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MINISTRY OF HEALTH

DEVELOPMENT OF HEALTH SECTOR REFORMS IN TANZANIA

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1: INTRODUCTION

This paper describes the challenges facing Tanzania in the 1990's, the National Health Policy and the Primary Health Care Strategy, what Health Sector reforms are, the basis and strategies for reforming the health system, Sector Wide Approaches (SWAps), and aspects of public sector and Local Government Reforms relevant to Health Sector Reforms.

2. CHALLENGES OF THE 1990's

2.1 Health Status

Health indicators in Tanzania, similar to those of other developing countries, are below acceptable levels. According to the 1988 Census, life expectancy at birth was estimated to be 51 and 55 years for males and females respectively.

The Infant mortality rate of 107 per 1000 live births is considerably high and so is the under-five mortality rate which currently stands at 161.1 per 1000 (Tanzania Reproductive and Child Health Survey, 1999) and it is expected to rise as result of HIV/AIDS. Maternal mortality rate is estimated at 529 per 100,000 live births (TDHS, 1996). Statistics indicate that 90% of mortality among inpatients is due to communicable and other preventable diseases (malaria, diarrhea diseases, HIV/AIDS, nutritional deficiencies, and measles).

Underfive mortality is mostly due to malnutrition, anemia, pneumonia and diarrhoeal diseases. Maternal mortality rates are pushed up by high fertility rates, the large percentage pregnancies which are high risk, poor access to and the utilization of essential obstetric services and poor quality of antenatal and postnatal referral system.

2.2 Health Sector Financing

In the period between 1961 and 1985 the country's strategic planning focussed on the equitable establishment of health care facilities with particular emphasis on the development of the rural health infrastructure.

This was very much in line with Government Policy as embodied in the Arusha Declaration. Subsequent surveys indicated a unique success story within the context of Sub-Saharan Africa Region. By 1985 the coverage of Public Health Care services in Tanzania was such that an estimated 90 percent of the population were living within 10-km distance from a health care unit and 75 percent of the population were within 5-km distance. Each district was provided with a district hospital or a district designated hospital (a voluntary agency hospital contracted to provide public services).

The achievements described above did not come without major implications. The infrastructure expansion created a greater demand for skilled health workers, medical drugs, equipment and transportation. The ensuing budgetary requirements over-stretched Government funding capabilities even when supported by external partners. In terms of provision of essential drugs and equipment for instance, annual budgets could only meet up to 60% of estimated funds.

2.3 District Empowerment and Community Participation

The district has always been an important level in the delivery of health care services in the country. A typical health district in Tanzania will demonstrate the following key characteristics:-

- Its geographical location and boundaries will be the same as the government defined administrative district.
- It will have a defined service population, usually 399,000 to 600,000 people.
- It will have a district hospital or district designated hospital with several satellite health centres and dispensaries.
- It will have a district health management team to lead other health workers in the provision of services and execution of programmes and projects.

The greatest challenge at this level has been to build capacities for planning, decision-making and provision of quality health services. In addition, health facilities including hospitals have for a long time been managed from central level authority, denying the population in the district their right to contribute administratively and economically. Prior to 1991 private participation in the provision of health care services was restricted through the Private Hospital Act.

2.4 Emerging and Re-Emerging Diseases

In the early 1980's the new disease HIV/AIDS that was to change the epidemiological map of the region hit Sub-Sahara Africa. Tanzania did not escape this scourge. Available statistics show that at the end of 1998 more than 100,000 AIDS patients were registered in treatment centre. This figure is only a fraction of all AIDS cases estimated to be 600,000 whereas those infected with the HIV Virus are estimated to be 1.6 million. Fuelled by HIV/AIDS, Tuberculosis has been on the increase. In 1999 over 52,000 patients were reported to suffer from the disease.

Malaria is re-emerging as an important public health problem. In Tanzania, annual deaths from the disease are estimated at 100,000 people, costing the nation as average US$ 120.0 million per year. Morbidity statistics indicate that on average 30 to 45 percent of all patients attending hospitals suffer from malaria. Other conditions, of no less importance, challenging the Tanzania health system are waterborne diseases and other infections.

2.5 The Refugee Crisis

Internal wars and political instability in neighboring states has persistently, throughout the years, made Tanzania one of the biggest refugee destinations in the world. During the last two decades the refugee population has fluctuated between 300,000 and over 1,000,000 people. A large refugee population will always have an impact on epidemiological patterns of disease in a country and the utilization of resources in service provision and disease control.

3. THE NATIONAL HEALTH POLICY AND PRIMARY HEALTH CARE STRATEGY

The overall objective of the National Health Policy is to improve the health and well being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the need of the people.

Strategies to achieve the national health policy include the following:

- Improve health status of the population to raise life expectancy, reduce population's burden of disease (BoD), improving reproductive and child health care, disease prevention and treatment of common diseases.

- Ensure that resources set aside for health services are distributed equitably and used for the intended purposes.

- Ensure that a sufficient number of adequately trained personnel at different levels in the health service infrastructure are available.

- Facilitate community involvement and participation in disease prevention (communicable and non-communicable diseases).

- Ensure that inter-sectoral collaboration in health on the understanding that health is a multi-sectoral responsibility.

- Ensure that individuals, families and communities take more responsibility for their own health.

3.1 The Primary Health Care (PHC) Strategy

While the national health policy has given broad guidelines on the health services delivery system in Tanzania, the PHC strategy has outlined how the policy is to be implemented.

Primary Health Care is, "essential health care" addressing the main health problems in the community, providing promotive, preventive, curative and rehabilitative services to individuals and families with their full participation.

The government adopted PHC in the 1970's as the strategy to address the objectives of the National Health Policy.

The contents of this essential health care include:-

- Education on prevailing health problems and methods of prevention/control.

- Promotion of household food security and adequate nutrition.

- Adequate supply of water and basic sanitation.

- Mother and Child Health/Family Planning
- Immunisation against major immunizable diseases
- Prevention and control of epidemic and locally endemic diseases.
- Appropriate treatment of common disorders and injuries
- Provision of essential supply (drugs) and basis equipment
- Provision of mental, oral and eye health care etc.

4. HEALTH SECTOR REFORMS

Health Sector Reforms has been defined as "a sustained process of fundamental changes in national policy and institutional arrangements, which are evidence based, spearheaded by government, designed to improve the functioning and performance of the Health Sector and ultimately the health status of the population".

The National Health Policy talks of "encouraging the health system to be more responsive to the needs of the people" and reality tells us that the health system is not doing so and it has not met its goals adequately. However, in order to understand the workings of the health system one has first to know and appreciate the complexities of the health sector.

4.1 Components of the health sector include the following

- All those who deliver health care
  Public or private, modern or traditional licensed or unlicensed and includes doctors, nurses, hospitals, clinics, pharmacies, village health workers and traditional healers.
- The money that finances health care – official or non-official, through
  Intermediaries or directly out of patient's pockets.
- Specialized inputs into the health care process – e.g. medical and nursing schools, drug manufacturers.
- Financial intermediaries, planners and regulators who control, fund, and influence those who provide health care.

- The activities of organizations that deliver preventive services – family planning, infectious diseases control health education. They may be public, or private, local, national, or international.

4.2 THE BASIS FOR REFORMING THE HEALTH SYSTEM

In order to device appropriate strategies for strengthening of the health system, the Ministry of Health reviewed the health sector in 1993 to diagnose factors that were responsible for under-achievement of the sector. Some of the major factors identified were:-

- **Inadequate public spending**

  Deliberate efforts of the government to expand health services in the rural areas in 1960's – 1970's put the government in the position of owning and running 42% of all hospitals, 94% of health centres and 70% of dispensaries in the country. The recurrent expenditures for these facilities were beyond the government means. Throughout the 1980's and the 1990's the government spending to health services were roughly US$ 3.4 per capita as opposed to US$ 12 per capita recommended by the World Development Report of 1993. This under-funding of the sector manifested itself through the deteriorating physical condition of health facilities, shortage of drugs and other medical supplies and the low morale of health workers.

- **Organization of health services**

  Management of health services in Tanzania operates at three district levels ; ***the National level*** where the Ministry of Health is responsible for National Hospitals and training institutions, the regional ***level*** where the regional administration is responsible for Regional hospitals and district hospital and the ***Local Authority Level*** which is responsible for district programmes including the running of health centres and dispensaries. The problem arises at the District level where the District hospital is administratively separated from the health centres and dispensaries. This organizational arrangement had negative influence in providing effective coordination of health services in the district.

- **Ideology of "free" medical services**

  The policy of free medical care had been practiced in all of the health facilities from 1960's up to the early 1990's. This alienates communities from ownership of health units. They looked at health provision as a responsibility of the government. Communities did not involve themselves in monitoring and following up development of health units situated in their areas. They were neither engaged in identifying their health problems nor fixing them. They were often waiting for the government to fix their health problems.

- **Lack of appropriate health planning and management skills**

  Effective health planning and management depends very much on personnel with appropriate skills. Very often clinicians were given health management responsibilities without proper skill preparation. Because of their background they have usually not seen health in its broadest definition. They have tended to focus more on curative services, which is often costly, and government resources could not meet adequately.

  Other problems include:

  - Poor coordination of activities among providers at the district level allows room for duplication of efforts and waste of scarce resources. Services such as transportation, procurement, distribution of medical supplies, equipment and training could cost-effectively be integrated.

  - Standard and quality control mechanism for public and private medical practice is weak and need to be strengthened and improved.

  - Some of the health related laws are either obsolete or no longer adequate, calling for urgent review in the light of the reforming health sector.

4.3 The objectives and strategies under Health Sector Reform

The Ministry of health has a vision of a reformed health sector and system that assures universal coverage to the population through a basic package of health services which is based on the principles of equity, efficiency, quality, affordability and sustainability with the satisfaction of both the clients and providers.

The overall objective of Health Sector Reforms in Tanzania is to improve the health and well being of all Tanzanians, especially the needy and poor, and to make health services accessible, sustainable, effective and efficient.

Specific Objective of Health Sector Reforms includes:

- Improving equity in health and health care
- Increasing and improving management of health resources
- Improving performance of the health system and quality of care
- Creating and sustaining greater satisfaction of consumers and providers of health care.

These objectives will be realised through:-

- Change in the way the sector is managed and financed
- Shift roles and responsibilities
- Introduction of measures that will ensure equity in provision of health and health care
- Application of effective strategies for community involvement and participation

The strategy for Health Sector Reform implementation is holistic. The Central Government, Local Government, development partners (donors), NGOs, CBOs, Faith based health service providers, communities, and private practitioners need to be involved. The District leadership is especially expected to play a key role during implementation. The ordinary Tanzanian needs to be involved and actively participate in the reform process.

All aspects of the Health sector are affected by the reforms, from administration and management of the health network, (i.e central, regional and local establishments) to the clinical facilities, promotive, preventive services, and the health training institutions.

4.4 The strategic changes that are being implemented under the reform agenda include:-

- **Diversification of Health Financing Options**

  Since the Government recognized that tax financing was not adequate to meet all health sector requirements it was decided to diversity health care financing by introducing user-fees in the form of cost-sharing in all government hospitals in 1993. The user-fees system is gradually being extended to dispensaries and health centres in phased implementation. In addition to the user-fees, the government is also introducing community Health

Funds in districts, again by phases. The Community Health Fund provides an opportunity for people in the informal sector to pre-pay for their medical benefits at the peak of their income, usually during crop harvest seasons. This year the government introduced the National Health Insurance scheme to the employees in the formal sector. The scheme starts with civil servants and hopefully in three years time it will cover all employees in the formal sector. The Government is also considering the introduction of earmarked taxes.

- **Re-organization of health services management**

  In order to increase effective community participation in the health services delivery the Ministry of Health has decided to devolve the management and administration of health services to the district level. The district hospital will now be under the administration and management of local authorities. At the district level they shall be established the District Health Board whose composition includes community representatives within the council. And at each facility level there will be a health facility committee to represent the interests of the communities.

- **Strengthening training in health planning, management and supervision**

  Because of the weakness in this area, the Ministry has developed training modules that are being used to train health professionals in district management and planning. Selected health workers have continued to train for macro health planning and management on longer courses at Master degree level. The Ministry is also enhancing its capacity in supervising health services and undertaking quality assurance inspections.

- **Strengthening the Drug supply system**

  One of the areas receiving a lot of complains from the public, within the health service delivery system, is the availability of drugs. In order to improve the supply of drugs, the Ministry of Health has made substantial changes by first liberalizing the importation of pharmaceutical products and also reorganizing the Medical stores Department into a semi autonomous institution with flexibility from existing government bureaucracy. Drug revolving Funds have also been introduced in all hospitals and drug indent system is about to be introduced in all health centres and dispensaries that were receiving drugs kits.

4.5 The Health sector Programme is being implemented through the following eight (8) strategies

Strategy 1: Concerns itself with the provision of accessible, quality, well supported cost-effective **district health services** with clear priorities and essential clinical.

Strategy 2: Provides back-up **secondary and tertiary level referral hospital services** (level 2 and hospitals) support primary health care.

Strategy 3: Redefines the **role of the central MOH** as a facilitator of health services providing policy leadership and normative and standard – setting role.

Strategy 4: Addresses the challenges of **human resources development** to ensure well-trained and motivated staff are deployed at the appropriate health service level

Strategy 5: Ensure the required **central support systems** such as personnel, accounting, auditing, quality drugs, medical supplies, equipment, physical infrastructure, transportation and communication.

Strategy 6: Ensure **health care financing** which is sustainable, involves both public and private funds as well as donor resources, and explores a broader mix of options such as health insurance, community health financing and cost-sharing.

Strategy 7: Addresses the appropriate **mix of public and private** health care Services.

Strategy 8: Restructures the **relationship between MOH and its partners** within the context of a Sector Wide Approach to health development.

5. SECTOR WIDE APROACHES (SWAp)

In the context of Health Sector Reforms, Sector Wide approaches have been development and are being implemented as a method of operations between government and partners organised around a negotiated Programme of Work (POW) for the sector. Sector Wide Approaches are advocated to achieve co-ordination of the donor efforts and strengthen partnership for sustainable health development.

In the implementation of Health Sector Reforms there has to be a prior agreement between the government and partners to apply SWAp principles. The two parties have to come up with a comprehensive "Sector plan" which has jointly agreed priorities, targets, indicators and resources to implement the plan.

This approach is in response to problems associated with donor support in the past, which were through a fragmented and uncoordinated projects and programmes. At the District level the application of SWAP principles is through the following:-

- Joint development of a comprehensive district health plan involving all stakeholders (community, health providers both public and private. NGOs local government authorities).

- The plan should indicate all required and committed resources of all stakeholders (Government and others) and it should indicate all output required to measure implementation progress in the district based on national minimum standards.

- Use of commonly agreed financial disbursement and technical reporting systems for both government and donor funds.

6. RELATIONSHIP BETWEEN HEALTH SECTOR REFORMS, PUBLIC SERVICE REFORM AND LOCAL GOVERNMENT REFORMS

Health Sector Reform is part of the overall reforms being carried out by the government with the view to providing equitable and quality services to its citizens. Its success depends very much on the relationship and collaboration with other reforms going on in the Public Service sector and Local Government authorities.

6.1 Public Service Reforms

Central to all the reforms being effected by the government is the Public Service Reform, which aim at restructuring the Government Machinery. The aim of these reforms is to reduce the role of the government in implementation while re-enforcing its functions, in; policy formulation coordination, regulation and creation of enabling environment for development. Thus accomplishment of the Public service Reforms entails major changes in the public Sector at central, regional and district levels as well as private sector. More specifically it entails a shift of functions, responsibilities and resources from the central ministries and regional levels to the Local Government authorities.

6.2 Local Government Reforms

This denotes devolution of powers and establishment of a holistic local government system, to achieve a more democratic and autonomous institution, the aim being to improve service delivery under conditions of available resources – which can be achieved through good governance and re-structuring Local Council Administration.

Under the ongoing Local Government Reforms, efforts are underway to achieve the following:

- Transfer real power to local government authorities.

- Bring administrative and political control over services to the point of delivery. This in turn will improve accountability and effectiveness and promote people's feeling of ownership of programmes and projects executed in their localities.

- Free local mangers from central constraints and, among other things, allow them to develop organization structures tailored to local circumstance.

- Improve financial accountability and responsibility all the way up and down the health system. Ensure financial disbursement from the centre are subject to acceptable technical and financial returns in line with approved plans developed by districts themselves.

- Making intersectoral, public and private coordination and collaboration effective and sustainable.

In this regard the department of Regional Administration and Local Government in the President's Office (PORALG) has been vested with the responsibilities of improving and strengthening the capacity of the regional level of coordinate, support and ensure effective implementation of the reforms in the districts.

Given the fact that all reforms are taking place in local government setting, it is essential for the RALG to support and facilitate the implementation of local authority reforms in close collaboration with all private and public sectors, involved in development and delivery of social services in the councils.

In this relationship, the MOH is responsible for strengthening its capacity to take up its new role in the reform process (advisory and regulatory role). It will also ensure that through consultation with RALG, local authorities are persuaded to establish Council Health Service Boards and Health Facility Governing Committee.

6.3 Roles of central Government Institutions in Health Sector and Local Government Reforms:

- Facilitation of the local government authorities in their responsibility to provide services.
- Development and management of the national policy and regulatory framework.
- Monitoring and accountability of the local government authorities.
- Financial and performance audit.
- Provision of adequate resources (human and financial) to enable the local government authorities to deliver services.
- MOH and PORALG are jointly responsible for delivery of public health services.
- MOH manages referral and specialised hospital and health training institutions.
- PORALG manages district and regional health services.
- MOH is responsible for health policy development, management of health SWAps, setting health norms and standards to be attained by all health providers.

7. CURRENT STATUS OF HEALTH SECTOR REFORMS IN TANZANIA

Since the approval by cabinet of the Health Sector Reform proposals in 1994 a lot of preparatory work has been done and implementation has started within the context of Public Services and Local Government Reforms. At the district level implementation has commenced following the phases under local government reforms.

Major policy changes e.g cost sharing, liberalization of the pharmaceutical and private health services are in operation. MSD is now operating as an autonomous body and a Pharmacy Board is now in place and functioning. Revolving Drug funds (RDF) have been established in hospitals and a Drug Indent system for dispensaries and Health Centres is being developed.

Efforts are underway to integrate the numerous health programmes and services, Guidelines and/or training modules on integrated planning, supervision, Health Management Information, transport, financial management and reporting and management training of Health Teams are in place.

Various Health legislations are being reviewed and updated, new ones are being put in place in support of reforms. Advocacy in support of reforms is in progress and will continue to all levels. Guidelines for the establishment of Health Service Boards and Health facility Governing Committees has been developed and in use.

Norms and standards of health care are being developed and a Package of Essential Health Services has been defined. Standard Treatment Guidelines have been developed and are in use. A Basket fund has been established between the government and its development partners in support of improving health services at all levels.

Testing of other reforms initiatives is underway in Kagera, Tanga, Mbeya, Morogoro, Coast and other regions. The tests are designed to pick lessons and enrich our efforts to develop a home grown model of reforms suitable for Tanzania, as there is no one blueprint of health reforms. Reforms need to be evidence based to ensure that they will work, and that the change will be relevant and sustainable. Importantly, while reforms are a necessity, they should be done with care so as "to do no harm".

While the government in its reforms efforts is decentralizing through devolution, it will still monitor progress especially the service provision component by districts and regional hospitals. The Ministry of health will ensure this through its "Eyes on, hands off" approach

Reforms is about changes. However, implementing these changes are meant to achieve something better and for the good of the people who use the health services. Health Sector Reforms in Tanzanians are not just a fashion because "others are also doing reforms" but a reality of the need to improve the existing situation of the health sector and the poor health status of Tanzanias. We have been used to doing things in a certain way and we are aiming to doing them differently but importantly in a better way to get improved results. This is in a way a circular or spiral process where

we learn by doing. The process involves making mistakes and improving on skills but aiming at developing health services that are more effective, efficient and delivering quality services. Besides the resulting satisfaction for both the clients and providers, these improved services should ultimately lead to improved health status of Tanzanians.

A final note, the Primary Health Care strategy is still the government's strategy to achieve its health policy objectives. Health Sector Reforms is not another health programme but rather a strategy towards operationalising the same ideals of Health for All and Tanzania National Health Policy.