

HERA

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THE UNITED REPUBLIC OF TANZANIA

TECHNICAL REVIEW 2005

**PUBLIC PRIVATE PARTNERSHIP
FOR EQUITABLE PROVISION OF QUALITY
HEALTH SERVICES**

FINAL REPORT

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**Independent Technical Review on behalf of the Ministry of Health,
the President's Office, Regional Administration and Local Government
and
the Government of Tanzania**

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Abbreviations and acronyms

ADDO	Accredited Drug Dispensing Outlets
AIDS	Acquired Immunodeficiency Syndrome
AMO	Assistant Medical Officer
ART	Anti-Retroviral Therapy
ARV	Anti-Retrovirals
APHTA	Association of Private Hospitals in Tanzania
BAKWATA	Baraza Kuu la Waisilamu la Tanzania (National Muslim Council of Tanzania)
CBO	Community Based Organisation
CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CO	Clinical Officer
CORDAID	Catholic Organisation for Relief and Development AID
CSO	Civil Society Organisation
CSSC	Christian Social Services Commission
DCI	Development Cooperation of Ireland
DDH	Designated District Hospital
DOTS	Direct Observed Treatment Short-course
EHP	Essential Health Package
FB	Faith-Based
FBO	Faith-Based Organisation
GTZ	German Development AID programme (Gesellschaft für Technische Zusammenarbeit)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMO	Health Management Organisation
HRD	Human Resources Development
HSSP	Health Sector Strategic Plan
INGO	International Non-Government Organisation
ITN	Insecticide Treated Net
LG	Local Government
MAT	Medical Association of Tanzania
MCH	Maternal Child Health
MO	Medical Officer
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NGO	Non-Government Organisation
NHIF	National Health Insurance Fund
NPF	National Policy Forum
NSGRP	National Strategy for Growth and Reduction of Poverty
PER	Public Expenditure Review
PFP	Private for-profit
PMTCT	Prevention of Mother-to-Child Transmission
PNP	Private not-for-profit
PORALG	President's Office Regional Administration and Local Government
POW	Programme of Work
PPP	Public Private Partnership

QA	Quality Assurance
REPOA	Research for Poverty Alleviation
RT	Review Team
STI	Sexually Transmitted Illnesses
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TFDA	Tanzania Food and Drug Authority
TGSPH	Tanzanian German Programme to Support Health
ToR	Terms of Reference
TPHA	Tanzania Public Health Association
USAID	United States Agency for International Development
VA	Voluntary Agency
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive summary

The review

This report presents the findings of an independent Technical Review that focused on the promotion of Public Private Partnership (PPP) for equitable provision of quality health services in Tanzania. The report is meant to contribute to the Annual Joint Health Sector Review 2005.

The ToR has been broadly defined, signifying the interest that many stakeholders currently take in PPP. The Review Team (RT), with two international and three national consultants, undertook efforts to consult stakeholders for prioritisation of the issues included in the ToR.

The RT had access to a large number of official documents such as laws, by-laws, policy documents, guidelines, etc. and a wide range of studies on PPP set in Tanzania complemented by international literature. The RT undertook efforts to interview relevant persons and committees, associations, organisations, ministries, donors, etc. at the national level as well as in four districts, two rural and two urban.

Nevertheless, time constraints did force the RT to limit itself and consequently not all actors that constitute the private health sector could be contacted. It is hoped that the Annual Joint Health Sector Review 2005 will allow a representative participation of all actors in the field of PPP to discuss this review and compensate for any issue or actor that was left out unintended.

A pluralistic health system

In Tanzania, like elsewhere, health systems gradually develop a more pluralistic outlook in which the boundaries between public and private sectors, have become blurred. This trend reflects a growing diversity in health care needs and effectuated demands, besides the reality of a liberalised system that allows a variety of providers to offer health services. If left unregulated this situation may compromise government responsibility for an equitable access to health services of an adequate quality. On the other hand there is a growing (international) perception that the complementary strengths of different health services providers may be the only viable option to accommodate the huge need for health care.

It is this notion that led to the inclusion of PPP as a viable instrument in the 2005 National Strategy for Growth and Reduction of Poverty (NSGRP). Moreover, it called for an implementation of the so-called "Strategy Seven" that featured in MoH documents over the last few years, noteworthy the 2003-08 Health Sector Strategy Plan (HSSP).

Although data are not fully verifiable it is commonly believed that the ratio between public and private health services stands at roughly 60 – 40. In urban areas the contribution of private health care is definitely higher; rural areas show a large variety in relative contributions. The private sector is not easy to define and consists of a vibrant mix of a large number of different service providers and actors.

A large contribution is made by Faith-Based not-for-profit providers, which includes health institutions that have served the Tanzanian population for decades, some of which have been assigned with district responsibilities (so-called District Designated Hospitals). There is an increasing notion that financial constraints leave non-DDH faith-based institutions no other option than to levy user charges. This may negatively impact utilisation of health services and hence partly compromise government policies aiming at equitable access.

The not-for-profit health services by FBOs are complemented by a range of activities by NGOs, often made feasible by external funding and increasingly HIV/AIDS related.

On the private-for-profit side the variety is even greater with a range of private hospitals, pharmacies, laboratories, maternity homes, drug sellers, traditional healers, etc. There is

evidently some legislature and regulatory framework in operation, which, however, does not contradict the widespread conviction that although this part of the private sector does meet a genuine demand, its quality of services is not consistent across the sector.

At the council level an increasing number of councils implement guidelines for multi-actor involvement in planning and implementation of health services. Guidelines for resource allocation are used for the benefit of a diverse group of actors. Nevertheless, improvements in performance of the public sector during the last years coincided with constraints met by the private sector, fuelling sounds of dissatisfaction.

Call for dialogue to promote PPP

As can be derived from the information presented above, the reality of a pluralistic health system is to be acknowledged and appreciated. A constructive dialogue between the various groups of providers should pave the way for using complementary strengths and positions to improve health service delivery to a population in need of these services. All providers may be called to cater for an essential health package besides participating in targeted interventions. In order to facilitate this, a range of regulations as well as incentives are available or need to be developed. At the council level these instruments could be combined and translated into a comprehensive plan which increasingly allocates available resources (such as human resources, financial, medical supplies and equipments) in accordance with the status of the institutions and their share in the provision of essential services.

However, reality does not yet confirm this kind of concerted action, neither at the policy level nor at the implementation (council) level. Although there are evidently genuine intentions, the RT sensed some distrust between various actors. This can be partly based on misperceptions, unfamiliarity with each other, limited understanding what is meant by PPP, lack of transparency and mutual accountability, and lack of organisation and self-regulation in the various sub-sectors. This calls for dialogue, but even more than that. It calls for leadership and endurance within each (sub)sector to define respective positions and to allow for formal representation in order to engage in an endorsed dialogue with the MoH. Moreover, it calls for a deliberate positioning of professional bodies. And it calls for the MoH and respective donors to designate goodwill and resources to facilitate a dialogue on and practical implementation of PPP.

PPP is not a new feature, and the history in Tanzania allows for a favourable comparison with other African countries. As mentioned before, the MoH used private facilities for formal responsibilities (e.g. DDH hospitals). Moreover, human resources for health have since long benefited from a large contribution by the private sector. Increasingly, also the private-for-profit sector is included in provision of essential services, for which some support is provided by local health authorities. Lastly, there is a gradually increasing health insurance sector that formally recognises and compensates health services provided by the private sector.

Observations

Based on the information and opinions collected and analysed, the RT comes to a number of observations, which are combined and summarised as follows:

1. PPP is a reality in Tanzania, albeit limited in concept and practice and definitely insignificant to realise the paramount objective to promote equitable access to health services of an adequate quality to the whole population.
2. There is need to deal with the mistrust noted between the public and private sectors ('us' versus 'them'), lack of adequate information, etc. through better organised sub-sectors and channels of communications that allow legitimate representatives of the various sectors to address any issue relevant to promote PPP. There are no three separate sectors in Tanzania; there is one sector in which different actors provide complementary services.

3. There is need to take health services provided and utilised as the centre of gravity, to be distinguished from the current arrangement that are based on ownership and function and leads to differentiation in registration, quality assurance, resource sharing, etc. All sectors consulted affirm the existence of sector-based bias in regulations etc., and underline the need to reduce or abolish this.
4. There is need for guidelines that allow for more equitable funding and resource sharing arrangements at the council level that would maximise public health output by effectively tapping the potential of all providers, public and 'genuine' providers alike.

Recommendations

The RT came to a large number of recommendations and suggestions that are evidently interlinked. It has been the conviction of the RT that public health care in Tanzania is best served by a set of recommendations that brings the current set of instruments and guidelines – that are part of the health reform process – one step further in the direction of PPP.

In summary the recommendations are:

1. The role of the central MoH as regulator and steward need to be further strengthened especially in the areas of regulation (registration, licensing and accreditation) and quality assurance.
2. The present and future role of different players as regulatory/policy maker, purchaser and/or fund-holder, providers of services should be more clearly defined.
3. All providers, public and private alike, should be invited to contribute to the delivery of the essential health package and targeted interventions of particular public interest; task division should be based on potential contribution to national health objectives.
4. Contract management (including service agreements) should be the basis of resource allocation, regardless whether services are provided by public or private institutions. In other words, resource allocation (finances, human resources, medical supplies and equipments) should (gradually) be moved from institution-based financing to service (output) based financing. This should pave the way for streamlining policies on user fees and their application throughout the public and private sectors.
5. The capacity and service utilisation of private sector health service providers as well as the sources of funding should become transparent through a comprehensive study. This will ease policy making at the national level and facilitate some discretion in resource allocation at council level in view of local circumstances and preferences.
6. Introduce national standards for accreditation and quality assurance that do not differentiate between public and private providers. Involve professional bodies, such as the Medical Association of Tanzania (MAT) and the Association of Private Hospitals of Tanzania (APHTA) to set standards and effectuate self-regulation. Invite the NHIF to use its increasing membership to enforce appropriate quality health services through accreditation and differentiate reimbursement mechanisms.
7. MoH and PORALG should positively and actively promote PPP, whereby national leader should set the positive tone for PPP. The PPP desk should be semi-detached from the MoH with a clear mandate and resources that allow it to perform.

8. All actors that are to be included in the PPP dialogue should be induced to organise themselves in such capacity that they may promote PPP through a PPP forum that receives formal backing from the MoH. Particular emphasis should be given to strengthening professional bodies like MAT and APHTA. NGOs should be encouraged to form a forum; CSSC should be supported to take a representative position and to develop the Inter-Faith Forum.
9. Creative means of communication should be used to promote best practices of PPP.
10. Donors should be encouraged to join the MoH in linking part of the national budget to promoting and implementing PPP and the achievement of specified milestones. Regular reviews of the progress of the PPP process should be performed.
11. Adequate participation of various stakeholders in the PPP discussion at the Annual Health Sector Review meeting should be assured.

The Review Team,
Reet, Belgium, 10 March 2005

Summary of Recommendations

Review focus	Recommendation	Timing	Level	Responsible	Need for additional resources
General framework of the health sector	Define more clearly the present and future role of different players as regulatory/policy maker, purchaser and/or fund-holder, providers of services. Define the concepts of PPP and partnership in the above framework. Decide on critical issues such as moving from institution-based financing to output-based financing. Consider decentralising drug budgets to council level. Develop medium term vision / action plan to move from present situation to future situation (roles, change process, output based financing, etc.) Develop PPP action plan as part of the above action plan	2005	Central	MOH, PORALG, MOF, representatives of FBO, PFP, NGO	No (workshops)
	Undertake a comprehensive private sector study: <ul style="list-style-type: none"> - study of the capacity and utilisation of private sector providers (FBOs and PFP) - study of the source of capital and recurrent income in FBO (and possibly PFP) health units - comprehensive inventory of private for profit institutions (service providers, drug outlets, maternity homes, laboratories, etc.) 	2005	Central	MOH, PPP unit, PPP SG	Yes (out-source study)

Use of resources and contractual arrangements	Allocate public budget finances based on services being delivered: <ul style="list-style-type: none"> - review present procedures of allocation of financial and human resources to DDH and VA - develop and test several scenarios for output based / performance-based financing to public and FBO facilities - test out-sourcing / contracting / service agreements of specific/selected EHP services to PFP in pilot urban settings 	2005-2006	Central	MOH, FBO, PFP	No
	Use public and private providers where they are available to deliver the EHP (or elements of EHP): <ul style="list-style-type: none"> - develop strategies for using selected PFP providers where public providers are limited - provide conducive environment for PFP to open practices in peri-urban areas; - introduce quality standards and accreditation as part of testing contracting of /out-sourcing to the PFP 	2005-2006	Central	MOH, PPP unit, PPP SG, PFP	
	Address the issue of human resources for public and FBO providers: <ul style="list-style-type: none"> - address council's capacity to attract staff - address budgetary constraints - consider reviewing staff establishment in function of volume of work - remove inequitable conditions of service between seconded and non-seconded staff - provide similar work conditions for public and FBO staff 	2005	Central	MOH, CSC, MOF, PORALG, FBO	Budget
	Finalise and institutionalise the service agreement between Councils and FBOs	2005	Central Councils	MOH, PORALG	No
Regulatory frameworks	Review and update health legislation, taking into account PPP and the role of the private sector	2005	Central	MOH	No

	Review the efficiency of the registration process for service providers (also including drug outlets, laboratories, etc.)	2005	Central	MOH, TFDA	No
	Install national standards for accreditation and QA for both public and private providers as per QIP	2005-2006	Central	MOH	No
	Streamline policies on user fees throughout public and private sectors	2005	Central	MOH, MOF, PORALG, FBOs	No
	Consider introducing mechanisms for setting prices in PFP sector (e.g. drugs, services)	2005	Central	MOH, MOF, TFDA, PFP	No

Institutional set-up and coordination mechanisms	MOH and PORALG to actively promote PPP in health promotion and health care	Continuous	Central Council	MOH, PORALG	No
	Quarterly meetings of the sector coordination forum with FBOs, PFP, NGOs	As from 2005 onwards	Central	MOH, PORALG, FBOs, PFP, NGOs	No
	Institutionalise and resource the PPP desk as a semi-independent entity. Provide full-time local champions to (wo)man the unit.	2005	Central	MOH	Yes (HR and operational budget)
	Continue using the PPP working group as a broker to engage with private sector representative bodies and build trust. Transform the PPP Steering Group in the PPP Forum with formal mandate and TOR.	Continuing until PPP desk could take over this role	Central	MOH, PPP SG, WG	Yes (operational budget; studies; pilot testing)
	Include NGO representative(s) in the PPP SG or Forum	2005	Central	MOH, PPP SG, NGO	No
	Encourage the NGO Policy Forum to establish itself in a coordinating role	2005	Central	MOH, PPP SG, NGO PF	No
	Consider housing the Medical council outside MOH	2005	Central	MOH, Medical Council	No
	Support MAT (or another representative professional association) to become an umbrella organisation for professional associations	2005-2006	Central	MAT, MOH, Professional associations	Yes (small seed money for capacity building – limited in time)

	Support APHTA to become a representative body for PFP actors	2005-2006	Central	APHTA, MOH, PFP	Yes (small seed money – limited in time)
	Support CSSC to effectively develop the Inter-Faith Forum as representative organisation of FBOs	2005-2006	Central	CSSC, MOH	Yes (small seed money – limited in time)
Monitoring and evaluation	Publish examples of best practices of PPP	2005 onwards	Central	MOH, PPP unit, PPP SG	Yes (as part of operational budget)
	Bi-annual evaluation of PPP action plan				

Introduction

The independent technical review with a focus on Public Private Partnership (PPP) for equitable provision of quality health services is one of the reviews contributing to the Annual Joint Health Sector Review 2005. As per ToR, the purpose is to assess progress, constraints and opportunities in the PPP for health service delivery, focusing on equity, financing and quality. The broad objectives are as follows:

- Analysis of the private health sector in Tanzania.
- Analysis of the roles of Regulator, Provider, Purchaser and Client
- Description and analysis of partnership arrangements between the private and public sector
- Assessment of partnership/contractual policies in view of maximising impact on performance of health systems
- Suggestions for promoting private sector involvement in equitable health service delivery

A team of three national and two international consultants has been appointed to perform the review¹. A wealth of policy and strategy documents, reports and studies has been provided to the team. Interviews were held with public policy makers (MoH, PORALG), public servants at central, regional and council levels (PORALG, LG, MoH), all types of health service providers (public, faith-based, for-profit sector, NGOs), CHMTs, Hospital Management Committees, Bishops and Diocesan officials, associations of health service providers (professional associations, CSSC, APHTA) and health insurance organisations (NHIF, HMOs). The Review Team (RT) visited 2 urban (Kinondoni and Arusha) and 2 rural (Muleba and Kilombero) districts.

The RT considers it relevant to make a few remarks in respect to the ToR that guided the Technical Review. The ToR appear to have been the outcome of a process that sought contributions from a variety of stakeholders. This as such is to be appreciated and signifies the widespread interest in promoting PPP. However, it appears that there has been little effort to undertake a final editing of the ToR. The ToR, as a result, contained 5 objectives and 27 more specific areas, introduced by a comparatively short preamble. The RT was asked to attend to a wide range of issues. These included research questions that would have justified a separate assignment of a considerable duration, requests to gauge perceptions of various stakeholders and requests to undertake inventories of specific arrangements related to PPP. And it may not even have been complete, as one respondent remarked that at some point in time issues were either not included or were dropped.

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In order to prevent unrealistic expectations and given the time constraints, the RT discussed the ToR with representatives of the MoH and the donor community. All representatives met confirmed the need to focus particularly on key issues that need to be addressed before it is possible to attend to more technical issues. These discussions offered some prioritisation of issues and stressed the responsibility of the RT to streamline the review. The RT appreciated this confidence and acted accordingly. The list of questions that guided the RT when visiting the districts is presented in annex 2.

The private health sector in Tanzania is a vibrant mix of a large number of different service providers and actors. The Review Team (RT) is aware that they have only been able to meet a selection of providers and that perceptions presented in this report may not always reflect the possibly differing views of all actors. This is the limitation of a quick review. The RT acknowledges that the contributions of traditional healers to health and possible ways of involving them more in decision-making have not been sufficiently covered by this review and would require a separate study. Also, some other important actors such as drug sellers and pharmacies have only been marginally covered in this review (apart from extracts from existing studies). Again, the latter may require further study. The RT invites the MOH to use this review report as a basis for discussion and collecting views from a broader audience, in order to get a well-balanced input from public and private sector actors in Tanzania.

Once consensus is reached about which recommendations are taken forward by MOH, PORALG and stakeholders, the recommendations can subsequently be translated into activities in the HSSP and budgeted.

The report presents briefly the international context of PPP in section 1, and some examples of international best practice in section 2. The health sector organisation and financing in Tanzania is summarised in section 3 (this section is mainly addressed to the reader who is not familiar with the Tanzanian context). National policy, strategies and legislative framework regarding the health sector are discussed in section 4. Section 5 presents the finding of the review and recommendations are detailed in section 6.

The terminology used in this report reflects international thinking. PFP stands for private for-profit sector, which includes a large variety of actors such as health service providers, pharmacists, laboratories, maternity homes, drug sellers, traditional healers, etc. This review addresses mainly the health service providers. If other PFP actors are addressed, this is spelled out in the text. PNP stands for private not-for-profit providers. However, as this concerns almost exclusively faith-based organisations, but sometimes also NGOs, the RT has preferred to use the wording of FBOs (faith-based organisations) and NGOs. The demarcation between for-profit or not-for-profit is not always clear. Also a FBO is not necessarily not-for-profit (although in general this is the case) and a for-profit organisation is not necessarily viable.

1. Public Private Partnership: the international context in brief

Introduction

In many low-income countries, such as Tanzania, health systems have developed a pluralistic outlook in which the boundaries between public and private sectors have become blurred (Bloom; 2004). For the greater part of the twentieth century, the health system had a dualistic outlook with public (governmental) health services existing alongside what we now call faith-based health services. In Tanzania, particularly after the Government welcomed liberalisation of the health services in 1991, the outlook is now by far more diversified, with a wide range of private providers complementing the aforementioned.

The public and private providers offer pluralistic services to a population that has evidently become more diverse as well, with a great variance in health needs and financial and other abilities to access health services. Even though the call for equitable access to health services by all in need of these services is dominant in most, if not all countries, one cannot but conclude that there is a rift between ideology and practice. Tanzania is no exception.

In a health system with '*market characteristics*' demand for out-of-pocket expenses is inevitable. Over the last fifteen years, the biggest source of finance in the health sector in low-income countries has become out of pocket expenditure². This finance is mainly spent in the private sector (though the public sector does levy fees too, formally but also informally), and particularly on pharmaceuticals. Poor households may spend disproportionately more of their household income on health than richer ones (IHSD; 2004).

The public health outcome of this evolution is less clear. Some studies suggest that it has shown to lead to substantial exclusion and self-exclusion of those who cannot pay, and to impoverishment from struggling to pay formal and informal health care charges (Mackintosh, Tibandebage; 2000).

In this paragraph we will dwell deeper in the history of public private partnership, list some of the experiences gained in various countries and provide a brief discussion of some of the formalised mechanisms that could be used to implement PPP.

What caused the pluralistic mixture of public and private health services?

The explanations for the evolving mix of public and private health providers are many and rather ambiguous. We wish to mention but a few:

- The structural adjustment programs in the eighties and nineties that led to deterioration of social services systems, creating a need and opportunity for pluralistic responses. Due to deteriorating performances of the public health system and lack of adequate financial incentives, a private health sector more or less grew out of the public health sector, often with health professionals engaged in both. Persistent shortages of essential drugs paved the way for an expanding number of private pharmacies. High quality private health facilities were an answer to the failure of the public system to deal with the demands of the well-to-do in society, with demands from the international communities, companies, etc.

² Private spending as percentage of overall spending on health services in Tanzania (2001) stands at 53.3%. (Source: WHO World Health Report 2004. Among other low-income countries this is one of the lowest percentages. Based on trends in other countries one may assume that the percentage may further increase.)

particularly in urban areas the conditions for the evolution of a private (for-profit) health care market were favourable.

- The emerging (in the nineties) and persisting international ideologies that propose a more market-oriented approach to curb poverty. This approach extends into the area of social services, including health.
- The evolving WHO thinking on the role of the government in health services provision. In its 2000 World Health Report, the WHO recommends governments to assume a more pronounced stewardship role, with less emphasis on direct delivery of services. Services may be contracted-out to those providers that have the best competence to deliver certain services effectively, efficiently and of high quality.
- The increasing preference of international (bilateral and multilateral) donors and funds to establish direct links with non-public providers in health care. Particularly after the Johannesburg Conference on Sustainable Development (2002) it has become common thinking that poverty may not be ended and the set Millennium Development Goals may not be reached unless governments, civil society actors and business join their complementary strengths. And hence, more international funds are directly linked to health interventions by non-public actors. Particularly in the field of HIV/AIDS this can be observed.
- The widening international treaties on exchange of products and services, offering new opportunities to trade and investments in health services and insurance covers. The recent initiation of HMOs (Health Management Organisations) in many countries can be linked to this new development.

Whichever of the above mentioned explanations is or are true and whatever we may think of it, the observation seems justified that *a pluralistic health system is a reality in low-income countries and will increasingly be so*. The role of public health services and low-threshold faith-based (FB) health services is bound to be contained in favour of a growing and more diverse private (for-profit) health sector (PFP). Once again, there is no reason to assume that Tanzania will be an exception to this international trend.

In the ongoing health reforms targeted policy and regulatory action is required to prevent an unguided evolution resulting in a highly pluralistic and fragmented health system. For this reason it is time to translate the intentions of the so-called “strategy seven” of the national health policy in practical terms.

2. International best practice and experiences

Some examples of best practice in the African region

The current pluralistic configuration of health services in Tanzania is far from unique in Africa. Other African low-income countries faced comparative developments as far as decentralisation, devolution and privatisation is concerned. Moreover, most of the trends mentioned above occur in the international arena and affect all countries alike. Hence, in many countries governments currently link up with non-public actors and discuss and formalize public private partnerships in health.

One can distinguish two distinct responses (IHSD; 2004):

- On the *supply side* one can distinguish interventions like regulation, contracting, social franchising or social marketing. There is a diversity of contracting arrangements, some of which eventually are used within the government system itself too. The latter can be regarded as an ultimate situation whereby regulation, policy making and financing are separated from implementation (i.e. service delivery).
- On the *demand side* one can distinguish vouchers, micro-credit and community insurance schemes. Such interventions are found in Tanzania too.

The evolving collaborations between public and private sectors in Uganda and Ghana offer relevant examples to Tanzania, as these countries have many similarities in terms of history, configuration of the health system, income status and distribution, etc.

In Ghana the Ministry of Health has a Private Health Sector Policy, which has been translated in a second 5-year Programme of Work (2002-2006) to promote collaboration and partnership between the public and private health care providers. This is part of an overall effort to instate better coverage and quality of primary health services and to foster greater partnership in the health sector by forging linkages between private and public healthcare providers.

The 2002-2006 POW outlines strategic objectives for developing partnership with private health care providers. These include creating innovative ways of promoting private sector and non-government provider participation in health service delivery, developing appropriate capacity for commissioning and/or contracting out services in line with comparative advantage criteria, supporting the development of private sector capacity to implement public sector contractual arrangements and promoting procedures that would ensure additional resource allocations to the private sector

The Programme of Work identifies two key steps that would be implemented to establish these arrangements:

- completing the Memorandum of Understanding to formalise commissioning arrangements with private sector providers to supply services as envisaged in the last Programme of Work and to begin such commissioning;
- building capacity of the Ministry of Health/Ghana Health Service and the private health sector to undertake contract negotiations and management functions in public and private partnerships at all levels

(Christian, Osei; 2003)

It is good to note that progress in Ghana with PPP has been steady, though slow. Analysis of the causes of the limited progress revealed problems like: lack of capacity with the Private Sector Unit at the MoH; the felt competition over scarce resources in the

event of contracts with private sector providers; mutual lack of trust in respect to transparency, accountability requirements; suboptimal communication channels between various stakeholders; lack of capacity with all actors to deal with technical issues such as how to replace input-based subsidy agreements by service level agreements or output based contracts.

Some of the observations are rather stereotype for a situation where rather distinct health services providers are bound to engage partnerships in a situation where respective positions, expectations etc are far from clear. Other observations indicate particularly the technical problems that have to be anticipated when implementing new contractual agreements in a situation where all stakeholders at national and local levels face lack of capacity. The various stakeholders in Tanzania could learn from the Ghana experience

In Uganda hospitals run by faith-based not-for-profit organisations (FB-PNP) have long provided over 50 per cent of beds and 60 per cent of hospital services in Uganda. They depended on high levels of self-financing from user fees but this became insufficient for some to continue.

In recognition that many of the FB-PNP hospitals were more efficient than most public hospitals, government initiated a scheme to fund them through *negotiated contracting*. It was agreed that the hospitals would use the funds to freeze user fees, improve services and improve staff wages based on the provision of specific services. Guidelines for the use of funds were drawn up and resources allocated according to an agreed formula. Simple contracts in the form of a memorandum of understanding (MOU) were deployed. Monitoring was contracted out to the medical bureau overseeing the FB-PNP hospitals.

Limited evaluation indicates that staff salaries have been increased, user fees have been reduced, and there has been increased utilisation of services especially by vulnerable groups and children. However, the funds released by the Ministry have been subject to delays, are lower than anticipated and some have been mislaid. The scheme could also lead to broader reform and benefits to the public sector as the agreements (MOUs) have now been extended to public hospitals.

(Source: England; 2004)

It is interesting to note that the process in Uganda benefited a lot from strengthened umbrella bodies of faith based organisations. Particularly the Uganda Catholic Medical Bureau (UCMB) set the pace by adopting as its single goal to strengthen the capacity and performance of catholic health services. The UCMB invested in human resource management, financial management, health management information systems, assistance to dioceses to compile strategic plans, and last but not least in quality improvement by adopting a gradually more sophisticated accreditation system called "faithful to the mission". The strengthened capacity pays off in an improved performance at unit level (in terms of utilisation, cost, quality of care) and a better negotiation position with the MoH at central and local level.

Voucher schemes

One prominent PPP strategy is the introduction of so-called voucher schemes. This is a form of demand side financing, used as a mechanism for transferring an earmarked subsidy to an individual for use in exchange for a specified product or services.

This strategy is currently being used in Tanzania with the distribution of ITNs to pregnant women, as part of a malaria control strategy. Initial reports suggest positive experiences.

But voucher schemes can be applied for other reasons as well. They can be used to allow identified low-income groups to access a defined package of services, whereby the

provider of the services will be reimbursed for delivering those services. Patients needing this kind of services could be issued with a voucher that would entitle any clinic treating the patient to a financial compensation, provided the clinic has a contract with the council authorities. In many countries successes with this kind of voucher systems have been reported.

PPP and training schools

Training of health professionals (nurses, para-medical staff, medical staff) is for decades an excellent and “avant-la-lettre” example of PPP in Tanzania. Training has a large private sector contribution (e.g. the majority of nursing training schools and medical colleges are run by private institutions) with a full complement of public subsidies (seconded staff, subsidies to individuals, curriculum development, provision of study materials, etc;). Private training schools provide graduates to private and public sectors alike. Recently, numbers of enrolled students at medical schools have been significantly increased to deal with the human resources deficit.

3. Brief description of the public-private sector in Tanzania³

Health Services provision

Tanzania has a total of 4,990 health facilities of which 3,060 (61.3%) are Government owned, 748 (15%) are owned by voluntary agencies, 205 (4.1%) by parastatals while 977 (19.6%) are privately owned (MoH-URT, 2003b). It is not really known what percentage of health services are being delivered by public and private sectors. A rough approximation could be based on the division of ownership (60% versus 40%), but this would exclude the large volume of health services delivered by NGOs, community health workers, etc.

Public Health Services

The public health sector owns about 60% of health care facilities in Tanzania. The public health delivery system is a three tier pyramidal infrastructure that closely follows the administrative structure of the country with village health posts, dispensaries and health centres at the first level, district hospitals (and VA hospitals) at the secondary level and consultant/specialist hospitals at the tertiary level. In districts that do not have a Government owned District hospital, there are Designated District Hospitals (DDH). These are usually owned by FBOs and function as Government hospitals on a basis of an agreement (the DDH agreement signed between the government and the FBOs). The public health system provides both curative and preventive services.

With the ongoing health sector reforms and decentralization, the role of the central Ministry of Health (MoH) in the health sector is changing with issues of policy, governance, regulation, legislation, financing, HRD, monitoring and quality assurance taking precedence over its involvement in health service delivery. The district is becoming the focal point in health planning and health services delivery. District health services are now the responsibility of the District Councils (LG) with the MoH and the President's Office, Regional Administration and Local Government (PORALG) providing technical, logistical and financial support. The MOH provides the councils with tools to develop Comprehensive Council Health Plans (CCHPs) based on district planning guidelines; guidelines on utilization of health basket funds and health block grants as well as various guidelines and protocols in services delivery e.g. procurement of pharmaceuticals, formulation of HMIS, standardization and quality control.

Contracting for services by the public health sector includes contracting or out-sourcing non-clinical or support services e.g. transport, kitchen and laundry services. District based contracts are generally managed at Council level. Experience in contracting clinical services exists mainly through above mentioned DDH agreements for district hospital services. Responsibility for contract management of DDH is likely to shift from central to Council level.

Private Health Services

Following the reintroduction of private medical practice in Tanzania in 1991, the private sector has been growing rapidly and is now playing a major role in service delivery. The

³ The description of the health sector is mainly based on A. Hussein and T. Urrio, Review of Public-Private partnerships in the health sector.

private sector consists of the FBO health facilities and a Private-For-Profit (PFP) sector that is rapidly growing (Tibandabage et al, 2001). They own roughly 40% of the health facilities. The PFP health sector mainly provides curative services while the FBOs usually provide curative and preventive services, similar to public facilities. Many of the FBO facilities have training schools attached to them.

The FBO health facilities are owned by various religious organizations such as the Lutheran, Catholic, Anglican, BAKWATA, Swedish Free Church, Moravian Church, Christian Mission to Many Lands and the African Inland Church. The Catholic, Lutheran, Anglican and non Pentecostal health services operate under an umbrella organization the Christian Social Services Commission (CSSC). Administratively the hospitals are headed by a Medical officer in charge who is an employee of the Diocese and governed by a Governing Board. According to the MOU in vigour, the Medical officer is responsible to the PS (MoH) and to the Bishop. Some of the private-for-profit hospitals come under an umbrella association called the Association of Private Hospitals in Tanzania (APHTA).

The other players in health services delivery at the community level operate in the traditional systems (traditional healers and traditional birth attendants).

The private for-profit sector encompasses a large number of other health-related facilities including pharmacies (Part I and Part II⁴), laboratories, medical imaging, drug sellers, maternity homes, etc. The RT is not aware of the existence of an up-to-date inventory of all private facilities and providers.

Health Care Financing

The Public Sector

For many years post independence, health services financing in public facilities in Tanzania was mainly from subsidies from general government revenue. It is only during the last decade that this responsibility is being shared, with the community partly contributing directly to the financing of their own health services through various health financing mechanisms that have been initiated (user fees, CHF, NHIF). Importantly, several public health priorities and target groups are exempted. People suffering from chronic disease conditions (such as tuberculosis and leprosy, HIV/AIDS, diabetes), the elderly, pregnant women and children under five years of age are exempted from paying user fees. In addition, poor people are supposed to be exempted from user charges through fee exemption mechanisms. According to health people interviewed, these are not so well implemented⁵.

In the health sector reforms diversification of funding is a strategy that develops alternative means of funding the health services which in principle should contribute to improving the quality of care. The various cost recovery and cost sharing programs that have been initiated include user fees (1993), Community Health Fund (1996) and National Health Insurance Scheme (2000). These schemes have widened the number

⁴ Part I drug outlets are those that, by law (Pharmaceutical and Poisons Act, 1978; as repeated in the Tanzania Food and Cosmetics Act No. 1 of 2003), are allowed to dispense both prescription and non-prescription drugs; Part II are allowed to dispense non-prescription drugs only. (Mujinja et al. in Alliance for Health Policy and Systems Research; 2003)

⁵ The REPOA study team (main finding 6) identifies the ineffectiveness of the present exemption and waiver mechanisms as the core problem in the user fee debate in Tanzania. A functional exemption and waiver system is actually non-existent putting vulnerable and poor people at risk by practically denying them access to public health services.

of players in health services financing and delivery. Efficiency of user charges and CHF are a topic of ongoing debates between different stakeholders.

Part of donor resources is channelled through the basket fund to district level and complement government grants for health service delivery. Other donor resources support directly specific projects or are channelled through NGOs, CSOs, etc. The NHIF is slowly becoming a more important player as a purchaser of health services, but its membership is still limited to about 250.000 people (about 1 M people including dependents).

The Private Sector

Financing of the PFP sector is mainly through user charges and health insurance (private health insurance including HMOs, and soon also NHIF). The FBO sector is financed through a variety of resources including subsidies from the Government, user charges, contribution from donors (also through the basket fund), income generating activities, sometimes other external resources and the NHIF. The Government provides funds for recurrent expenditure of 21 FBO hospitals (19 DDH and 2 Consultant Hospitals) and provides bed and staff grants to 62 FBO owned hospitals⁶. The government also provides students grants for training schools run by FBO hospitals. VA hospitals in the districts are entitled to up to 10% of the District Health Basket Fund as compared to up to 35% for the DDH. Although FBO facilities are part of the private sector, some MOH staff perceive the FBOs as public services providers, as they deliver the same type of services as the public sector, are present in rural areas as is the case for public facilities and are subsidised by government.

Individuals who can afford to pay higher fees or those whose health care is paid for by their private employers or private health insurance tend to use the services of the private for-profit sector.

⁶ “Medical (Grants-in-Aid to Voluntary Agencies) Regulations started in 1952 when the population was very small and religious bodies could sufficiently supplement government health services. That is not the case now. In addition, the practice of using DDH agreement began in 1972 when health needs were not as enormous as today. These are the only means that have so far been used to foster the public-private partnership in the country.” (T. Mapunda, 2005).

4. Policy and legislative framework for PPP in Tanzania

The **National strategy for growth and reduction of poverty** (NSGRP, 2005) acknowledges the responsibility of both the public and private sectors in achieving the national objectives, including the provision of social services. Private sector related strategies include private sector development, capacity building, scaling up of private-public partnership consultation mechanisms and accountability. Attempts to quantify the contribution and financing requirements of private actors require more time and data.

The NSGRP is coherent with other documents and confirms the intention to involve the private sector in various sectors, among which provision of social services. This involves dialogue and consultation prior to the NSGRP and participation in implementation through partnerships and accountability. Translating it into financial commitments is found difficult.

The draft **Health policy** (2003) defines what PPP means and what MoH's intentions are towards making PPP work ('complementary and not confrontational'):

- Aspiring at a mutually beneficial cooperation
- Jointly and transparently mobilising and sharing resources
- Continuing communication, cooperation, coordination, collaboration
- Regulating the establishment of health facilities
- Promoting health services delivery by private sector organisations

The health policy document acknowledges the relevance of private sector contribution to health care delivery, training and insurance, and states that such should be promoted through partnerships. It refers to collaboration, coordination, cooperation, but also to planning requirements, regulations, monitoring of quality, etc. Reference is made to contractual arrangements, but the document does not refer to public contracting of private sector services. The document does not spell out how the MoH will achieve above mentioned policy intentions.

Health legislation

Most of the laws with exception of the Private Hospital Act and the private Health Laboratories Act do not spell out the role of the private sector as a partner in providing and financing health services, as most of those laws were enacted when PPP was not yet initiated or in its infancy. However, the laws leave room for the public sector to contract out health services to the private sector (see T. Mapunda, Jan. 2005). In view of the weaknesses pointed out above, the author of the health legislation review proposes two key actions. First, all laws must be re-examined and amended to suit the new policy position, spelling out the role of the private sector. Secondly, it is proposed that a new law, specifically governing public-private partnership, be enacted in Tanzania. The purpose of this law is to expressly empower specific government authorities (not only health) to establish and sustain public – private partnership for the purpose of improving services to the people (T. Mapunda, Jan. 2005).

The **2nd HSSP (03-08)** comprises a specific strategy on PPP (strategy 7). Strategy seven focuses on promoting private sector involvement in delivery of health services; and improving the collaboration with traditional medicine. With regard to promoting a better public private mix in service delivery, the only significant achievement reported

from the 1st HSSP is the registration of new facilities. There was success with regard to collaboration with traditional medicine, through passage of a Bill on Practice of Traditional Medicine. It is acknowledged that there is generally poor collaboration between the private sector and government: examples include inadequate dissemination by government of its policies and guidelines. Private sector networks, which would facilitate communication and collaboration, are rare. The private sector is still weak and it needs 'reconstructing'. There is still mistrust between the public and the private sector. Proposed strategies are limited to a) support the formation of networks for interaction between private and public sectors, and b) to separate the Public Private Partnership desk from the hospital registration desk. Under the strategy framework, the central ministry should a) prepare and introduce service agreement and contracting out modalities for use by councils and secondary and tertiary level hospitals; b) explore and initiate effective options for enforcement of accreditation of health institutions (public and private); and c) undertake regular consultations/collaboration with professional bodies, professional associations, private providers and civil society to enhance discipline, ethics, code of conduct, standards, morality and caring attitudes by health workers.

The HSSP acknowledges private sector (including NGOs, VAs, DDH) contribution to health care and seeks to create a conducive environment for promotion of greater involvement (e.g. in annual health sector reviews), participation in health service delivery (contracting). Yet, one admits lack of insight in private sector financing and the need to address lack of private sector organisation. Lack of trust between public and private sectors is mentioned. Reference is made to contracting, outsourcing accreditation, regulation, etc. Nevertheless very little budget is set aside to support this. How one expects to move from intentions to practice is not quite clear. There is limited analysis of perceived obstacles and a limited number of proposed measures. There is no clear differentiation between various categories of private sector providers and proposed measures are not provider-specific.

The recently reviewed, **joint MOH and PORALG health basket fund and health block grants guidelines** provide budget allocation guidelines to public and private not-for-profit (PNP) facilities. *The guidelines do not explicitly include private for-profit providers (PFP). The resource allocation criteria are focused on the type of provider (public/private and level) rather than on type and volume of health services to be or being delivered.* Guidelines are interpreted differently by different CHMTs/Councils visited (e.g. allocation of resources to PNP dispensaries).

PORALG guidelines on renovation of private health care facilities include PNP facilities.

The **Public Expenditure Review 2004**⁷ does not provide data on non-public spending. The **Local Government Fiscal Review 2004** makes only limited reference to non-public actors. It states that parallel spending is hard to capture in the social sectors and proposes to bring these resources inside the SWAp. The report does not make reference to additional non-public funding. The **Joint donor-government review of the Local Government Reform Programme** does not make specific reference toward public-private cooperation in social sectors.

⁷ Only a few references have been made to NGOs, DDH and faith-based organisations.

Summary statement on framework documents:

- *NSGRP and draft Health policy acknowledge and appreciate the role of the private sector in social services*
- *Intentions of improving public-private partnership are described in the health policy and HSSP, but situation analysis and proposed solutions/strategies are limited and not specific per type of private provider.*
- *Health legislation is not fully up-to-date, specifying the role of the private sector in providing and financing health services.*
- *Budgets for PPP are limited and may reflect the lack of priority given.*
- *PPP is not mainstreamed but considered a separate strategy.*
- *Budget allocation guidelines do not include explicitly PFP.*
- *PPP gets not much attention in recent LG reviews.*

5. Review findings

5.1. MAIN OBSERVATIONS FROM INTERVIEWS AND FIELD TRIPS

Private sector health service delivery is a reality in Tanzania, with about 40% of health services estimated to be delivered by private sector actors, including FBOs and PFP providers (up to 70-80% in some urban environments)⁸. These estimations are based on health facility ownership and omit other community based health services provided through a variety of actors including NGOs, traditional healers, traditional midwives, maternity homes, etc. Real private sector involvement may thus be different from and even more important than the above figures suggest. Basically, the three most prominent sectors (public, FBO and PFP) are considered three different systems with their own 'behaviour' and 'objectives'. Views on differences in so-called institutional behaviour are based on historical experiences, assumptions, 'belonging to the right camp' rather than on real knowledge of which services are being delivered to whom, and how these services are being financed. Better knowledge may lead to better understanding and lessening mistrust.

The RT has observed feelings of "mistrust" between different partners (although at different degrees, depending often on individuals), lack of basic understanding of PPP, and examples of lack of transparency / accountability. But at the same time the RT acknowledges positively changing attitudes, a greater degree of openness to talk about PPP, a private for-profit sector less depicted as "deviant behaviour", more (but still insufficient) involvement in policy discussions and planning by private actors, more involvement of private actors in preparing the CCHP. However this greater openness is not yet translated in efficient use of available actors and resources for equitable service delivery. A general attitude (both in public and private sectors) is to refer main responsibility for inefficient collaboration to the other partner(s); it's about "us" and "them". Some MOH staff refers to a "cultural vacuum" at MoH as no one in the Ministry has a PFP background, which may hinder mutual understanding. However, it is not clear whether the presence of mutual experiences between church and government has led to better understanding and lesser tensions.

If PPP is still in its infancy as a true partnership, this is a shared responsibility by all actors, including MOH, public providers, FBOs, PFP providers, professional associations, private sector representative bodies and donors. It also reflects national history where public service was the national standard and private for-profit health service provision was not allowed between 1977 and 1991.

Partnership and resource use

The Government has a range of measures at its disposal to promote public private partnership and particularly the performance of private health services providers by offering a range of resources. These resources are either offered indiscriminately (e.g. bed grants based on officially recognized number of beds) or purposely (e.g. supply of equipment and vaccines to stimulate private practice to provide MCH services). Basically resources refer to finances, human resources and medical supplies, drugs and equipment.

⁸ See section 3 for explanation of figures.

From our interactions with representatives of the private sector at national level and during the district visit the RT developed the following impression:

- **Financial resources**

There are obviously a number of reasons that explain the fact that at present the health budget at council level as represented in the CCHP is made up of a complex of up to 14 different resources, some in allocations, others in kind and a limited part in cash. Consequently, the budgetary arrangements at council level are complex demanding detailed financial plans and accountability. There is limited room for discretion in budget allocation in line with felt needs. Basket funds comprise only a minor percentage of overall spending, with guidelines that limit allocations to private providers (with the exception of DDH and to some extent VA hospitals). This kind of inequitable funding arrangement causes financial constraints with those private institutions that lack means to substitute this apart of charging fees to patients. This inevitably impacts health care utilisation patterns with potentially undesirable public health outcomes.

- **Human resources**

Private not-for-profit institutions either receive a comprehensive staff financing (DDH, seconded staff plus staff grants) or only staff grants (VA hospitals) or no staff grants (PNP health centres and dispensaries). Resource allocation varies according to ownership or category of facility, irrespective of functionality in terms of delivery of the essential health services package. At lower level units and particularly in rural areas there is evidence of a human resources crisis. In (peri-) urban areas limitations in budgets for personal emoluments provide a greater explanation of the shortfall between actual staff and staff requirements than scarcity of staff.

- **Essential drugs, medical supplies and equipment**

The current arrangement of provision of drugs and medical supplies functions reasonably. However, when 'out of stock' at MSD interrupts an adequate drug supply, health institutions experience limitations in freeing funds to access other drug providers. Church units can circumvent this by using income from user charges. PFP units have no access to MSD, although they would prefer to be offered the opportunity. PFP providers criticize the absence of a general tax waiver system for all essential drugs, medical supplies and equipment.

At council level, budgetary provisions for medical equipment is felt to be too low, with little or not budgetary discretion available to compensate this by tapping from other budgets.

PPP Steering Group

The PPP Steering Group⁹ is in existence just over one year. It gradually evolved from an informal group of "interested partners" to a group which has MoH recognition and significant external donor support. It is housed at the TGPSH-GTZ Dar es Salaam office where it receives some technical support. The members explicitly stated not to conceive themselves to represent distinct groups of stakeholders; the Group has neither an adequate composition, nor have the stakeholders organised themselves in such a way that they are in the position to designate representatives.

At present, the PPP Steering Group is chaired by Dr. Mung'ong'o, head Private/Voluntary Section at the MoH, registrar of the FBO/Private and Coordinator PPP and co-chaired by Mrs. Dr. Kimambo, Deputy Director CSSC. It implements an agenda with 6 different outputs, of which the most prominent and topical one is the development of a new Service Agreement Format, to be used to formalize relationships between

⁹ The PPP Steering Group is composed of representatives from MoH, CSSC, TPHA, TGPSH, APHTA, DCI and donors like CORDAID and USAID.

private service providers (to begin with VA institutions) and respective councils/districts. The available budget caters for the engagement of local consultants to do baseline inventories, review legal arrangements, etc. Already some base line studies and desk studies have been commissioned and carried out (see e.g. Hussein et al. Urrio;2004). Members of the group have familiarised themselves with promoting PPP, a.o. by visiting Uganda.

The RT appreciates the activities of the current PPP Steering Group. These activities are evidently relevant and to be welcomed. However, the lack of quorum and formal endorsement of the Steering Group (from all stakeholders, public and private) may hamper its long term effectiveness. The use of the word 'steering' in its name is not at par with its actual status and/or the perception of the members.

The RT recommends transforming the PPP Steering Group into a PPP Forum, with a formal mandate and Terms of Reference and formal backing from the most prominent private actors. The Forum's primary objective should be to create a safe meeting place for representatives of identifiable groups of stakeholders to discuss any matter arising in respect to promoting PPP and to suggest ways forward.

5.2. REGULATORY FRAMEWORKS

Introduction

In any health system there is need for regulatory frameworks and legislation that ensure minimum levels of quality and safety, predominantly through standard-setting. This kind of consumer protection is particularly required in a decentralised system in which a variety of actors provide services to the public.

However, in a liberalised health system an optimal (i.e. equitable health services of adequate quality) situation may not be induced by using standards only. Economic measures may have to deal with market imperfections that are notorious for the health sector. (Kumaranayake et al.;2000). These measures e.g. would focus on promoting appropriate distributions of facilities and professionals, on promoting certain services (e.g. social marketing of condoms) on dealing with imperfect competition influencing (height of) user charges and thus affect accessibility of health services to the population, segmented by wealth, age or gender.

Observations on regulatory frameworks

The RT came to a number of observations in respect to the regulatory framework currently in place.

- **Centralised systems for registration of health facilities are in place.**

However, a number of interviewees shared with the RT that the current system was found to be cumbersome, time consuming and leading to additional cost (investments not generating income while awaiting outcome of the registration; turn-over of qualified staff that have to be in place at the time of inspection but cannot be kept on the pay-roll until activities start, etc.). Private facilities are supposed to pay an annual registration fee but it is not clear what they are provided with in return (although the assumption may be that registration fees ought to cover the costs of registration and inspection). CHMTs, especially in urban areas, expect to play a more active role in the registration process, planning new facilities in a strategic health coverage plan rather than be informed ex-post about facilities having been accepted for registration by the central level.

- **A centralised inspectorate is in place but not yet decentralised.**
However, regular supervision of private and public health facilities is done through the CHMT, using locally made or adapted checklists. The regularity of supervision depends on the priority given to this by the CHMT as well as the means available. The outcome of the supervisions may lead to deregistration of facilities that fail to meet the minimum criteria. However, it was reported that deregistration is not a frequent practice.
- **Registration (of public) and private facilities does not take into account health services needs (strategic planning).**
Registration of new facilities primarily depends on whether these facilities meet the official requirements in terms of facilities, staffing, etc. Particularly in resource constrained environments additional facilities may compromise local resources, either directly (if the new facilities would be entitled to share available council funding) or indirectly (reducing levels of patient utilisation due to increasing capacity).
During the field visits the RT learned that opening new facilities, expanding and upgrading existing ones, both public and private facilities, was in progress in many councils. However, it appears that this kind of strategic planning is not adequately discussed in the council health planning team, if at all. Council comprehensive health plans, which tend to focus on (financial matters relating) short term interventions and service provision, did not mention these investments. The RT was told that external political pressure, church politics, and evolving priorities and funding opportunities by INGOs often played a leading role.
The RT recommends the initiation of long-term strategic planning at council level that addresses registration issues of new or expanded/upgraded facilities.
- **Centralised systems for licensing health professionals are in place.**
However, there is no system of renewing licensing of professionals (e.g. time-bound licensing based on achieving certain criteria of up-keeping knowledge and expertise). This is a missed opportunity to motivate professional staff up- keeping knowledge and expertise. Such a system is presently being discussed for nurses and the Association of Private Hospitals in Tanzania (APHTA), the Medical Association of Tanzania (MAT), and the Medical Council are in favour of such as a system for medical professionals.
- **There is presently no comprehensive national quality assurance system in place.** However, a recent study into the need and opportunities for a national quality framework led to the “Tanzania Quality Improvement Framework” (September 2004). This framework has been endorsed by the MOH and is ready for distribution/implementation. The RT observed that the quality framework, which is of highest importance, takes into account decentralisation and does not explicitly distinguish between public and private health providers, but promotes a single set of standard setting and a single set of procedures for both public and private sectors (e.g. accreditation). Although all actors may have to respect uniform quality standards, existing variations in types of services, juridical configuration, etc. may require a fit-to-measure approach.
- **There is no national standard for accreditation of health facilities.**
The NHIF has meanwhile developed its own standard, which is being implemented. The RT observed that the NHIF accreditation standards are not applied consistently throughout the health sector. Public facilities are being

accredited without a formal on-the-spot assessment, while private facilities are being visited during the accreditation process and have to adhere to the set standards.

There may be a practical reason for this, i.e. lack of capacity at the NHIF to accredit large numbers of public and private facilities within a short span of time so that NHIF insured civil workers may access their benefits. But the RT found that this was perceived to be a rather biased form of accreditation. Most interviewees at Municipal, Council, CHMT, FBO, PFP level are in favour of one standard set of criteria for accreditation and quality assurance being applied throughout the public and private sector. The Quality Improvement Framework proposes a single accreditation procedure, applicable to both public and private sectors. MOH opts for the “integrated model” where “membership and resources come from government” (as per Zambia Accreditation Council), rather than for an independent (voluntary or government-financed) body.

- **Regulation of the pharmaceutical sector is yet to be more effectively enforced.** The documentary review has revealed a number of issues regarding public private partnership and regulation of the private pharmaceutical sector. The regulatory framework is reported to be weak (Kumanarayake, et al, 2000). It is also documented in the National Drug Policy that highlights the shortage of pharmaceutical personnel especially in retail drug outlets, which in turn contributes to irrational drug use among consumers (Mujinja et al, 2003).

The relationship between the pharmaceutical sector and the government is that of the ‘regulator’ and the ‘regulated’ and not partnership per se. The Pharmacy Act (2002), for example, enforces the registering, enrolling and listing of all pharmacists, pharmaceutical Technicians and Pharmaceutical Assistant, and regulates the standard of conduct and practice of the profession of pharmacy. On dispensing the Act and Dispensing Manual emphasizes the need for qualified person to dispense “right medicines of good quality, to the right patient, in the right quantity and with correct and full instruction”. However, the powers to regulate pharmaceutical practice rests in the hands of the Tanzania Food and Drug Authority (TFDA) which is currently lacking enough personnel to regulate the sector in the districts.

Currently pharmacists and pharmaceutical technicians are mainly trained in government institutions. It is a requirement that a pharmacy shop has to operate under the license of a pharmacist, and is licensed by TFDA. However, presence of a pharmacist or pharmaceutical technician is not a requirement in operating a drug (Poison Grade II) shop. And, the local government licenses these shops as normal shops, although they are to be inspected and regulated by TFDA. The owners of drug outlets are related to TFDA as the regulated although not licensed by them. There is no ‘two way partnership’ but one partner is only a ‘to be regulated partner’.

The government agents, TFDA and other district authorities, regulate and inspect drug outlets. The relationship between drug outlet owners (pharmacies, drug shops and other drug outlets) and the government agents is reported to be of scepticism, causing reluctance to respond to researchers’ interviews (Mujinja et al, 2002, Chambuso et al, 2003, Mujinja et al, 2003). Owners are reluctant to respond to interviews. Researchers visiting drug shops are in most cases suspected to be inspectors, tax assessors or any other law enforcers. Despite these fears, the effectiveness and efficiency of the regulatory framework in

pharmaceutical sector has been reported to be weak (Kumanarayake et al, 2000). Lack of funds and enough human resources are among important factors leading to inefficiency in regulating the sector; as a consequence drug outlets have continued to sell prescription drugs without a prescription. Drug shops (DUKA LA DAWA) have continued to sell antibiotics and other drugs that they are not, by law, allowed to sell (Mujinja et al, 2003; Chambuso et al, 2003). In addition, due to drug shortages there exists case of irrational prescribing and dispensing which is in contradiction with the Good Dispensing Manual of the Ministry of Health.

The Tanzania Food and Drugs Authority (TFDA) and Ministry of Health have established Drug quality and Assurance Programme with the aim of ensuring quality drugs that are manufactured and imported in the country. The move is in line with the National Health Policy (2002) and Second Health Sector Strategic Plan (2003 – 2008) emphasizes on provision of quality health services, stressing on the need for public/private partnership and promoting private sector involvement in delivery of health services. In addition, in order to improve access to affordable, quality drugs and pharmaceutical services in retail drug outlets in rural and per-urban areas, the TFDA in a Ruvuma region pilot project has trained Nurse assistants on how to hand out prescription drugs. Both Nurse assistants and drug outlets have been assessed for accreditation according to a set of standards. Now, more than 150 drug shops (Accredited Drug Dispensing Outlets or ADDOs) have been accredited in the pilot area (MOH-ADDO Evaluation Report March 2005).

There are a number of more *economical measures* in place too, though less standardised and partly left to the discretion of council health management teams. These particularly deal with resource allocation (e.g. division of basket funds; allocation of staff and bed grants), inducement allowances for staff employed in hardship areas, grant allocations based on poverty index and population density. In this report the RT focuses on additional and alternative measures to promote improved service delivery through public private partnerships, using measures that link incentives to desirable performance of services.

5.3. PARTNERSHIP BETWEEN PUBLIC AND FAITH-BASED HEALTH SERVICE PROVIDERS

Introduction

Collaboration between public and faith-based health service providers in Tanzania is a historic fact. Church involvement in health care, its so-called 'healing ministry', dates back to the earliest part of the 20th century, prior to any comprehensive government health services, policies, legislation etc. After independence, the Ministry of Health gradually created a regulatory framework in which church health services performed their services, and provided various forms of resources that complemented the traditional sources of external funding and limited income from direct contributions by patients.

The introduction of SWAp, the health reforms, to name but a few, gradually changed the perspective of faith based health facilities from offering services to whoever is in need to incorporating selected church health services in district health plans, complementing public health services. Concurrent developments of increasing cost of service provision and reducing contributions to recurrent expenditure from abroad caused financial constraints. Although a large part of the faith-based health service providers could access some form of government support, increasing dependence on user charges could not be prevented.

Even before the 'subsidiarity principle' became common thinking in the health reforms process, it was already practiced by churches. Although health secretariats were established at diocesan and national level, the ultimate authority remained with the proprietor, usually a Bishop of a particular Diocese. The Bishops in turn entrusted management of health institutions to governing congregations and/or health professionals, without losing ultimate authority.

The decentralised autonomy on the one hand is an asset and can be evidently linked to the quality and reputation of diocesan health care over the years. On the other hand it complicates policy development and coordination at the national level when this addresses issues that are beyond the levels of the dioceses. In most (African) countries, national, regional and diocesan health secretariats report persisting challenges to effectively coordinate diocesan health care services in view of e.g. contractual arrangements with the MoH. This generally coincides with calls for greater capacity, whereby it is for debate whether a greater professional capacity will ensure greater coordinating authority. There are examples, however, (Ghana and Uganda) where in National Catholic Health Secretariats this did happen.

The organisation of the church in the field of health care in Tanzania: CSSC

Following a stakeholder consultation in Moshi in 1991, the Christian Social Services Commission was founded as an ecumenical body representing the interests of about 15 member Churches and 10 Church related Organizations in Tanzania. CSSC represents over 600 and 400 Church-owned Health and Education Institutions in the country. CSSC's main role is facilitation of delivery of social services, education and health. *There is no explicit reference to any decision making or coordinating authority on behalf of the member churches.*¹⁰ CSSC's core budget is financed by mainly church-related donor agencies abroad, with other sources contributing to specific programmes (such as rehabilitation of schools and health units).

The services CSSC provides in the field of health care are a mixture of technical (maintenance services; consultative services) and logistical services (e.g. managing a rehabilitation project from which a large number of church health units and schools benefited) complemented by facilitation of communication with the Government. In view of ongoing reforms (and decentralisation) in the educational and health sector, CSSC organised itself on a "zonal basis", creating 5 so-called Zonal Policy Forums. These have been instrumental in the field of education. However, in the field of health care CSSC's role has been continuously challenged by the health professionals, particularly where it concerned CSSC's strength to promote more equitable resource sharing at district level.

The RT is of the opinion that it is of utmost importance that the churches delegate coordinative authority to the CSSC in view of promoting PPP. (See also next section.). Likewise, and likely to be heavily intertwined, CSSC should demonstrate its capacity to facilitate productive interaction with the MoH and other stakeholders.

MoH and FBO interaction

At central level, there is no official forum where faith-based organisations meet regularly with MoH for information, communication and coordination purposes (although MoH states that they meet 'regularly' with FBOs). There is no overall umbrella organisation representing all faith-based actors. Nevertheless there are occasional ad hoc meetings.

¹⁰ From the CSSC constitution (1998) and the Bagamayo statements (2001) the objectives of the CSSC can be distilled: "to participate effectively in the formulation of policy proposals to the government which may assist the Government in the formulation of gross policies in all matters related to the provision, improvement ... of health services; "to harmonise or reconcile Churches policy relevant to provision and support of social services in education and health sectors".

CSSC is probably closest to fulfilling that role but in principle covers only Christian actors (Catholic, Lutheran and Anglicans being the main faith-based actors at rural level). CSSC meets occasionally with other actors (Muslim, Hindu) that provide health services too¹¹. It is the intention of CSSC to coordinate also with non-Christian actors (through a so-called Inter-Faith Forum; which draws WB support) in order to defend their views in joint government meetings. However, this kind of joint representation is still to be firmly established.

The Government has been fairly consistent in expressing its wish that the faith based organisations 'speak with one voice'. The RT supports the need that in view of PPP a mandated and well-equipped body should be instated. This body should receive the basic consent from the faith-based groups involved in health services delivery and interact with the Government on issues that particularly refer to faith-based health services providers. The initiative to initiate such a representative body should be with the FBOs themselves.

The MOU between faith-based organisations and MoH are outdated and do not take into account recent health sector reforms and decentralisation of authority to council level. A standard for service agreements between councils and service providers is being developed by the PPP Steering Group and about to be completed. Both Council staff and CHMTs (but also faith-based providers) are eagerly awaiting this type of more formal arrangement with service providers (hospitals, health centres, dispensaries). The agreement should clarify the mutual relationship of the partners involved, the responsibilities, guiding principles (e.g. on cost-sharing, service provision) and accountability and should describe designated human and financial resources.

At the local level

The presence of representatives of FBOs in decision-making bodies and planning exercises at council level seem to become more institutionalised (Health Services Board, Council Planning Team). However, representation and 'power to influence decision-making' generally do not (yet) match importance or responsibility in local service delivery. Although the RT has the impression that involvement of FBOs in decision-making is improving, faith-based and public providers are not yet 'treated' as equal partners pursuing the same goal of providing equitable quality health services.

Support rendered by the MoH to faith-based health services providers.

In Tanzania public subsidies to faith-based health service providers are substantial and more important than in some other countries in the region. The Government subsidises all salaries of seconded staff and operational costs to 21 FBO's, including 19 DDHs and 2 consultant hospitals); staff and bed grants to VA hospitals and student grants to training schools; faith-based dispensaries generally do not receive direct funding, apart from a share of the basket funds (no uniform practice) and LG renovation budgets.

Financial and human resource support is significantly different between type of hospitals (DDH or VA) and does not sufficiently include faith-based dispensaries (which have to raise fees in order to cover salary costs). *Subsidies are based on the type of facility rather than on the volume or quality of services being delivered.* This affects equity in service delivery as less subsidised facilities have to look for additional resources, including user fees¹².

¹¹ The share of non-Christian actors (Muslim, Hindu, Bahai, etc.) in overall faith-based and not-for-profit health care services provision is stated to be limited. As mentioned elsewhere, there is need to clarify relative contribution through desk- and field studies.

¹² Discussing the impact of user charges on health care seeking behaviour and subsequently on health status indicators is outside the scope of this review. Reference is made to the REPOA study "equity implications of health sector user fees in Tanzania" by Laterveer and Schwerzel, 2004.

During the district visits the RT saw examples of the impact this had on service utilisation but also on the kind of services provided. Implicitly, this kind of selective service provision may cause patients to spend time and money on travelling to institutions they can afford. This may lead to a delay in presentation and therefore may affect morbidity and mortality indicators, particularly concerning essential services like obstetric care or control of malaria in children.

The RT notes that *financial support mechanisms are not or not sufficiently used to improve performance* (e.g. output-based financing; linking resource allocation to quality assurance / accreditation) *or to promote delivery of certain desirable services or targeted interventions*. In any PPP promoting strategy there is need to include options to induce desirable health system outcomes.

Mistrust, lack of mutual understanding and appreciation, perceived lack of transparency and accountability

Studies on collaborations between public and faith based health services providers consistently refer to what we may call lack of cohesion between these two sectors. We may not dwell too deep into this, as this is outside our ToR. However, the RT was told of disputes on resource allocations, on biased decision taking and inadequate representation, on relevance of service provision, on unreported income, etc. The mistrust seems to be more persistent at the national level, though it does exist at the local level as well.

The RT is of the opinion that unless this mistrust is addressed openly it may hamper the furthering of PPP. Two basic issues feature most prominently and may be addressed by studies that aim to make an inventory of:

- The relative contribution made by FBOs to health service provision at council/district/regional/national level (i.e. the types of services provided and their respective utilisation by the people; actual size versus actual utilised size versus approved, etc.);
- The origin of financial means available to FBOs (i.e. a “financial tracking study” that unambiguously describes the sources of income in cash and kind available at health unit level for recurrent and capital expenditures)¹³.

In order to provide a comprehensive picture it is proposed to extend the first study to all private sector providers.

Human resources are in crisis.

The 2004 Joint Annual Health Sector Review confirmed that Tanzania faces a human resources crisis. Several other studies confirmed the same and linked the deficit in human resources available to the need to scaling-up priority interventions (Kurowski et al.; 2003, McKinsey & Company; 2004).

Field observations confirm that the human resources crisis is much more prominent in rural areas, affects both public and faith-based facilities, affects more the professional cadres (MO, CO, AMO, Nurse/midwife, pharmacist, lab technician, etc.). Because of better and improving work conditions in public facilities (although salary levels are the same) professional staff are now leaving faith-based facilities for public facilities and recruitment of new staff for faith-based facilities is increasingly difficult. This also affects urban faith-based dispensaries. In addition, the “caste” system of having different remuneration levels for ‘seconded’ staff and ‘own’ or ‘diocesan’ staff is inequitable and inefficient.

¹³ The recent (2005) NSGRP document recommends quantification of the contributions by various actors too; reference is made to par. 8.4.

Whether or not measures are needed to curb competition between two groups of providers over scarce human resources is not easy to conclude. The need for corrective measures depends on the impact the competition has on performance of health services providers (this may be a public interest) and their ability to improve service conditions in such a way to restore the equilibrium.

5.4. PARTNERSHIP BETWEEN PUBLIC AND FOR-PROFIT ACTORS

Introduction

Private for-profit (PFP) actors include PFP hospitals, health centres, dispensaries, pharmacists, drug sellers, laboratories, maternity homes, traditional healers, etc. It comprises a wide variety of formal and less formal actors who work in a poorly regulated environment. Quality tends to vary strongly between different actors and is not always up to expected standard.

PFP dispensaries in rural district capitals are often owned by public sector professional staff providing part-time private services (combining public duty with private practice) or retired health staff. In urban settings private dispensaries are often owned by public doctors or business men employing private staff or by full-time private doctors. In order to reduce costs professional staff is sometimes replaced by lower cadres. Quality of performance at dispensary level seems a relevant issue. The RT was informed by one of its members that ongoing research addresses this.

The retail pharmaceutical sector is a large sector, particularly in urban areas with a large number of outlets that supply either drugs under prescription (Part I) or without prescription (Part II). (see also note 3). Recent research has indicated that regulation and quality is a highly relative issue (Mujinja et al., 2003). The research indicated a lot of concerns, such as inadequate qualifications of drug dispensers, lack of knowledge on regulations, prescription of Part 1 drugs without a licence, etc. This is of particular relevance as reportedly 25% of the respondents of the study opted to self-treat at some point during a recent illness.

The RT acknowledges the relevance of the retail pharmaceutical sector in a liberalised health environment. However, there the RT lacked the opportunities to have a first-hand impression on the performance of this sector. It therefore wishes to refer to the research done by one of its team members, which contains sufficient arguments to have a closer look at this sector.

Support provided by Government to PFP health service providers

MoH states that the PFP health sector is to be considered as a different system and should not be subsidised by public resources.

In fact, government already 'subsidises' PFP sector indirectly. Examples are financing undergraduate training of health staff (training fees do not cover the full cost of training; public health staff may leave the public sector for work in the private sector), allowing public professional staff to combine private practice and contributing as employer to the NHIF providing access to PFP providers (the latter is still in its embryonic phase) . Also, on-the-job training of health staff organised at council level includes sometimes (depending on the district) PFP health staff. Some districts select some PFP health providers for delivering specific EHP services such as MCH and provide MCH supplies. Other examples are the provision of TB drugs for DOTS and provision of VCT services in combination with provision ART.

PFP providers cannot properly implement some national policies today (such as providing essential services to the poor or providing some drugs free of charge), as government does not (or not sufficiently) supply them with the necessary subsidies (e.g. vouchers to cover essential EHP services provided to the poor) or supplies (e.g. free STI drugs, drugs and supplies for chronic diseases, MCH supplies). Even if some MCH supplies are supplied to selected PFP providers in some urban districts, government does not cover the cost of the service delivery (salaries, recurrent costs).

There may be some confusion between what is understood by 'public subsidies' and 'out-sourcing'. The RT (and so are many people interviewed) is in favour of MoH (or Council Health Boards) out-sourcing the delivery of the EHP¹⁴ or elements thereof (e.g. MCH services) by contracting selected PFP health providers (only registered and accredited providers, based on comparative advantage, quality standards, transparency and accountability). This means that selected PFP providers could deliver essential services on behalf of the government, in areas where public facilities are not sufficiently available. As discussed earlier in section 2, the voucher system could be considered. They can be used to allow designated low-income groups to access a defined package of services, whereby the provider of the services being reimbursed for delivering those services. This is a sort of exemption scheme, though with some additional features. Exempting patients from payment is usually associated with a variety of complications (e.g. institutions incur additional costs without receiving additional income), earning it a reputation of not being effective.

Alternatively, selected health service providers could be contracted to provide certain essential health services on behalf of the government and at agreed prices, e.g. STI treatments or TB DOTS, immunization, ART and PMTCT, etc. Patients needing this kind of services could be issued with a voucher that would entitle any clinic treating the patient to a financial compensation, provided the clinic has a contract with the council authorities.

Also, examples exist of MoH contracting PFP providers for delivering the curative aspects of the full essential package (e.g. Egypt, EHP at primary level).

Regulation of the private for-profit sector

Regulation has been discussed in section 5.2. Only additional aspects regarding the PFP sector are presented here.

Government does not provide incentives to improve or uphold quality in private practice (with the exception of regular supportive supervision being implemented in some municipalities). There is no standard accreditation system being applied for the PFP sector (but NHIF has started accrediting PFP facilities). However, standardised accreditation systems could be linked to other public health goals such as providing regular HMIS data to the MoH and Council Health Board (e.g. renewal of accreditation status). A proper accreditation system is based on regular provision of information on quality standards and services delivered. Without a functional (albeit selective) HMIS this is not easily established.

Prices are not set by government or through regular negotiation with private provider organisations. This results in a wide variety of prices being applied both for services and supplies (e.g. drugs). In principle the health market would self-regulate itself taking into account capacity to pay and competition between providers. International experience indicates that this system is inflationary. However, in a resource constrained environment this may be somewhat less prominent. In a health system whereby the PFP sector plays an increasingly important role and where private services are not limited to

¹⁴ In Tanzania the Essential Health Package is a Primary Care Package.

the “happy few” (e.g. PFP provide up to 70% of primary facilities in Dar es Salaam), there is a need for government to set prices at least for essential health services and essential drugs in order to guarantee access to basic health services.

Expectations from PFP health service providers

PFP actors expect more support from government in order to facilitate quality service delivery. This includes a variety of issues such as import tax-exemptions, access to essential/generic drugs through MSD or other tax-exempted wholesaler, access to information and in-service training. HMOs such as AAR call for further liberalisation to create good working environment for HMOs. However, it is the point of view of the RT that the latter may only be feasible after there has been sufficient regulation, which at present is not yet the case.

PFP providers are in favour of one standard set of national criteria for accreditation and quality assurance, being applied to both private and public providers. Their concern is that government seems to be interested in regulating the private sector, while not applying the same standards to the public sector. A similar view has been expressed by PORALG.

The Medical Association of Tanzania (MAT) recommends a negotiated private practice in public institutions (which started already in Muhimbili National Hospital). This is a win-win situation whereby public facilities can generate additional resources by using their facilities more efficiently while preventing PFP providers from having to invest in costly infrastructure, where some may be tempted to compromise on this in order to secure a profit margin.

NACP wants the private sector to be involved in e.g. ARV provision and promotes support to be offered to PFPs for compiling business plans. TACAIDS has a mandate to distribute finance to private and informal sector, however it is not yet done at large scale (little during round 3; proposed during round 5 of Global Fund).

The PPP landscape is definitely changing due to need to link different actors in order to promote effective HIV/AIDS response system. Social marketing of condom distribution is a welcome example of intervention-targeted public private collaboration that appears to be functioning.

Representation of PFP health service providers

PFP providers are generally not well represented in bodies and councils that are established by law to guide health practice (e.g. Medical Council, Nurses and Midwives Council, Pharmacy Board).

Health professionals are organised in a large number of professional associations. Not one association covers all potential members. No umbrella organisation exists representing the 26 existing associations. This situation does not facilitate effective communication between MoH and professional associations nor makes it easy for professional associations to effectively achieving their goals.

A number of PFP hospitals are member of APHTA, but APHTA aims at a larger, nation-wide representation including also non-hospital private facilities. Currently active APHTA membership stands at 95 with a potential of over 800 in Tanzania mainland and nearly 100+ in the islands of Zanzibar and Pemba.

PFP are in principle represented in bodies at council level such as Health Services Board and Council Planning teams. The Comprehensive Council health plans reviewed by the RT generally do not take into account PFP. However in both Arusha and Kinondoni municipalities PFP receive some support in kind (e.g. vaccines, refrigerators, weighing scales).

In principle PFP have no access to government grants or to basket funds. However, government resources are used also for supervision, on-the-job training of PFP, HMIS, some services such as MCH supplies or TB drugs to selected providers), especially in urban settings where PFP are numerous.

APHTA and MAT, potential key players in the PFP sector

Introduction

The RT had consultations with APHTA (Association of Private Hospitals of Tanzania) and MAT (Medical Association of Tanzania). These two professional organisations are felt to be potentially instrumental in improving quality of health care in Tanzania. Both associations take ample interest in PPP. APHTA has a prominent representation in the PPP steering group.

The RT did not have sufficient time to consult other similar associations like those for medical laboratories, nursing homes, pharmacies, maternity homes or any of the other 20+ associations that represent other categories of medical, para-medical and nursing professionals.

APHTA

The association exists slightly over 10 years. Although its name refers to private hospitals, its focus possibly comes close to what can be labelled 'private-for-profit' health institutions. As is the case with NGOs, the entities that could be included under this generic name have a large diversity, from basic private practice clinics to third-level hospitals like the Aga Khan and Hindu Mandal Hospitals. Although the sector is known to be for-profit, it includes so-called charities, some of which are faith-based. In other words, any attempt to define private-for-profit institutions is likely to become a semantic struggle.

On the other hand when no comprehensive, factual information is available on this growing sector, it may severely handicap any future policy making on the side of APHTA, but perhaps even more so on the side of the MoH. There is sufficient reason to research the sector in some detail.

APHTA's membership in comparison to the size of the sector is limited and particularly focuses on urban areas (where most of private-for-profit institutions are located). Lack of resources limits the level of its activities. Meanwhile, it has attracted some subsidies, which will enable it to undertake a constitutional review in order to expand its roles and its services. These services include "a comprehensive array of advocacy, administrative, knowledge-sharing and networking products and services to the sector, especially its members and constituents."¹⁵

MAT

The association exists 40 years to date and votes to represent all medical doctors eligible to practice in Tanzania. Its objectives include upkeep of standards of medical ethics and conduct, representation of the medical profession; promoting interests; liaison with medical associations elsewhere and information dissemination in relevant fields. Like APHTA, the MAT membership is limited in comparison with the total number of medical officers practising in Tanzania. Income from membership contributions is low, hampering the efforts of MAT.

¹⁵ Excerpt from APHTA briefing note to RT dated 22nd February 2005.

According to a recent study done, commissioned by GTZ, the number of associations of medical, clinical and nursing professionals exceeds 20, some of which are rather limited in size. The GTZ study indicates the need for an APEX body, a Federation of Medical Associations of Tanzania that could represent medical professionals in ongoing discussions on promoting PPP and quality of services in the country.

Observations made by the RT

Although both APHTA and MAT have a mandate and thrive by a limited number of active members, their general political clout and institutional capacity are still too limited to allow for a more prominent role in PPP. APHTA comes closest to this through its membership of the PPP steering group.

Both institutions lack adequate representation of individuals (medical professionals) and institutions (for-profit facilities).

5.5. PPP AND NGOS

Introduction

“NGOs” is a generic description of a complex of organisations/entities ranging from grass-root self-help organisations (CSOs or CBOs) to nation-wide operating non-governmental organisations with or without an established link with an international consortium. Indigenous NGOs are generally perceived to be the ultimate form of civil society mobilisation. In addition, there are a large number of international NGOs active on the ground, either independently or through local subsidiaries.

For Governments NGOs in general are a fluid ‘lot’, hard to follow leave alone to control. The latter may not be desirable as the Constitution does endorse freedom of organisation. However, where NGOs do occupy themselves with essential social services for which the Government ultimately holds responsibility, some formal interaction and constructive partnership may be required.

NGO involvement in health care

The number of NGOs (including CBOs/CSOs) active in health sector can only be ‘guesstimated’, but may very well exceed one thousand. Many of these may well be very small, locally based groups (or collectives) providing support/welfare services including in health. Those types of NGOs are substantially different compared to NGOs working at the national level either providing direct services or involved in public education, etc. Some local and/or international NGOs are involved in service provision, complementary to public services. This can either involve selective services, such as reproductive health or VCT, or more comprehensive services (e.g. running a dispensary). They can often be found in more isolated areas and for more impoverished communities/individuals, aiming to promote/improve access to essential services, especially for the poor. Other NGOs see their role more in community support, advocacy, capacity building, training, research, etc. These activities aim at installing a capacity besides creating an environment in which local CSOs/CBOs can render direct (health) services to the public. Particularly in the field of HIV/AIDS, backed by comparatively large funding, NGOs and INGOs operate and fill part of the seemingly endless needs.

Observations by the Review Team

Partly due to their large numbers and diversity in appearance, juridical arrangements, objectives, etc., NGOs as a sector have not been very well organised. An NGO driven, cross-sectional NGO Policy Forum (NGO PF) exists where some larger NGOs tend to participate (dealing with issues such as NSGRP, PER, MTEF). The RT observed that the NPF cannot yet accommodate the wish and invitation of the Government in general or ministries like the MoH in particular to have an entry port that can speak and act for

the NGO 'sector' as a whole. According to the NGO PF it is also not the purpose of the NGO PF to develop a nation-wide network of every NGO, CBO, etc; but rather to strengthen and coordinate the efforts of policy-oriented NGOs to engage with national policy processes including PER, PRSP, etc. As an example, the NGO PF has facilitated two NGO slots in the MOH Technical Sub-Committee on Budgeting, Planning and Evaluation. However, active membership of health NGOs in the NGO PF is (still) very limited and, as far as the RT has been able to ascertain, there exists no other potential umbrella organisation for NGOs in health. The NGOs interviewed tend to agree that it is the NGOs' responsibility to improve coordination among themselves in the health sector.

There is evidently a definition problem at hand, as the Ministry does not feel it should even attempt to 'define' what groups or sub-groups are to be placed under the generic description of NGOs. In any case the ambiguity of the NGO sector fuels discomfort and suspicion, particularly as 'undisclosed and seemingly unlimited funding' allows a significant proportion of the NGO sector to operate alongside government and to some extent outside its influence. The latter view may not apply to all NGOs, but this seems a common perception on NGOs by the public sector.

As a result, the NGO sector feels and is somewhat excluded from policy discussions and strategic planning, especially at central level. At the local level, collaboration with CHMTs at council level seems to be more effective, but varies by district, dependant both on pro-active attitudes of NGOs and CHMTs.

It is the view of the RT that the *NGO sector cannot be left aside when promoting PPP*, simply because they lack an adequate organisation or functional definition.

One of the overarching recommendations by the RT concerns an increasing focus on actual services rendered, rather than on institutions/organisations. NGOs, in whatever form they appear, are known to provide useful services¹⁶ that fit in and complement MoH strategy plans. It is here that their incorporation in comprehensive health plans, particularly at council levels, could be instrumental. Hence they should be invited to participate. It is the RT's assumption that at council level the definition and transparency issues do not cause a lot of discomfort as NGOs are judged by their deeds.

5.6. PPP AND PRIVATE ENTREPRENEURSHIP

The RT acknowledges the fact that some of the larger companies have set up health services that cover their employees and families and at times extend into the direct communities where the companies are based. Particularly in respect to HIV/AIDS control a number of companies have been progressive, motivating others, government agencies and non-governmental agencies, to follow suit. The RT has not been in the opportunity to engage directly with the private entrepreneurial sector or indirectly (e.g. Chamber of Commerce), nor has it been able to access any documents that provide baseline data on the contribution by the private sector to health services.

A recent trend world-wide is that international private companies tend to invest more and more in social services, as part of their 'social engagement'. Often funds are channelled to developing countries through local companies, NGOs or CSOs. This parallel funding is difficult to 'grasp' and quantify. It may be difficult for CHMTs to be aware of these additional resources unless they actively search for them. This may indeed be needed in order to maximise their benefit in support of national health goals.

¹⁶ "Services" should be interpreted as a comprehensive term, not only including health services but also public education, research, advocacy, etc.

5.7. PPP AND TRAINING SCHOOLS

Training is for decades an excellent and “avant-la-lettre” example of PPP, as explained in section 2. Training has a large private sector contribution with a full complement of public subsidies (seconded staff, subsidies to individuals, curriculum development, provision of study materials, etc;). Private training schools provide graduates to private and public sectors alike. Recently, numbers of enrolled students at medical schools have been significantly increased.

The RT has not been in the position to investigate why PPP in the area of training of health professionals appears to run comparatively smoothly. There is a fair amount of government supervision, regulations in training, much more than in service provision at health unit level. While Dioceses usually are adverse to too much regulation affecting their cherished autonomy, this seems manageable with training institutions. Could it be shared interest combined with equity in cost/benefit? Or is there a functional trade off between private or faith-based identity, culture and values and government professional standards? Often health institutions benefit from accommodating trainings due to higher quality standards, plenty of students performing partly relevant work etc. Perhaps there is an attractive trade-off too.

Lessons may be drawn from this that could be useful when studying ways and means to promote PPP in service delivery. It is suggested that the PPP steering group commissions such a study.

5.8. COMPREHENSIVE COUNCIL HEALTH PLANS

Capacity in strategic health planning varies substantially between districts and requires continued support. Administrative procedures for acquiring financial resources tend to set the agenda more than strategic health planning. However, comparing to previous reviews, quality of health plans is improving but *strategic health planning at district level does not yet properly accommodate PPP*. This is not surprising as PPP is not strongly promoted at the central level.

According to TACAIDS, the scale and diversity of HIV/AIDS funding and targeted interventions outmatch any capacity at district/council level to develop “comprehensive planning”. It is the view of the RT that any would-be PPP Forum (see recommendations) as well as TACAIDS/NACP should make an attempt to enforce adherence of these funding strategies to decentralisation principles.

Council health planning also faces some practical coordinating problems. A variety of actors at council level have their own respective planning cycles (that may differ from those of the council) and have their outside pressures, mandatory limitations, institutional settings (one diocese or NGO to deal with a multiple number of councils; one council to deal with a multiple number of NGOs and dioceses).

Planning on upgrading and expanding of existing health units or founding of new units appears to take place without consultations with the Council Health Services Board. During the district visits the RT found several examples of this (see also Par. 5.2 3rd dot under observations).

5.9. PPP AND TRADITIONAL HEALERS

The RT acknowledges that the contributions of traditional healers to health and possible linkages to the vision on PPP have not been sufficiently covered in this review. This should be the subject of a separate study.

Traditional healers are considered to be part of the private health sector, whereby traditional medicine is clearly distinguishable from conventional medicine. In 2002 the Traditional and Alternative Medicines Act was passed in the National Assembly. The act does not refer to the ongoing decentralisation process.

Traditional medicine is stated to supplement conventional medicine, but not to substitute it. At council level it may be relevant to make an inventory of traditional healers and birth attendants. It appears to be useful to promote participation of traditional healers in ongoing health education. Moreover it may be considered to invite them to be represented in the Health Services Board.

6. Main recommendations

6.1. HEALTH SECTOR FRAMEWORK / REGULATOR, PURCHASER, PROVIDER

The health sector roles of regulator, purchaser and provider have been evolving over the past years. The situation today may still be different from how roles would or could evolve in the future. Below, the RT makes an attempt to draw the present situation and behaviour of different actors as well as proposals of how the future situation could be.

As discussed in section 2, the **role of the central MoH** is evolving, as proposed in the health sector reforms, towards a more regulatory role including responsibilities of governance, policy making, national strategic planning, legislation, regulation, human resource development, quality assurance, monitoring and evaluation. At the same time, public health service provision has been decentralised and devolved to LG (public health services up to district hospital level). Public tertiary care facilities are still governed by the central MoH.

The role of the central MoH as regulator and steward need to be further strengthened, especially in the areas of regulation (registration, licensing and accreditation) and quality assurance. The proposed framework for quality improvement is a step forward, using a unique set of standards and criteria for all public and private providers and proposing a single system for accreditation. Promoting and furthering PPP requires strong leadership from the MoH, proper mechanisms and sufficient resources (see further).

The **purchasing function** (although not yet perceived as and implemented as such) in the Tanzanian health system is in principle implemented by different actors including the MoH (tertiary health services), LG (primary and secondary health services), NHIF (health package for insured public servants and dependents), CHF (pre-payment scheme at community level) and private insurance (health package for insured people). With the exception of the private insurance companies (including HMOs) none of the above actors is acting yet as a true purchaser of services but rather as a subsidising authority (MoH), a fund-holder (LG), a reimbursing authority (NHIF) and a voluntary scheme (CHF).

This situation could evolve in the future with the NHIF progressively increasing its membership and using comparative advantage between health service providers to selectively contract with better performing providers (higher quality) and/or using different reimbursement levels reflecting quality/performance. Similarly, a Council could evolve from a passive fund-holder to a more active purchaser of services: contracting with public and private providers alike, promoting quality and cost-efficiency (see recommendations 6.2 for how PFP providers could be contracted). MoH could (or could not) decide to treat tertiary care hospitals and the Zonal Training Centres as semi-autonomous institutions directly contracted by the MoH. This would allow MoH to split service provision from its more important role as regulator.

The RT acknowledges that introducing true purchasing behaviour will take time and may not be the first priority. However, the government has to be clear about what the future sector context and respective roles will be, in order to guide key actors to move in the agreed direction. For example, introducing service agreements between Councils (CHSBs) and FBOs is a first step towards confirming the role of the Council as the fund-holder with authority to contract with FBOs. This would allow the Council to monitor performance and quality of service providers, and by doing so promote better performance. Testing similar agreements with public sector providers and selected PFP providers provides learning experience for how performance can be improved.

The tools to decide at Council level on allocation of grants and basket funds already exist. They could be used more effectively to promote performance using output-based financing (e.g. part of basket funds to public facilities linked to performance). Service agreements with FBOs could be based on the same principles (e.g. staff and bed grants allocated could be at least partly linked to performance; for example starting with bed grants 80% fixed and 20% variable linked to performance; and basket funds partly linked to performance). Councils more and more acting as active fund-holders with (progressively increasing) discretion on resource allocation, implementing government policies is the way forward. To a certain extent this is already being done and requires building Council's and CHMT's capacity in contract management. As discussed further in this chapter, **moving from institution-based financing (bed and staff grants; basket funds) to service based financing (financing services provided; linking financing to output) is the proposed way forward.**

The RT differs from the MoH (as discussed during the debriefing) in its **view on the health system**. Rather than pursuing the perception of three different parallel systems (public, FBO, PFP) which should be treated differently, the RT perceives one health system with different actors. The health system has one overall responsible authority which is the government. Different actors should implement government health policy and contribute to the overall health goals. It is the responsibility of the government to set the regulations, actively develop a conducive environment for achieving this and preventing harm through poor service quality, taking into account all type of providers. FBO and PFP providers should indeed organise themselves into representative bodies to facilitate communication and coordination with government.

Accreditation and quality assurance are functions which the MoH decides to out-source or not. In principle these functions are better implemented through (semi)independent bodies which do not favour ownership of facilities or type of providers (public or private). Keeping those functions within the central MoH may be perceived by non-public providers as being 'biased'.

At present the NHIF uses the principle of accreditation to 'select' service providers and improve quality. However, it is not clear how much this principle is consistently applied as all public providers have been easily accredited while procedures seem to have been

more strictly applied to FBOs. NHIF is now in the process of, somewhat reluctantly, accrediting selected PFP providers.

Specific recommendations are presented in the following sections, but the main one is as follows:

- Define more clearly the present and future roles of different players as regulator/policy maker, purchaser and/or fund-holder(s), providers of services. This includes the role of the NHIF (today and future) as purchaser, the role of the government as regulator/policy maker and as financier / purchaser, the role of the council as purchaser / fund-holder (and as monitoring implementation of regulations?), the role of different providers, the institutional set-up for accreditation, licensing and QA. Define how to move from the present situation to the future situation and within this context how to develop PPP.

6.2. GET OUT OF THE BLACK BOX

As discussed during the debriefing, lack of knowledge about what services are provided by whom, how, their quality and how these services are financed creates a feeling of “walking in the dark” or “black boxes”. This contributes importantly to feelings of mistrust, lack of understanding, and consequently to limited transparency and accountability.

The first thing to do is to know each other better. This may lead to changing the attitude of “us” and “them”, and at least to adapt service provision and financing strategies to reality in order to achieve the overall health goals.

The RT therefore advises to perform a number of studies to bring light in the darkness and provide clarity on the position of and services by private sector health providers, in particular FBO and PFP:

- **a study into the capacity and utilisation of private sector providers (FBO and PFP)**
This refers to the types of services provided and their respective utilisation by the people; actual size versus actual utilised size versus, etc.
This study is partly a desk study, partly an on-site study. E.g. the second could be an unbiased selection of districts (e.g. 20% of total) that could be used to draw indicative conclusions on other districts and the sector as a whole. The study should unambiguously describe the contribution made by the private sector to health services at district level in Tanzania
- **a study into the source of capital and recurrent income in FBO (and possibly PFP) health units**
This refers to a “financial tracking study” that unambiguously describes the sources of income in cash and kind available at health unit level for recurrent and capital expenditures. As with the utilisation study, it could be a comprehensive desk study with an on-site study at a selected number of districts (e.g. 20%) that could be used to draw indicative conclusions on other districts and the sector as a whole.

The RT is aware of reluctance towards such analytic studies with some FBOs. However, trust can only grow and performance can only improve if transparency exists. The least the Government may expect to justify resource allocation to FBOs, such as subsidies, grants, seconded staff, etc., is that FBOs produce annual accountant reports that present at least summaries of all income and expenditures, plus balance sheets; as well as annual reports on type and volume of services provided.

6.3. USE OF RESOURCES

In order to efficiently implement the national health policy of providing equitable quality essential health services to the people of Tanzania:

- **Allocate public budget finances based on health services being delivered rather than on the type of provider** (adagio “resources follow the patient” rather than the type of provider):
 - Review present procedures of allocation of financial and human resources to DDH and VA hospitals; to public and FBO dispensaries or HCs; this should be done using the present instruments rather than creating new ones. It does not require again a review of the grant and basket funds procedures but rather.
 - Allow districts where DDH or VA hospitals exist to use the allocation criteria more flexible, taking into account volume of services being delivered
 - Assure that guidelines are properly understood by all districts, especially regarding allocation of basket funds for FBO dispensaries and health centres.
 - Test output financing by linking part of the basket funds (hospitals, HCs, dispensaries) and/or part of the bed grants (hospitals) to performance. This means that part of the allocation would be fixed (as is the case today) and part would be variable (linked to performance). The RT proposes to test this approach in a few districts in order to learn from the experience before introducing it nation-wide.
 - Out-source specific EHP services (primary level) to selected PFP providers and/or provide specific essential supplies to selected PFP providers (e.g. access to MSD for selected essential drugs and supplies for public health problems, including HIV/AIDS; access to basket funds for training of PFPs); again using available instruments and tools. Out-sourcing for providing clinical services would have to be tested before widening its scope.
- **Use public and private providers where they are available to deliver the essential health package (primary level) or elements thereof** (do not consider PFP providers or NGOs as “gap-filling” where public coverage is insufficient, but consider them as equal providers of services, which capacity should be effectively used to achieve the national health objectives):
 - Use (selected) PFP providers in urban settings where coverage of essential services by public providers is limited
 - Provide a conducive environment for PFP to settle in rural / peri-urban areas of urban districts rather than extending the network for public facilities, if this proves to be more cost-effective
 - Consider using (selected) PFP for implementing government health policies, in order to increase equitable access to health services that are considered a public health priority (e.g. MCH services; DOTS; access to STI drugs; chronic diseases; ARV drugs; VCT; PMTCT; etc.). This can be achieved by out-sourcing or by the previously described voucher system.
 - By out-sourcing to or sub-contracting (selected) PFP, introduce quality standards and accreditation systems in the private for-profit sector (positive approach rather than only control, inspection approach).
- **Address the human resource issue for both public and FBO providers in an equitable way:**
 - Address the capacity of councils to attract staff and fill established posts both for public and FBO facilities
 - Address the budgetary constraints for employing staff

- Consider reviewing staff establishment realistically in function of volume of services being delivered and in function of available human resources on the market (today and in the nearby future). It is the view of the MoH that established posts should be filled ASAP: *“let us first get all the staff we are supposed to get, and then look at efficiency”*. However, it is the view of the RT that both should be addressed in parallel as the fast-track strategy (reviewing post requirements in function of utilisation) provides quicker results (re-allocation of staff), can be adapted when human resources become again more available and increases efficiency of use of human resources. The second strategy requires higher undergraduate training output (which requires time) and resources for employment (including incentives to attract staff to isolated areas). However, the RT has had no time to address this issue in detail and the recommendation requires careful evaluation by the MoH/HRD.
 - Remove the inequitable conditions of service between seconded and not-seconded staff at FBOs. This is a shared responsibility of FBO (diocese) and MoH. Dioceses should review salary conditions of their own staff and bring it in line with seconded staff work conditions.
 - Provide similar work conditions for public and FBO staff (career opportunities, access to upgrading, training, etc.). Although the MoH is somewhat proud that FBO staff prefers working for the public sector and holds the FBOs responsible for improving work conditions in their facilities, it is a short-sighted vision to expect “them” to solve this unilaterally. Again, this is an issue that should be addressed in a consistent HRD plan addressing HR issues in the whole (public and private) sector, involving representatives and resource persons from both sectors.
- **Consider decentralising budgets for drugs to council level**, allowing providers to purchase drugs from MSD and from other competitive wholesalers if MSD cannot supply (out-of-stock). The RT is aware that this issue has been discussed before and that MoH is reluctant to decentralise budgets, as those have been misused before. MSD is a strategic store for the government which does not restrict PPP in drug provision. However decentralisation of the procurement to Councils needs a strong machinery to avoid misuse of drug funds. Decentralising drug budgets may therefore be premature. Rather, as a first step, the monopoly of MSD should be addressed, preferably by inviting competition.

6.4. CONTRACTUAL ARRANGEMENTS

- **Finalise and institutionalise the service agreement between Councils and FB providers.** Test a similar agreement for contracting PFP or out-sourcing some essential services (see above). Learn from the PFP contracting experience (pilot testing of contracting, pricing, contract management, quality assurance) before going into contractual arrangements with a larger number of PFP. Test different options (full EHP contracted versus selected services such as MCH; access to all essential drugs versus selected priority drugs; etc.). The MoH stresses that service agreements have to be implemented cautiously not to create over prescription and that there should be a mechanism to curb corruption (e.g. inflated statistics). However it may also be the case today that government is over-subsidising “empty beds” as bed grants provided are not linked to beds being used.

- **Consider using service agreements with both public and private providers in order to promote performance** (output-based or performance based financing as discussed above). Link part of the quarterly allocation of grants/basket funds to performance (as discussed above).

6.5. REGULATORY FRAMEWORK (LAWS, REGISTRATION, ACCREDITATION, QA)

- **Review and update health legislation as required**, in order to take into account private sector financing and provision of services. Consider introducing a new law, governing specifically PPP, as proposed by the author of the legal review.
- **Review the efficiency of the registration process** (duration and practical constraints of the procedure; revisiting criteria of registration in function of new accreditation criteria being developed in order to assure complementarity of both set of criteria). The RT also recommends the initiation of long-term strategic planning at council level that addresses registration issues of new or expanded/upgraded facilities.
- **Install national standards for accreditation and quality assurance**, treating private and public facilities as equal service providers, as proposed in the recently adopted Quality Improvement Framework.
- **Consider positive approaches to introducing quality standards and accreditation in PFP sector through contractual arrangements** (see above), through facilitating access to capacity building courses for private providers (management capacity, professional in-service training, peer reviews). The latter could also be 'out-sourced' to private sector bodies such as APHTA.
- **Streamline policies on user fees throughout public and private sectors**. Assure properly working exemption schemes (if user fees are maintained) in order to guarantee access to essential services by the poorest. In case user fees would be abolished, pro-actively develop financing strategies in order to avoid FBO dispensaries to close down and FBO hospitals to face serious financial constraints.
- **Consider introducing mechanisms for setting prices for essential drugs and essential services**, applicable in the PFP sector. Setting prices requires mechanisms for negotiation between government and private sector and mechanisms for controlling adherence to agreed prices. This is a major undertaking for which the government does not have the resources available yet. However, through contracting selected PFP providers these mechanisms may be introduced stepwise.
- **There is a need to better define the concepts of PPP and 'equal partners'**. There may also be a need to define better different type of providers such as for-profit and not-for-profit, faith-based, NGOs, etc. Alternatively, rather than putting providers into separate boxes, the concept of concentrating on quality services to be equitably delivered, especially to the poor (as opposed to concentrating on providers) and dealing with all actors in the same way (if possible) may go a long way in avoiding semantic discussions.

6.6. INSTITUTIONAL SET-UP AND MECHANISMS FOR COORDINATION

- **Both MoH and PORALG should positively and actively promote PPP in health promotion and health care.** This is fully in line with promoting private sector development, especially regarding social services, as one of the main strategies presented in the NSGRP. National leaders from public and private sectors should set the political tone in order to create a conducive environment for PPP and in order for technical people to work out the mechanisms, tools and procedures. The underlying objective should be to maximise quality private sector input for achieving the national poverty reduction and health goals.
- **Install a formal forum for regular meetings,** information sharing, communicating and coordination between MoH and representative organisations of the FBO and for-profit sector. Some MoH staff say that these meetings already happen. However other partners have claimed the need for this forum to be officially recognised with comprehensive representation of the private sector (or other stakeholders) and with meetings held regularly.
- **Separate the PPP desk from the private hospital registration desk.** Make it a separate (semi-independent) entity with a clear mandate (and resources) to develop PPP, PPP policy and strategies, voice the view all health service actors, develop required tools, collaborate with other MoH departments to ensure that private sector is taken into account in all relevant health strategies ('mainstreaming PPP'). The private sector may also wish to contribute resources to this PPP Forum. Allow the staff responsible for PPP to be full-time allocated to PPP (e.g. not mixing responsibilities with hospital registration). Find local champions to staff the unit and actively move things forward.
- **Continue, formalise, recognise (and provide the necessary resources and accountability for) the ad-hoc PPP steering as a "broker" to engage with private sector representative bodies,** help the MoH in developing tools, voicing the viewpoints of the different actors. The RT recommends transforming the PPP Steering Group into a PPP Forum, with a formal mandate and Terms of Reference and backing from the most prominent private actors. The Forum's primary objective should be to create a safe meeting place for representatives of identifiable groups of stakeholders to discuss any matter arising in respect to promoting PPP and to suggest ways forward. This ad-hoc committee should continue until the above mentioned PPP unit is properly institutionalised, (wo)manned and operational. Its role should then be reviewed in function of the role and function of the PPP's unit.
- **Include NGOs as an important health services actor in the policy debate,** planning and implementation. Have an NGO representative in the PPP steering group. Invite NGOs to the health sector reform main review; invite NGOs to make presentations of 'best practice' in the main review (similar to DMO presentations). Have NGO representatives as full or co-opted members of the HSB, planning meetings at council level.
- **Encourage the NGO Policy Forum (NPF) to establish itself in a coordinating role,** representing a comfortable proportion of the NGOs that have been officially registered. Donors should be encouraged to provide resources that are required for this purpose.

- **Consider housing the Medical Council outside of the MoH** in order to underline its independency.
- **Different private sector providers (FBOs, PFP, NGOs) and professional associations (26!) should organise themselves in representative bodies or umbrella organisations** which can represent their views and communicate with MoH through the above mentioned forum. Use professional associations in helping self-regulating and promoting quality (and ethics) of care in the private and public sectors. But as has been well stated by the CMO, “You can’t drag the horse to the water and force it to drink”. It is a condition ‘sine-qua-non’ that there has to be an initial movement from within the private sub-sectors. Nevertheless, the government, backed by donors can go a long way in creating a conducive environment and availing financial resources for targeted capacity building.
- One possible option is **to support the Medical Association of Tanzania (MAT) to become this umbrella organisation for professional associations**. Another possible option is **to support APHTA to become a representative body for PFP actors** (hospital, clinics and single providers). This would require the following steps:
 - To undertake a comprehensive inventory of private-for-profit institutions.
 - To stimulate formation of two separate apex or federation bodies that incorporate and represent all medical professions and private health service institutions. The mission, vision and strategy statements should be coherent with MoH intentions to promote PPP.
 - To promote membership by offering a variety of services, among which capacity building so that members are better equipped to involve themselves in ongoing PPP dialogues and planning at council and district level. It may be relevant to decentralise the two associations (perhaps jointly) to avail support to members residing upcountry. One cannot expect the associations to bear all costs, so donor funding is recommended to complement membership fees.
 - To set standards/benchmarks that indicate adequate professional performance; to apply these standards for self-regulation purposes; to promote these standards to the MoH and Medical Council to be adopted and to be verified periodically, say every 5 years.
 - The associations should identify themselves and support the accreditation exercise by NHIF (but preferably an independent unit; see elsewhere); membership to earn additional credits.
 - It is recommended that CHMTs and CHSBs will give preference to members of the professional bodies in case certain public health services are contracted out to private providers
- Finally, an option could be **to support CSSC in its endeavour to effectively develop the Inter-Faith Forum as a representative organisation for FBOs**. The Christian Council of Tanzania and the Episcopal Conference of Tanzania should entrust CSSC with a firm mandate to liaise with non-Christian FBOs and engage a working relationship with the MoH to promote PPP. The capacity of CSSC at national and zonal level should be enforced, based on a strengthened mandate, so that CSSC could provide instrumental support in local negotiations on institution based service agreements.

6.7. OTHER RECOMMENDATIONS

- **Publish examples of 'best practice' of PPP** and share this information with all providers and stakeholders, including NGOs. Lessons can be drawn from existing examples of best practice such as PPP in training (see section 5) and the ITN voucher system that may be useful when studying ways and means to promote PPP in service delivery. It is suggested that the PPP steering group commissions such a study.
- **Donors should be invited to support fostering** PPP and building capacity in public (MoH) and private sector to address PPP and develop a more detailed / concrete strategic plan. Seed resources could be provided also for developing the capacity of MAT, CSSC and APTHA. The present budgetary allocations for PPP development in the HSSP should be reviewed and proper funding should be assured both from government, donors and private sector. Proposed budgets should cover the costs of proposed recommendations (milestones) that may be adopted during the Annual Health Sector Review such as installing the (semi-independent) PPP desk, functioning of the ad-hoc PPP Steering group, proposed studies, capacity building of above representative bodies, regular forum, etc.
- In general, **most of the above proposals focus on existing arrangements, instruments and tools and suggest to use those tools** (eventually reviewing, adapting, improving them when necessary) rather than developing new instruments. Examples of existing instruments include the proposed service agreements, the existing registration and accreditation schemes, the grants and basket funds.
- **Perform periodic (e.g. biannually) evaluation of how PPP develops** and how action plans are implemented.
- **Ensure adequate participation of various stakeholders in the PPP discussion at the Annual Health Sector Review meeting.** It is perceived to be of importance that there is equitable participation so to promote wide support for the resolution arrived at during the review discussions.

Revolution or evolution?

The RT does not claim to promote a revolution in the Tanzanian health system by promoting a more active development of PPP. Rather, a rational step-wise approach to how the health system can progressively adapt from the present situation to a future situation is being proposed. This future situation aims at achieving the national health goals of equitable quality essential health services, accessible to all Tanzanians, but especially the poor, using the available (financial, human, logistical) resources, the existing providers and the available instruments and systems most effectively. Revolutions tend to happen over-night. Substantial changes need time, resources and most importantly, political will and championship to implement them.

The RT promotes a different and new mind-set (moving away from the attitude of “us” and “them”; aiming at essential services to be delivered rather than focusing on providers), but within existing systems and using existing tools, mechanisms and guidelines. This includes progressively moving from a focus on management to a focus on service delivery and on patients’ right to have access to affordable quality health care.

The Health Sector Review Team on PPP
Reet, Belgium, 11th March 2005

Dr. Leo Devillé, HERA, Belgium, team leader
Jos Dusseljee, ETC Crystal, the Netherlands
Prof. Philip Hiza, public health consultant, Tanzania
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Dr. Phares Mujinja, senior lecturer, health economist/planner, Tanzania

7. Annexes

ANNEX 1. TERMS OF REFERENCE

TOR for Technical Review 2005 Public Private Partnership for equitable provision of quality health services

INTRODUCTION:

As an input and an important resource document for the Annual Joint Health Sector Review it has been decided to conduct an independent technical review with a focus on Public Private Partnership (PPP) for equitable provision of quality health services. The purpose is to assess progress, constraints and opportunities in the PPP for health service delivery, focusing on equity, financing and quality. The report need to be concise, targeting priorities and be implementable within the available health sector budget and in line with the NATIONAL STRATEGY FOR GROWTH AND REDUCTION OF POVERTY (NSGRP) and the Health Sector Strategic Plan, 2003-2008 (HSSP).

In conducting this study, it has to be considered that the Private Health Sector in Tanzania is marked by distinct sub-sectors: Private not-for-profit (Mainly religious or faith-based institutions and Voluntary Agency units) and Private for-profit (licensed and tax paying)

It is therefore expected that the study should cover these sub-sectors. Any information and/or conclusions should be specific and clarify separately the state of each sub-sector in the PPP review as regards equitable provision of quality health services.

Weak collaboration between the Public and Private Health sectors was identified in the 1993 sectoral analysis as one of the areas that needed attention. The HSSP (2003-2008)¹⁷ is geared towards addressing this weakness. A Public Private Partnership (PPP) Steering Working Group consisting of members from the MoH providing a Coordinator of the group, Private Health sector, Faith-Based Health sector (CSSC, BAKWATA and others) Development Partners (GTZ, DCI, CORDAID etc) and TPHA was set up to address issues that will strengthen the required collaboration between the Public and the Private Health sectors.

According to the Health Sector Strategic Plan 2003-2008 (HSSP) the role of the Government (MoH) will be more of a facilitator in creating a conducive environment for the growth of private sector in the provision of equitable health service by both public and private sector. The focus of the government will be more on policy formulation, governance, regulation, financing, monitoring and quality assurance. Included will be its role in standardisation of equipment, devising quality assurance schemes and strengthening of Health Management Information System (HMIS).

One of the main objectives of the ongoing Health Sector Reform is to utilize available resources through participation of the private sector in the implementation of the reforms and the integration of the **private services** in the decentralized district health care systems. **The private sector** is partly represented by different umbrella organisations, which are supposed to play a key role in the partnership approach. Up to date, however,

¹⁷ Strategy 7

capacities on both sides remain weak and cooperation and collaboration are insufficiently institutionalised and depend mainly on individual efforts, relations and motivation.

OBJECTIVES OF THE STUDY:

1. To assess the state of the Private Health sector in Tanzania: Trends, opportunities, strengths, weaknesses and constraints that need to be addressed in order to strengthen PPP and raise the quality of healthcare provision.
2. To analyze the roles of Regulator, Provider, Purchaser and Client in the Tanzanian Health System and its implications for the Private Public Partnership
3. To assess the existence of partnership arrangements in the field of health and how far rules and principles are in harmony with national health policy; and HSSP
4. To assess partnership/contractual policies in view of maximizing impact on the performance of health systems, how they harmonize practices of all parties in a transparent way, and how they avoid adverse effects.
5. To provide a concise report of the findings and recommend tangible recommendations on how to move forward in strengthening the partnership in health services provision between the Public and Private Sectors in line with health sector strategic plan (HSSP, 2003-2008), the NSGRP 2004 (draft) and in the larger context of Vision 2025.

The following specific areas need to be addressed:

Regarding Policy and Planning:

How to further a pluralistic policy environment, including a fruitful policy dialogue between MoH, and the private sectors.

- i. Gauge perceptions of government (How do planning modalities (guidelines, practice, supervision etc.) integrate the private sector?, mainstreaming or focal point in MoH? Are policies of PORALG, of Decentralisation conducive?)
- ii. MoH – private sector participation in Policy formulation, monitoring and evaluation.
- iii. Role and capacity of organisations of private sector associations to assist MoH in evaluation and monitoring of the Private Health Sector.
- iv. Development Partners' relationship with the private sector in view of their desire to raise the quality of care in Tanzania and taking into consideration the fact that Private sector contributes nearly 40% of care, and is growing.
- v. How much government resources contribute to financing the private sector and how much is spent out of pocket?

Regarding Human Resources:

- i. Assess how planning of Human Resources for Health (HRH) is taking care of the interest of both the public and the private providers (“user” of the workforce)
- ii. Consider competition for the same staff categories between the private and public sector and interchange of staff between public & private.
- iii. comment on how public and private institutions of basic and continued education are contributing to the provision of the health work force in adequate numbers and quality.

(take into consideration recent studies on Human Resources for Health in Tanzania)

Regarding Quality assurance

How is quality of care assured in both Private and Public Health Facilities? What can be improved?

- i. Regulations and enforcement (Inspection)
- ii. Role for self-regulation (Role and membership of Professional Associations)
- iii. Role of accreditation and franchising
- iv. Comparative assessment of quality of care within the Public sector
- v. Incentives for the private sector, particularly encouraging to work towards the GoT's goals (in terms of PRS, HSSP etc.),

(take into consideration recent studies and the proposed Framework for quality improvement)

Regarding Financing:

- i. How are GOT and DP subsidies to the Health Services enhancing PPP? What can be improved? Long term perspective?
- ii. How does the policy on cost recovery, the policies of pricing (both public and private) and the interaction of prices in the public and private influence consumer choices in terms of availability, physical access and cost of services at the point of use of care?
- iii. How do CHF, NHIF and Private Insurance Companies support funding of equitable provision of quality health services through both private and public health services

Regarding collaboration between the two sectors at district level:

How does PPP support efficient coverage of equitable quality health services in the districts including quality of care?

- i. How does the private sector contribute to the general improvement of quality of care – that is equitable and gender sensitive
- ii. are essential interventions being implemented (and to what degree) through both public and private health care providers according to EHP guidelines with focus on disease and health conditions responsible for disease burden (HIV/AIDS, Malaria, TB, IMCI, EPI, SMI and Nutrition)
- iii. how far do private providers participate in joint planning? Are there comprehensive facility plans available which include the private sector? What can be improved?
- iv. are allocation of subsidies (basket, block grants, projects, others) used in a way to strengthen PPP (e.g. through service agreements and contracting out of non core health services) and making use of the comparative advantages of different types of health care providers
- v. accountability on subsidies and funds from different sources in both public and private structures
- vi. relate cost and funding of private health services and the accessibility for the sick poor who cannot pay for care?
- vii. are potentials for outsourcing of certain services to the private sector identified and used? (e.g. TB programmes, VCT services, HIV/AIDS Treatment and Care – ARVs services, Immunisations, Nutrition, Specialists services from Private sector for the Public sector)

- viii. Is the referral system integrating health facilities from both sectors according to their comparative strength and advantages?
- ix. Is there joint planning and sharing of human resources including personnel development and continued education
- x. Access to essential drugs and medical supplies
- xi. Roles of drug sellers/Pharmacists and traditional healers

Methodology/Approach

Given the limited time available, the assessment cannot be expected to gather primary data. The team should rely upon interviews with key informants, documentation already prepared, and relevant data available at the national and district levels. The study team is encouraged to split up to be able to cover the scope of work as described above. Also due to time limits, it will not be feasible to cover a large sample of districts.

It is proposed that at least four districts be covered.

The mission should start with a meeting with members of the TC and the PPP working group to clarify the scope of work and receive inputs and recommendations on the details of the approach

The team should:

- i. review relevant literature, studies, available milestone progress reports, etc
- ii. assess activities of the PPP Steering Group so far in enhancing PPP objectives as regards:
- iii. interview representatives of the MoH, PORALG, CSSC and other Christian Health organisations, BAKWATA, APHTA and other relevant organisations and some key stakeholders to get their impression on progress or lack of progress.
- iv. Undertake field visits to a few selected regions and at least 4 districts (interview CHMTs, health care providers (both private and public), drugs store and pharmacist sellers, some traditional healers and users of health services)

Outputs

An Inception (Draft?) Report to be circulated to key stakeholders for comments and input due

Debriefing Note and presentation to the Ministry Management Team and Technical Committee February 2005

A Report, with a short main text, supplemented by annexes if deemed necessary, and as much as possible referring to existing texts and documentation 1st week of March 2005

A presentation at the Main Sector Review Meeting – March 2005.

A final Report - due on 31st of March and forming part of the final documentation of the 2005 Joint Annual Review of the Health Sector - should take into consideration major amendments from the Review Meeting.

Composition of the Team

One international (as team leader) 30 WD
Three (3) nationals , 30 WD each

The team leader will be responsible for the output of the team as a whole, including managing and quality-assuring the contributions of individual team members.

Reporting Arrangements

The team will through its team leader, liaise with the HSRS Secretariat for coordination, logistics support and time tabling of the planned steps and activities by the team

Timing

January – February 2004

The Team Leader and the National consultants will attend the Main Health Review (probably) 4th – 6th of April 2005 and present the findings and recommendations of the team

ANNEX 2. INFORMATION FOR DISTRICTS VISITED

This letter was forwarded to the districts visited by the Review Team prior to the visits in order to facilitate preparation of the CHMTs and other stakeholders.

Information for districts to be visited by the consultants of the Technical Review 2005:

“Public Private Partnership for equitable provision of quality health services”

1. Preamble

GoT/MoH¹⁸ is acknowledging and appreciating private sector contribution to health care in Tanzania. The GoT/MoH intends to promote the health status of its population. It actively seeks involvement of any actor that may possibly contribute to more equitable access by the population to essential health services of adequate quality.

Current official documents (HSSP; PRGSP, etc.¹⁹) give ample considerations to the role and position of private health care sector and seek to promote private sector involvement in various ways. In these documents the intentions of the GoT/MoH have been phrased explicitly. Nevertheless, the policy documents are less clear on how objectives/strategies need to be implemented, what exactly needs to be achieved when, etc.

Stakeholders from various categories of private sector health care providers seek promotion of private health sector involvement in the health care too. Their overall objective by and large matches that of the GoT/MoH. Nevertheless, the underlying considerations may vary, as may the suggestions how to address this in policy and in practical terms.

The Technical Review has been commissioned to stimulate discussion on public private collaboration in health care in Tanzania. A variety of stakeholders contributed to the ToR²⁰, which is witness by a great variety of issues proposed for analysis. The outcome of the Technical Review will be used in the annual Health Sector Review meeting, which is scheduled in April 2005.

2. Introduction

Besides analysing a large number of formal, review and research documents that refer to PPP²¹, the Technical Review involves a series of discussions with a variety of stakeholders at the national level. In addition, the Technical Review involves assessment of the PPP implementation at district level. For this reasons, brief inventory visits to four identified districts have been scheduled: two urban (Kinondono/Dar Es Salaam and Arusha) and two rural (Ifakara (Morogoro)/Mvumi and Muleba) districts.

¹⁸ GoT/MoH stands for Government of Tanzania/Ministry of Health

¹⁹ HSSP stands for Health Sector Strategy Plan; PRGSP stands for Poverty and Growth Strategy Plan. The consultants have had access to a large number of other policy and strategy plan dealing with health sector reforms, periodical expenditure and health sector reviews, etc.

²⁰ ToR stands for Terms of Reference.

²¹ PPP stands for Public Private Partnership

A team of three national and two international consultants has been engaged to do the review. The consultants will form two teams to undertake the district visits.

In order to introduce the district visits the consultants have listed a number of objectives and corresponding questions, which are based on their ToR. They are distributed to the respected districts prior to the visits, basically **FOR INFORMATION PURPOSES ONLY**. They may be shared among those that the consultants may contact during their visit. The consultants will use the list during the interviews and discussions, and may divide from the list if this should be required, e.g. as the situations in between the four district may vary greatly. As a matter of course the consultants will introduce the questions during the interviews and the discussion, and provide explanations whenever required.

3. Broad objectives of the study:

Following are the broad objectives of the study

- Analysis of the private health sector in Tanzania.
- Description and analysis of formalized arrangements between the private and public sector
- Suggestions for promoting private sector involvement in equitable health service delivery

4. Issues for discussion at the districts

A. Overall issues to be addressed

- i. Do respective stakeholders (public, private not-for-profit, private for-profit) support the GoT/MoH considerations mentioned in the preamble?
- ii. What benefits do respective stakeholders expect from the promotion of private sector participation in health services delivery in Tanzania? Benefits may be regarded in terms of accessibility, coverage and quality.
- iii. What are the concerns felt?

B. Specific areas to be addressed:

1. Policy and Planning

Objective:

To analyse the (decentralised) policy and planning environment at district level, in respect to the provision of equitable health services, utilising the capacity of various actors/stakeholders (public, private for-profit, private not-for-profit, and consumers). This includes the presence and performance of the council health board and district health management team.

Questions:

- i. Are respective stakeholders familiar with the policy statements on public private partnership?
- ii. To what extent are respective stakeholders actively involved in the policy and planning processes?
- iii. Do respective stakeholders consider that their interests are well attended in the current policy and planning processes? Are there any suggestions for improvement?

2. Resource Allocation

Under this heading a number of issues will be addressed which relate to formal (contractual) arrangements, financial resource sharing; human resources sharing, provision of essential drugs and medical supplies.

2.1 formal arrangements

Objective:

To analyse the formal (or informal) arrangements between the public and private sector, aimed at improving service delivery.

Questions:

- i. What kind of formal/informal arrangements are found at the district, such as contractual arrangements (DDH-agreement, contracting-in or -out), memorandum of understanding, out-sourcing arrangements, service agreements)?
- ii. Are these arrangements well-understood by all respective stakeholders?
- iii. Do the respective stakeholders have the capacity and capability to manage contractual arrangements?
- iv. What are according to respective stakeholders the strengths and weaknesses of the contractual arrangements applied at present? Are there any suggestions for improvement?

2.2 financial resource sharing

Objective:

To analyse the current arrangements of sharing financial resources (subsidies, basket funding, insurance income, cost recovery, etc.) between respective categories of health services providers at district level.

Questions:

- i. Are respective stakeholders familiar with current financial arrangements? This regards the different sources of funding at district level as well as the budgeting process.
- ii. Are respective stakeholders informed (transparency/accountability) and involved (consultation) about the application of the regulations regarding financial resource sharing?
- iii. Do respective stakeholders appreciate the way the budgetary arrangements serve their interests in view of their contribution to health service delivery? Any suggestions for improvement?
- iv. What are the current practices of cost recovery and pricing in both the public and private sector? What impact do these practices have on equitable health care utilisation and financial resource mobilisation?

2.3 human resources sharing

Objective

To analyse the current arrangements of human resource management at district level in respect to the needs of respective categories of health services providers. Human resources are considered to be the most critical issue related to health sector performance.

Questions:

- i. Is the human resource crisis experienced at district level? What is the magnitude of would-be resource deficits, and what staff categories are

- particularly affected? Is there any competition and/or exchange between public and private facilities in respect to key professional health staff? If so, please describe?
- ii. Do current HRH²² planning mechanisms address the interests of respective stakeholders? What could be improved in which way?
 - iii. What is the contribution of respective stakeholders to basic and continued education to HRH?

2.4 provision of essential medical supplies, equipment and drugs

Objective:

To analyse the current arrangement of access to essential medical supplies, equipment and drugs by respective categories of health services providers.

Questions:

- i. Are respective stakeholders able to access essential drugs, supplies, equipment provided under MoH arrangements?
- ii. Do respective stakeholders face equal pricing and taxation regulations? If case of differences, please explain.
- iii. Any suggestions for improvement?
- iv. What role do private pharmacists and drug sellers play at district level in respect to medical supplies and essential drugs provision?

Quality assurance

Objective:

To analyse the quality assurance systems in place and required in both public and private sectors.

Questions

- i. Which systems of quality assurance are found in Private and Public Health sectors? Do these systems allow for comparative assessment of quality of care?
- ii. Are the referral procedures between various levels and categories of providers in place and well monitored?
- iii. Is there any training provided aiming at quality promotion? Is this accessible to all providers?
- iv. Describe the enforcement (inspection) of regulatory systems in place.
- v. Describe accreditation and franchising systems and practices
- vi. Are there any particular services that may benefit from out-sourcing in view of quality assurance?
- vii. Special attention may be given to TB and HIV/AIDS (VTC and ARV services, immunisation and nutrition programmes, etc. A variety of NGOs, not necessarily health care providers, may be active in these areas, at times assisted by substantial financial resources outside the government budgets. Are these NGOs invited to participate in health care planning at district level?

The unasked though relevant question

The above placed questions may fail to address other issues that are felt to contribute or to impact significantly on health sector performance at district level, in particular that of the private sector. Please share your considerations with the consultants.

²² HRH stands for Human Resources for Health.

ANNEX 3. LIST OF LITERATURE CONSULTED

Tanzania, national policy, strategic documents, guidelines, reports

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PORALG, LG Reform Programme, Joint Government-Donor Review, Draft, November 2004

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Report of the Tanzania Joint Annual Health Sector Review, 15-17th March 2004

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National PPP Steering Group, Terms of Reference

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NHIF, Standard surveying checklist

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Maureen Mackintosh, Paula Tibandebage, Sustainable redistribution with health care markets? Rethinking regulatory intervention in the Tanzanian context, Open discussion Papers in Economics, Open University, United Kingdom, November 2000

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B.T. Mapunda, Review of health sector legislation for development of the public-private partnership in Tanzania, January 2005

Tanzania, Private sector organisations

Dar-Es-Salaam Public Health Delivery System Boards Association, descriptive note

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Medical Association of Tanzania, newsletters

Tanzania Medical journal, different issues

APHTA, Operational Plan 2004-2005

APHTA, Constitution

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CSSC-SEC, Promoting the role of Professional Health Associations in Regulating the Health Sector. A contribution to enabling the private sector

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Women's Dignity project, Poor People's Experiences of Health Services in Tanzania, Literature Review, 2004

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Gerald Bloom, Private provision in its institutional context, lessons from health, DFID Health Systems Resource Centre, March 2004

ANNEX 4. PEOPLE AND ORGANISATIONS MET

Consulted Participants at MoH 14.2.2005

No.	Name	Title
1.	Dr.F.Njau	Head HSR Secretariat-MoH
2.	Mr. J.Kelya	Administrator HSR Secretariat-MoH
3.	Mr.Rubona	Head HMIS -MoH
4.	Dr.E.Mung'ong'o	Registrar of the FBO/Private and Co-od. PPP
5.	Dr.Mnaliwa	Head –Traditional Medicine -MoH
6.	Dr.H.Ngonyani	Head Inspectorate Unit- MoH

Consulted Participants of the PPP Steering group 14.2.2005.

No.	Name	Title	Organisation
1.	Dr. S.M.A. Hashim	President-Association of Private Hosp TZ	APHTA
2.	Dr. A.I. Kimambo	Deputy Director CSSC/Exec. Secr.	CSSC
3.	Dr. A. Hussein	Head Community health Dept.	SPHSS-MUCHS
4.	Dr. E.B. Mung'ong'o	Head Private/Voluntary Section	MoH
5.	Dr. Tengio Urrio	Consultant in Service Agreement	
6.	Dr. Godfrey E. Gomile	Policy Analyst (H)	TPHA/CSSC
7.	Jos Dusseljee	Consultant ETC Crystal	PPP
8.	Prof. Philip Hiza	Health Consultant	MoH/PPP
9.	Dr. Leo Devillé	Review Team HERA	
10.	Dr O.M.E. Kisanga	Member and Consultant PPPreview	TGPSH

Consulted Participants from Institutions 15.2.2005

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2.	Dr.Kiwale	Director AAR
3.	Mr. Humba	Director NHIF
4.	Dr.J.Temba	TACAIDS
5.	Mr.Jerome Ringo	Chair Dar-es-Salaam Health Board
6.	Mr. Vedasto Rwiza	Secretary DHB

Consulted Participants from PORALG 16.2.005

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2.	Mr.Alfred L.R. Kabagire	Programme Manager, LGRP
3.	Mr.M.W.F. Maganga	Central PORALG-Health Sector Coord.
4.	Mr.Andrew N.M. Sayile	PORALG coordinator – DHIRC
5.	Mr.Hans Olsen	Advisor, DLG/PORALG
6.	Mr.Brendan O. Driscoll	CTA, LGRP
7.	Mr.Brendan Glyun	HR & OD Advisor, LGRP
8.	Mrs.Venus B. Kimei	OM (c), LGRP
9.	Dr. Leo Devillé	Lead Consultant PPP Review Team
10.	Dr. O.M.E. Kisanga	National consultant HSR PPP Review
11.	Prof. Philip R. Hiza	National Consultant PPP Review Team
12.	Jos Dusseljee	Consultant PPP Review Team

Consulted Respondents in Kilombero District 17/18.2.005

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3.	Mrs. Malongo	District Executive Director
3.	Dia M. Ally	District Health Secretary
4.	Dr. Woinfoo Munisi	District Medical Officer
5.	Mr.H.Mponji	District Health Officer
6.	Sr. Stella	NO i/c Ifakara DDH Hospital
7.	Mr.Magwira	Hospital Administrator –Ifakara DDH
8.	Dr. F. Moshi	Director Watani Private Dispensary and Co-ordinator KIPHA

Consulted Participants of the Kinondoni Municipality 21.2.2005.

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1.	Mr. B.Berege	Municipal Director
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4.	Mr.Donat P.Mlay	Laboratory technologist
5.	Mwise Kyariga	Reproductive and Child Health
6.	Rachel Ng'oga	Co-ordinator Private Sector
7.	FR Kipesha	Municipal Health Officer
8.	Dr.Silvia Mamkwe	Health programs Co-ordinator
9.	Ziada Sellah	RCH Co-ordinator.
10.	Dr.Leo Devillé	Lead PPP Consultant
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Consulted Respondents Mission Mikocheni Private Hospital 21.2.2005

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4.	Mr. Fredy Mwissa	Asst. to Matroni- Mission Mikocheni Hospital
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5.	Elly Ndyetabura	Programme Specialist	UNDP
6.	Ilaria Dali	Deputy Country Director	SDC
7.	Mohamed Makame	Health Advisor	DCI
8.	Takahiro Moriya	Asst. Resident Repres.	JIKA
9.	Phares Mijinja	Consultant	MUCHS
10.	Dorothy Temu Usiri	Assist. Representative	UNFPA
11.	Eli Nangawe	Health systems	WHO
12.	Dr. Leo Devillé	Health Sector Review Team Leader	HERA
13.	Jos Dusseljee	ETC Crystal Consultant	PPP Review
14.	Prof. Philip R. Hiza	Health Consultant	PPP Review
15.	Dr.O.M.E.Kisanga	Consultant PPP Review	TGPSH

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2.	Dr.A. Gavyole	Head of Programmes -AMREF
3.	Dr. P. Waibale	Country Director –AMREF.

Consulted persons Kagera region

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4.	Management Team	Rubya Hospital	Cath. Diocese Bukoba
5.	Management Team	Ndolage Hospital	ELCT NWD
6.	Rt. Rev. Timanywa	Bishop	Cath. Diocese Bukoba
7.	Rev. Fr. Rwehumbiza	Diocesan secretary	Cath. Diocese Bukoba
8.	Dr. Kato	Hospital director Ndolage/medical secretary ELCT NWD	ELCT NWD

Consulted persons Arusha

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1.	Dr Laiser	Municipality Med. Offier	Arusha Municipality
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3.	Management Team	Selian Hospital	Arumeru District
4.	Management Team	St. Elizabeth Hospital	Arusha Municipality
5.	Dr. Mardai	Private Practitioner	Arusha
6.	Dr. Peter Kobwe	ELCT Health Director	Arusha

Debriefing of the Consultancy report on Public Private Partnership, held at the MOH Conference room on 25th February, 2005

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