems, as the accounting and reporting will have to continue at a line item level, and it is necessary to guarantee integrity of financial transactions and report accordingly following government guidelines. Once these provisions in the execution stage of the budget have been addressed, the way facilities receive their budget can be reformed to make it more output oriented. One way of doing this, would be by pooling government and donor funds (RBF and basket) that are dedicated for front line service delivery and make them available to facilities in the form of block grants. The actual value of these could be adjusted by performance measures. The processes that underpin this are outlined in figure 7.

Figure 7: Toward an output-based payment



Source: Authors.

Next steps: The following presents a roadmap for alignment of financing mechanisms, and a discussion of areas that are in need of attention.

Step 1 (Short term): Integrate PBF and DFF in the basket through donor support. It is critical that donors merge fragmented financing and develop a join mechanism to finance facilities that builds on the basket and RBF experience. Here, the DFF formula could be revisited to integrate critical PBF experience to focus attention on results related to maternal mortality. This may include partially replacing the DFF formula (focus on OPD, capita and equity) to include institutional deliveries, family planning and quality dimensions (e.g. star rating) instead.

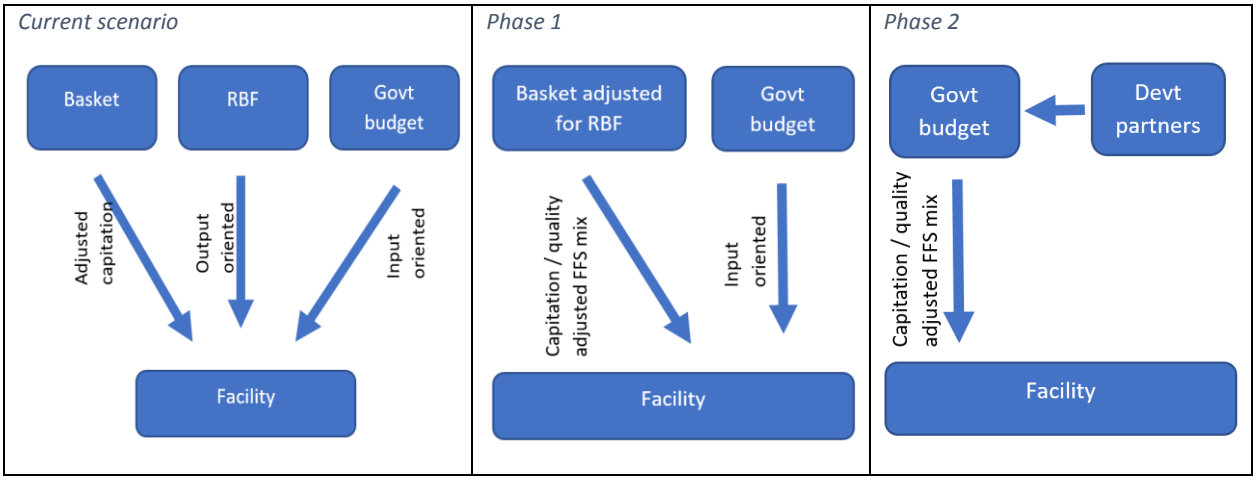
Step 2 (Short term): Government has already set up facilities as separate spending units and has also committed to channel government funds through facilities. This should be closely monitored to ensure that this also happens.

Step 3 (Short to medium term): Work on government PFM structure so they become more flexible, and output oriented, with the vision to eventually be able to fully absorb the donor financed strategic purchasing mechanism. This work necessitates an active dialogue, and technical assistance to accelerate reform in this area. This should happen in parallel to step 1 and 2 and eventually facilitate step 4.

Step 4 (Medium to long term): Gradually reduce donor capitation/FFS funding and transition to sector budget support with strong conditionality that government draws on these funds to continue strategic purchasing entirely through government systems.

The flow of funds scenarios for unifying financing streams is shown across different phases is shown in figure 8.

Figure 8: Unifying financing streams



Areas that require attention to accelerate unification of financing streams:

Alignment at the planning stage. Quarterly business plans as currently done for PBF may be difficult to maintain. It may be necessary for PBF to give up the practice of quarterly business plans and alignment with the annual budget process. This would however require that a mechanism be developed that allows for sufficient flexibility during budget execution such that facilities can adjust spending and be held accountable for the delivery of outputs.

Flexibility in spending will need to be improved. There are currently various rules in place that govern how facilities can spend funds, including a negative list of items that may not be spent on for basket funds, and strict input based commitment control for the government budget. Integration of PBF into the general budget would require that some of these rules would be relaxed. Given that this would constitute the entirety of the facility budget a negative list of spending would likely have to be abandoned, and facilities given the opportunity to also invest in small scale infrastructure and be allowed to pay salary bonus payments. Some control against spending categories will likely still be necessary. For example, it will likely be important to protect PE expenditures and utilities as these are quasi statutory. However, within categories – especially within goods and services, greater flexibility should be granted.

The budget credibility in health must be improved. Currently PBF works on the premise that facilities will be reimbursed against the outputs delivered. This can only work, if the promise is actually maintained and financing follows performance. Currently, the government budget allocations are often not financed leading to low budget execution rates. This situation must be drastically improved such that facilities can rely on transfers, as this may otherwise fundamentally undermine the reform.

Accounting and reporting will use full FFARS functionality. If there is alignment in the planning process and increased flexibility in spending, full use of FFARS should be possible. FFARS functionality will have to be updated to reflect updated rules and regulations.

Verification and budget evaluation. Verification for PBF is rigorous and non PBF funds are not subjected to the same level of scrutiny. Verification in itself is administratively not in conflict with DFF PFM processes, but likely to be prohibitively expensive in a nation-wide scale up. Details of reporting against outputs, verification of reporting and costing implications will have to be worked out. All funds would however be subject to regular annual compliance audit and value for money audit to adjust mechanisms for the subsequent budget cycle.

List of documents consulted

PFM and Flow of Funds

PEFA 2016 (draft) / 2013 final
LG PEFA 2016
Mapping of Transfer of Funds to LGAs (URT 2013)
PETS Stock take and Recommendations for Tanzania (DfID 2013)

RBF and Health Finance

RBF Operations Manual and Design Documents (2016)
Health Sector Public Expenditure Reviews (various)
Health Sector Strategic Plan (2015)
Health Finance Resource Allocation Study (2013)
Options for FM and Reporting Paper (2014)
Fiscal Space for Health Paper (2014)
Provider Autonomy Options Paper (2014)

Laws and regulations

Public Finance Act (2001)
Public Audit Act (2008)
Public Private Partnership Act (2010)
Public Procurement Act (2011)
Local Government Authorities Act (2002 Urban / District)
Regional Administration Act (1997)
Local Government Finance Act (1082)
Local Authority Financial Memorandum
Local Authority Accounting Manual

Appendix 1: PFM realities that may affect implementation

Budget credibility is low. It is important that the recurrent budget becomes credible. If facilities are to be reimbursed against services provided the government needs to honor its commitment. If the funding envelope is unreliable and facilities are not reimbursed adequately against services provided, this may act as a strong disincentive and undermine the reform. The 2016 local government PEFA assessment noted that in only 2 out of 12 LGA under review was the variance of budget to expenditure below ten percent and the quantum of expenditures varied in most councils by more than 15 percent. (PEFA 2016) This was predominantly driven by poor predictability of transfers from higher level government. It will be paramount for the reform agenda that government commits to honoring budget appropriations.

Councils cannot cushion against risks. As facilities receive funds directly, this has the upside of more reliable funding streams for the individual facilities. On the downside, however, facilities will be more exposed to disbursement fluctuations. While, districts would have been able to cushion against funding shortfalls and reprioritize to districts in most need, this will no longer be possible under DFF. As the general budget performance is relatively poor (PEFA 2016) at the district level, this may pose a serious risk.

The revision of plans after the determination of final budget ceilings should involve the facilities. A deviation between proposed plans and actual government ceilings for districts has been documented (World Bank 2016). As adjustments to plans are made at the council level or above with little input from the facility, this is likely to diminish a facility's ability to predict what it can expect from the council and undermine its ownership of the budget. As facilities are given increased financial autonomy, it will be important that they play a more active role in revisiting plans, once final budget ceilings have been determined.

The chart of accounts at central level need to be aligned with reforms at the local level. The chart of accounts at the central level do not capture the output orientation of the budget that is implemented at the local level. Alignment of the chart of accounts is not urgent, but would facilitate better stewardship and coordination by the MOH in the medium term.

Output based budgeting needs to be implemented at execution. The chart of accounts has been updated to allow for the classification of outputs. While this is a welcome first step it is crucial that execution follows suite, and elevates the level of expenditure control to this level by economic function. As long as expenditure control remains at line item or activity level, facilities do not have the necessary flexibility to respond to need, which fundamentally undermines the output orientation of the budget. If facilities are paid against outputs, they need to have the autonomy to produce the outputs that are required. This cannot be perfectly anticipated in the beginning of the year. Public financial management reform will be necessary to facilitate increased flexibility, at least within cost categories. The current modus operandi at council and facility level is strict ex-ante commitment control by Epicor and FFARS. Limited flexibility within votes and categories is possible.

The cost of services is difficult to determine. An output-oriented budget system in which facilities are reimbursed against services delivered requires the determination of the unit cost of

the various services. This requires detailed spending information, which is difficult to obtain especially for the allocation of staff time.

Acknowledging the role of FFARS in general government financial management. FFARS is taking on a core budget execution responsibility at the facility level that is managed by the financial management information system (Epicor) at the council level. In essence, the capabilities of the systems overlap in that internal controls are enabled in FFARS and it is integrated with Epicor at a higher level. It is thus important that FFARS will be considered as the roll out of the FMIS to lower level facilities to prevent a separate parallel FMIS roll out engagement that could fundamentally undermine the progress that was already being made. As this goes well beyond the purview of the health sector, it should be done in close collaboration with the treasury and PORALG.

Governing by decree. Government has devolved authority to facilities by decree, but will have to revisit its local government financial management act to formalize the process. While this is not urgent, it will have to addressed in the medium term to avoid possible conflicts, and ensure there is accountability across all stakeholders.