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**THE PUBLIC-PRIVATE INTERFACE IN PUBLIC SERVICES REFORMS:
ANALYSIS AND ILLUSTRATIVE EVIDENCE FROM THE TANZANIAN
HEALTH SECTOR**

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The public-private interface in public services reforms: analysis and illustrative evidence from the Tanzanian health sector

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Abstract

This paper begins by contrasting the importance given to supply-side public-private partnership (PPP) within Tanzanian health policy documents with the acknowledged limited progress on PP to date. The paper then examines the broad public-private interface in the Tanzanian health system, from both demand and supply sides. We outline the key role of public funds in supporting private activity within the liberalised health care sector and argue that on the demand side, private health expenditure is substantial but poorly documented. On the supply side, patients increasingly resort to private shops, while private facilities struggle to fund competent care. For patients and the health system as a whole, the private expenditure delivers poor value for money. We describe the view from the private sector about why this is so, and then discuss potential directions of transformation. Our central argument is that changes in the public-private interface at the system level are needed to support and incentivise better individual public-private partnerships on the supply side at local levels. Our proposals include better modalities for the management of fees and charges; greater transparency and effectiveness of public subsidies; support for collaborative networks of non-governmental provision; and an acceptance that heavily subsidised, accessible provision, free or near-free at the point of use, for those on very low incomes is essential to reshape the role of private provision within the system as a whole.

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1. Introduction

The role of basic social services in socio-economic transformation for poverty reduction cannot be over-emphasized. Social services greatly influence the performance of both market and non-market activities in society. This is basically because they can either enhance or constrain capabilities of the people depending on the extent of their availability, accessibility and quality. Tanzania has made enormous strides since independence towards ensuring access to quality basic social services including health to its population. However, challenges remain in terms of ensuring provision of adequate quality services and achieving equity in access. Efforts to address these challenges thus continue through various reforms intended to improve delivery of basic social services.

This paper focuses on Public-Private Partnership (PPP). It is not a full review of the relevant literature. Rather, we use primarily our own research evidence and experience, as well as drawing on other evidence. Public-private partnership (PPP) has been a leading feature of both Tanzanian policy approaches to health sector reform and international initiatives in the health sector in Tanzania. Meanwhile, while liberalisation in the health sector has allowed public, private and non-governmental non-profit suppliers to interact in provision of services, there are still major acknowledged failures in access to good quality health care, despite the importance of such access for tackling poverty and disadvantage.

This paper begins (Section 2) by noting that the definition of PPP used in Tanzanian health policy is quite broad, while there is repeated commentary that relatively little has been achieved. We outline the understanding of PPP in the policy documents. To analyse the challenge and scope for PPP, we then step back (Sections 3 and 4) from discussion of particular public-private interactions to inspect and evaluate the public-private interface within the health sector produced by the health sector reforms, examining both the demand and the supply side, and their interaction. We argue that, in order to understand and promote effective PPP on the supply side it is necessary also to understand the public-private interface on the demand side.

In these sections we interrogate the definitions of both ‘public’ and ‘private’ within the largely marketised Tanzanian health care system. We then argue (Section 5) that one of the core problems for policy in promoting public private partnership (PPP) is to achieve *value for money*. That is, those who expend the relatively large private resources that go into the Tanzanian health sector are not currently receiving or producing value for money understood in terms of provision and access to good quality care. This needs to change. But the policy problem must be addressed as a problem of health sector organisation as a whole, not just of the particular role of the private sector or of individual public-private arrangements.

In section 6 we suggest what can be done to achieve better value for money, better quality of care and better access for patients, through reworking the public-private interface, and hence changing the scope for supply side partnerships. We suggest in the final section that both system-wide changes in the public-private interface, including the roles of both public and private organisations, and also promotion of decentralised local initiative in designing and incentivising diverse supply-side PPPs

will be needed, if complementary and collaborative activity among public and private actors is to be achieved.

2. Public-private partnership in the health sector

Health Sector Reforms (HSRs) in Tanzania have been implemented since the 1990s. Among these reforms was re-introduction of for-profit private practice. Abolished in 1977, private health care practice in Tanzania was reintroduced in 1991 and user fees and charges were subsequently introduced in public health facilities commencing with hospitals. This aspect of HSR was billed as intended to ensure provision of quality and accessible health services.

Since then, the government has committed itself to the promotion of Public-Private Partnership (PPP) in the provision of health care services. A large number of policy and strategy documents, and external and internal reviews, have developed and reflected upon this commitment. Relevant government policy documents include the *Health Policy* (2007), the 1999-2002 *Programme of Work (POW)*, 2002-2008, *Primary Health Services Development Strategy (PHSDS)*, and the 2009-2015 *Health Sector Strategic Plan III (HSSPIII)*. In HSSP III, collaboration with the private sector is identified as Strategy 6 among eleven strategies for improving health services delivery.

The definition of PPP in these documents is rather broad. Key aspects include the following.

- The broad vision is for complementarity between private and public provision within a single integrated health sector. In the words of the HSP III the aim is ‘increased participation [of the private sector] in achieving access to health services at all levels’ (p.33) Through this process, the aim is to move to an integrated system, and away from a widely accepted view at present of the private providers as constituting ‘a separate system coexisting with the public in the provision of services’ (HSSPIII p.33)
- Private contributions are seen as an important contribution to filling gaps in health sector finance both in terms of current funding and investment needs (Health Sector PER 2001 p.12; HSSPIII p. 12). These contributions include insurance mechanisms and fees.
- In operational terms, the emphasis is on supply side partnerships, which may include Service Agreements through which the government funds privately delivered services. PPPs on the supply side are characterised as ‘various’, and ‘characterised by the sharing of common objectives, as well as risks and rewards ...so as effectively to deliver a service or facility to the public’. (HSSPIII p.33)

It is generally agreed that progress on PPP has been modest to date. There is now a negotiated Service Agreement template approved by the Ministry of Health and Social Welfare (MOHSW) and Prime Minister’s Office – Regional Administration and Local Government (PMO-RALG) in 2007. A national PPP Steering Committee

was formed in 2008 and there was work on drafting a PPP Strategic Plan in 2009. There is a PPP office in the MOHSW, and PPP draft policy guidelines have been developed and discussed with stakeholders. However, external reviews and Tanzanian research find relatively little evidence of progress in establishing mutually agreed PPP frameworks and progress. The External Review 2007 (COWI et al 2007) found that:

There is little evidence of progress to advance the strategy of Public Private Partnership during the evaluation period, although there are some examples of good cooperation at council level (p.13).

Itika et al (2011) documented and classified such PPP activity at local level, including quite extensive informal cross-sectoral collaborations, but identified substantial constraints to more effective PPP. The HSSPIII documented slow policy progress, saying: ‘The Ministry has no guiding policy how to put the PPP concept into practice’ (p.33).

The interactions between public and private in the health sector are of course much more extensive than supply side public-private contracts or collaborations. The Tanzanian health sector is a mixed health system with large elements of private payment and of private and non-governmental non-profit provision, as we document below. It is our argument in this paper that in order to understand the scope for progress on PPP in health – and to identify its nature and limits – it is necessary to analyse the interface between public and private on both demand and supply sides of the health system.

3. Understanding the ‘public’ in the public-private interface

3.1 The continuing importance of public care and public spending

Despite liberalisation of private practice, the public sector continues to be the main supplier of health services in Tanzania. About 60 percent of all health facilities in Tanzania are public (USAID 2011). The Government has a range of public health facilities ranging from dispensaries and health centres which largely deal with primary health care, to district, regional and referral hospitals. By 2006 the country had a network of about 5,728 health care facilities, of which 60 percent were owned by the government, and the remaining 40 percent by the non-profit, parastatal and private sector (URT–MoHSW, 2008). Public health care provision is designed on a referral system, whose effective operation has however been questioned since patients frequently bypass lower level facilities (Akin and Hutchinson, 1999; COWI et al. 2007).

To support and sustain health care provision, the government has increased the share of government total expenditure that goes to health as compared to the 1990s. Since 2004/05 the government has committed between 11 and 14 percent of total government spending to health care (Table 1).

Table 1: Government spending on health as a percentage of total government expenditure

	2004/05	2005/06	2006/07	2007/08	2008/09
	Actual	Actual	Actual	Actual	Estimate
Health as a percentage of total expenditure (excluding CFS)	11.3	14.1	13.3	12.2	11.2
Health as a percentage of total expenditure (including CFS)	10.1	11.9	11.8	11.0	10.2

Source: USAID, 2011

However Table 1 shows a more or less stagnant trend in this share over the period 2004/05 to 2008/09. The percentage of the government budget spent on health has remained below the target of 15 percent set in the Abuja Declaration. In absolute terms however, there has been a significant increase in the budget allocation to the health sector: an eightfold (nominal) increase since in 2000/01 from TZS 80.7 billion, to TZS 637 billion ten years later (USAID 2011).

That increase in nominal budget allocations has been associated with a real increase in per capita *total* spending on health. Actual total per capita expenditure on health over the period 2004/05 to 2007/08 increased steadily in nominal terms from USD 7.42 to USD 11.29, which represents a real terms increase of 29% (USAID 2011). In 2009/10, per capita expenditure on health was TZS 21,327 (USD 14.7) (URT-MoHSW, 2010). This sharply increased spending still however remains much below the 2011 WHO estimate of USD 34 required to deliver a minimum package of health services (USAID 2011). Recent increased government expenditure on health, furthermore, has depended heavily on donor funding. In 2009/10 36% of government expenditure on health was financed by external funds, and that percentage was expected to rise to 46% in 2010-11 (Health Sector 2009-10 PER Final Report p.18).

Health sector reforms are being implemented within the boundaries of a decentralised local government structure. In line with the decentralisation programme, the MOHSW was to increase funds allocated to the local government level. The aim was to enhance health care service delivery at the most accessible level for the majority of health care service beneficiaries. Table 2 indicates however that health expenditure continues to be concentrated at the central level (approximately 60%), spent mainly to support personnel emoluments (including district level medical and nursing staff) and national public procurement of pharmaceuticals.

Table 2: Public health expenditures among layers of the Government

	2005/06	2006/07		2007/08		2008/09		2009/10		2009/10/11
	Actual	Approved	Actual	Approved	Actual	Approved	Actual	Approved	Actual	Estimates
Central	72%	66%	62%	60%	59%	61%	58%	54%	55%	60%
Regions	4%	5%	5%	7%	7%	7%	8%	6%	7%	6%
LGAs	24%	29%	33%	33%	35%	32%	34%	39%	38%	33%
Total	100%									

Source: PER 2010 p.24

The share of health resources spent at local government authority level increased from 24% in 2005/06 to 38% in 2009/10. However, there is concern that this trend may be reversing. For example, the allocation to the Local Government Authorities (LGAs) in 2010/11 is expected to decline to 33% from the 2009/10 level of 38%. Although this change might seem small, it is nonetheless worrying if we consider the intentions of decentralisation.

3.2 The flow of public money to other health care supply sectors and partnership with the private sector

The government health budget, from taxation and external donors, directly supports provision in the private sector. It also provides funding to support and promote provision of quality health care services in other health care supply sectors. The absolute level of this funding and its monitoring is not well documented. Major elements of this funding flow to the nongovernment sectors are the following.

- Direct support in terms of e.g. staff grants

The government second skilled health care workers to faith-based providers, paying their salaries directly from the government budget. Other forms of support include bed grant and provision of medicines. Recent assessments show, however, that direct support of this type for for-profit activity is still very limited, being largely at the concept stage (USAID, 2011)

- Basket fund allocation

The 'basket funds' are donor funds allocated as a consolidated budget at local level; in 2009/10 these constituted 21% of total local government authority (LGA) health expenditure (PER 2010 p.8). They can be spent on public and private sector activity. We have not found data on their allocation to faith-based and private for-profit activity, though these funds' allocation is relatively well monitored (USAID 2011)

- District Designated Hospitals

The Government has also designated certain hospitals owned by faith-based organisations to operate as district hospitals. There were 30 such district-designated hospitals (DDHs) by 2009. DDHs are supported by the government through basket funding and direct payment arrangements.

- Service agreement

Council Health Management Teams (CHMTs) and private health care providers have begun entering into formal partnerships through Service Agreements: 6 have been signed, and 27 were under way by 2009 (National PPP Steering Committee, (2008). So far the agreements are between CHMTs and providers in the faith-based sub-sector. These allow for government programmes to be also delivered by private providers, who are in turn supposed to be sufficiently remunerated. The aim is to increase availability of quality health services.

However, for-profit private providers are now increasingly collaborating with the government in some areas of health care provision such as Reproductive and Child Health (RCH). Such services are provided by some facilities in the for-profit sector with the support of the government e.g. through provision of vaccines, refrigerators and other medicines for maternal health. Nurses from the public sector are also sometimes provided, and allowances. On their part, private providers agree to provide a room for RCH services (Itika et al., 2011 p.14; also on-going research by Tibandebage, Mackintosh, Kida and Ikingura).

- Indirect support to the private sector

There is a range of less formal ways in which the government provides indirect support to private sector activity. Examples include skilled health workers trained by public funds working either full time or part time in the private sector, and tax breaks for health care related imports.

While this formal and informal support/facilitation of the private sector by the public sector has been ongoing, sometimes there have been signs of mistrust between the two parties and some laxity in commitment to promoting the partnership (Itika et al., 2011).

3.3 The regulatory role

The government has an important role to play in regulating the private sector. In Tanzania there has been rapid expansion of private health care provision following the re-introduction of for-profit private practice in 1991 (Private Hospitals Regulation Amendment Act) after it was banned in 1977. The regulatory role of the government is thus important to seek to ensure that the private health care providers offer good quality and, to the extent possible, equitable health care.

In terms of formal regulatory activity, private practice in the country is governed by the Private Hospitals (Regulation) Act of 1977, which was amended in 1991, and Guidelines of Standards for Health Facilities issued by the Ministry of Health (MOH). With decentralization of health services, some authority for monitoring health care provision has been transferred to Local Government Authorities (LGAs). The MOHSW however remains responsible for policy formulation, regulation and quality assurance, (COWI, 2007).

The intention is thus close collaboration between the MoHSW, PMO-RALG and LGAs which oversee all district based health care provision by both the public and private sector. At the LGA level regulatory activities include enforcing regulations and standards guiding health care provision and ensuring adherence to professional conduct and ethics. Problems in implementation and enforcement of the basic

regulatory requirements have been noted, including inadequate information and knowledge on regulations among health care providers, inadequate capacity at the council level to enforce regulatory requirements, and poor involvement of consumers in the regulatory process (Kida, 2009). Furthermore, consumer protection mechanisms related to provision of health care services are weak.

We have argued earlier (Mackintosh and Tibandebage, 2002; Tibandebage and Mackintosh 2002; Tibandebage 1999) that the regulatory impact of the public on the private sector is not limited to formal regulatory oversight. In a marketised context where most people make out of pocket payments for care, fees and charges in the public sector influence private pricing (Tibandebage 1999). An effective and accessible public sector can put a ‘floor’ under quality in the health care market as a whole and public-private partnerships with competent non-governmental actors can improve access and quality. Effective supply side PPPs must respond to the nature of the wider public-private interface in health. We return to this argument below.

4. Understanding the ‘private’ in the public-private interface

While government and donor funding for health care is estimated to be dominant in percentage terms, funding for health care in Tanzania also displays a substantial element of private payment at all levels of the health system and of the income distribution. These fees and charges strongly influence access. Furthermore, the particular pattern of demand-side private payment and its evolution also strongly influences the level and quality of supply of services (Kida 2010).

4.1 The demand side: private health expenditure

Private health expenditure in Tanzania has three main elements:

- Out-of-pocket spending, whether spent in the public, NGO/FBO, or private commercial sector;
- Private insurance spending on care: measured not by the premiums people pay, but by the spending by the private funds on health care; this will include the expenditure of community health funds but the inclusion of social insurance funds in private spending is debatable since these are normally, in international statistics, included in ‘government’ since they depend on income;
- Private expenditure on providing subsidised or free care e.g. external non-governmental funding of NGO services (if the services charge, then the charges must be netted out, or there is double counting of private expenditure).

All data on private payment for care are estimates with unavoidable margins of error, and there are some puzzles in the available data for Tanzania. The PER 2010 shows (p.49) that the National Health Insurance Fund (NHIF) represented about 4% of total health spending in 2009/10, and described the community health funds’ performance as ‘disappointing’. These funds are mainly spent in the public and faith-based sector, and there are recorded problems of slow reimbursement undermining public sector finances (USAID 2011). About 10% of the population is in principle covered by

some health insurance (ibid), but the low spending demonstrates continuing reliance on out of pocket spending and public sector funding.

Tables 3 and 4 are taken from international WHO and World Bank data. The data summarised in Table 3 show Tanzania moving from a situation in 2000 where over half of health expenditure was private, to a position where (as noted above) roughly two thirds is government spending and roughly one third private. At the same time, Tanzania has seen a huge rise in the reliance of the health system on external funding, now at half of total spending, associated with a large increase in the ratio of health spending to GDP (Table 3).

While the increase in external funding has been associated with a rise in government's share of health expenditure, the external funds represent however such a large share of the total, that some external funding must have gone directly into private expenditure. In Tables 3 and 4, 'private expenditure' includes the expenditure of non-profit, largely faith-based organisations. The data do not tell us the extent to which the external funding of private health expenditure has been supply side expenditure – that is, expenditure on direct provision of care by private or non-profit agents – or expenditure on private demand side subsidy e.g. of community health funds.

Table 3: international data on health expenditure: Tanzania 1995, 2000, 2007

	1995	2000	2007
Total spending on health as % GDP	3.8	3.8	5.3
External funding as % total health expenditure	9.2	18.4	49.9
Government as % total health expenditure	53.6	43.4	65.8
Private as % total health expenditure	46.4	56.6	34.2

Source: WHO World Health Statistics 2010 downloaded 18.06.2010

<http://www.who.int/research/en/> ; World Bank GNI/head and country classification data downloaded 18.06.2010 <http://data.worldbank.org/>

The internationally published data also include information on the breakdown of 'government' expenditure on health between social security funds and direct government spending; and the breakdown of 'private' expenditure between out-of-pocket spending and 'pre-paid plans', that is, health insurance (Table 4). As Table 4 shows, there is a further gap in the Tanzanian data: the figures for out-of-pocket spending and pre-paid plans as a percentage of private spending do not add to 100%. So there is a substantial element of private spending unaccounted for in each year, and the gap is largest in the latest year. This gap may represent unrecorded out-of-pocket payment, or may be externally funded private spending: the data are incomplete so the gap is unexplained. We have not found local data to fill this gap in our knowledge of private spending on the demand side in health.

As a result of these gaps in the data, there may perhaps be a question mark over the otherwise welcome implication of these data, calculated in the last two rows of Table 4, that there has been a sharp fall since 2000 in the burden of out of pocket payments for health care in Tanzania relative to total health expenditure and also relative to GDP.

Table 4: elements of total health expenditure: Tanzania 1995, 2000, 2007

	1995	2000	2007
Social security funds as % government health expenditure	0	0	3.3
Out of pocket payments as % private health expenditure	93.5	83.5	75.0
Pre-paid plans as % private health expenditure	0	4.5	10.4
Out of pocket payments as % total health expenditure	43.4	47.3	25.7
Out of pocket payments as % GDP	1.6	1.8	1.4

Source: WHO World Health Statistics 2010 downloaded 18.06.2010 <http://www.who.int/research/en/> ; World Bank GNI/head and country classification data downloaded 18.06.2010 <http://data.worldbank.org/> .

4.2 Private health care supply

As is clear from this discussion, private expenditure (on which we have some data) is not at all the same thing as private supply of health care (which is poorly documented). This fact is not specific to Tanzania: internationally there is no cross-country correlation between the extent of private health expenditure and the extent of private sector supply in health care (Mackintosh et al under review).

The usual way to measure private supply is on an ownership or asset basis. That is, private suppliers are those suppliers owned by individuals or companies, and run for private gain. In the health sector, the non-profit, non-governmental sector is often included (or, confusingly, partly included) in 'private', so 'private' suppliers are then counted as all those suppliers of care not in government ownership.

There are two ways to document the extent of private supply within the system. First, by number of firms, facilities and/or beds. As noted above, government facilities represent about 60 percent of the total in Tanzania (see Table 5 below). The remaining facilities are predominantly non-governmental faith-based facilities in rural areas, while urban areas have substantial numbers of private facilities at the dispensary level. Private hospitals are relatively few.

Table 5: Distribution of health facilities by level and ownership 2004/05

Ownership	Level of health facility			
	Hospitals	Health Centres	Dispensaries	Total
Government	87	331	3038	3456
Voluntary	87	101	763	952
Private	37	39	733	809
Parastatal	8	10	145	163
Total	219	481	4659	5379

Source: URT 2006: Annual Health Statistical Abstract

Another approach is to examine the use of private as compared to government facilities. One source is the Demographic and Health Surveys, which provide data on

the use of different types of facilities for childhood illnesses and childbirth. For the childhood illnesses, these data include use of shops to buy medicines over-the-counter. Table 6 shows the very sharp rise in the use of private shops for treating children since the 1990s. Increasingly, children who are ill have not been taken to facilities at all. The data show a rise in use of private facilities, but it is modest as compared to the shift to reliance on purchase of medicines in drug shops (which are not normally registered pharmacies), and very little change in the small percentages that rely on NGO/FBO facilities.

For those taken to facilities, and particularly for the type of out-patient care mainly registered in these DHS data, the public sector still dominates. It is not clear whether the expenditure of parents taking children to shops rather than facilities is included in the private health expenditure figures. If not, then the drop in out of pocket expenditure registered in those data is over-estimated since some of the out of pocket spending has switched from facilities to shops – while potentially remaining a burden.

Table 6: Tanzania: Percentage of children taken to private, NGO/FBO, and public facilities and to shops

	ARI				Diarrhoea			
	For-profit facilities	NGO/FBO facilities	Public facilities	Private shops / pharmacies	For-profit facilities	NGO/FBO facilities	Public facilities	Private shops / pharmacies
1992	3.3	8.5	82.9	5.4	3.9	8.4	85.4	2.2
1996	4.7	3.6	81.5	10.2	3.6	5.5	81.7	9.1
2004	6.6	7.6	60.8	25.0	8.1	5.3	63.5	23.0

Source: Demographic and Health Survey data compiled by Amos Channon and reproduced here with permission.

A different source of data on usage is the Tanzanian Household Budget surveys. Table 7 shows data from the HBS for 2001 and 2007. The data are percentages of all those who visited a health provider in the four weeks before the survey. These data omit private shops, hence again underestimating usage of private health sector suppliers. The table shows that there is a high usage (almost 50%) of private dispensaries in urban areas, and that the ‘missionary’ sector has relatively low usage. (However, DDHs, run by faith-based organisations, are likely to be included in ‘public’ facilities in these data, hence underestimating the usage of faith-based facilities over all.) The data suggest that usage of the non-government sector facilities has declined relative to use of the government sector between the two surveys.

Table 7: Usage of Private Health-care Provider by Individuals (% of total visits)

HBS	Dar es Salaam	Other Urban Areas	Rural Areas	Total
2000/01				
Private dispensary/hospital	47.4	31.8	19.3	22.3
Private Doctor/dentist	1.9	5.1	7.6	7
Missionary hospital/dispensary	1.2	6.6	10.1	9.2
2007				
Private health center /hospital	8.8	5.7	2.6	3.6
Private dispensary	34.1	22.6	16.8	19
Private doctor/dentist	0.4	2.6	2.5	2.3
Missionary facility	1.8	2.2	5.1	4.3

Source: HBS 2000/1, 2007

Finally another way to measure private supply would be to measure the turnover of private establishments: the amount spent, whether by individuals, insurance companies, external funders or the government in buying services from private firms and individuals. The same measure of NGO/FBO turnover would also be possible. This would probably be the best indicator of private supply of health services in Tanzania, but as far as we know, no such data are available.

4.3 Private transactions

It follows from the above discussion that the extent of private initiative in the health system is not limited to the relatively small private facility sector. Rather, there is a wide range and large number of private transactions in the health system, including many purchases with private funds in the public sector. This is what we mean when we describe the system as ‘marketised’: access depends on private (fee) payments right across the different sectors.

Our current research on payments for maternal health care¹ bears out this generalisation: less than 7% of women interviewed had made no payments for maternal care during their most recent pregnancy, and that percentage was below 5% in the two urban districts where the fieldwork was undertaken in 2011 (see Appendix 1 for a summary of fieldwork method). The scale of these transactions is likely to be substantially under-estimated in the main data sets (as used above) to describe the health system.

Here is a rough typology of these types of ‘private’ health market transactions:

- Out of pocket spending in the private sector on formal fees and charges and also on informal charges

¹ See Acknowledgements.

- Private, social and community insurance spending in the private sector
- Out of pocket spending in the NGO sector on formal fees and charges and on informal charges
- Private, social and community insurance spending in the NGO/FBO sector
- Out of pocket spending in the government sector on formal fees and charges and on informal charges including informal purchase of supplies and medicines
- Social and community insurance spending in the government sector
- Out of pocket spending on medicines and supplies from private shops

We argue in the next section that the types of transactions that dominate the system shape the supply side behaviour in terms of access, quality and value for money.

5. Value for money and quality of care : the challenge for PPP

In research done in the late 1990s (Tibandebage and Mackintosh 2002, 2005) we explored the care seeking decisions of individuals in rural and urban areas, asking interviewees, among other questions, to explain which facilities offered the best value for money. We found, as others have also found (Leonard et al 2002; Leonard 2007; Kida 2009) that health service users in Tanzania think hard about value for their limited money when seeking care. People will spend more, if they have the resources, to access care that is perceived (often correctly (Leonard 2007)) to be of higher quality. Markers of quality that are used include not only staff attitude but also staffing and perceived staff competence, and the experience of others on issues such as over-charging, over-prescribing and effective response to emergencies.

Yet in the Tanzanian context, users find it hard to access value for money health care in all sectors. Available research suggests a number of reasons why this is so, all of which pose a considerable challenge to those seeking care – and to those designing policies for effective public-private partnership.

First, in field research we have repeatedly found that there is good and bad value for money in all sectors. The faith-based sector – despite its generally higher reputation – contains facilities displaying bad practice (Tibandebage and Mackintosh 2005). Public hospitals vary very sharply in performance and behaviour towards patients (Tibandebage and Mackintosh 2002). Private facilities vary hugely within the same district in competence and probity (Kida 2009). *Sector* alone cannot therefore be used as a marker of quality. This is why users collect and apply information on particular local facilities, and try to avoid those with a bad reputation for abuse and neglect.

Second, all sectors display informal charging, though the level and extent varies greatly within sectors. The problem is most discussed in relation to the public sector, over-charging and extortion of informal payments occurs in all sectors. For patients, one of the most serious aspects of informal charges is their unpredictability : a person will prepare a certain sum of money, and then find that more is required in circumstances that can be frightening. This problem leads some people to save to pay the higher charges required in a private hospital where they believe that additional payments will then not be required – though this may not always be the case. Private dispensaries often charge according to the ‘look’ of the patient (Mackintosh and

Tibandebage 2008), so that supposedly formal charges will in practice be unpredictable.

Third, personal relationships can be important in mitigating problems for patients. This is reported also in all sectors, though we have particularly noted this as affecting care in the public sector including rural public dispensaries. (Current research includes exploration of opinions on the ethics of this influence on quality of care.)

Fourth, a major problem faced by users of the public sector is lack of supplies: medicines and other essentials. People going to the public sector for care are often required to buy such supplies in the private sector, adding to total costs – and to undocumented out-of-pocket payment. Health service users try to allow for these expenditures, and to take essentials with them when they know what is needed – adding to the complexity of seeking value for money.

In short, it is very hard for users making out of pocket payments to ensure, in the words of several of our earlier interviewees, that they ‘get what they pay for’. There is no clear link between payment levels and quality in many areas of care, and no way for patients to ensure that they can obtain even services for which they are able to pay.

The view from the private sector

Why do these problems occur? What prevents individual health care users from obtaining value for money? Some major factors – some familiar, some less so perhaps – emerge from the interviews with clinicians and managers in the non-government sectors.

- Low ability to pay and the shortage of competent staff

All facilities rely largely or in part on fees and charges. There are no exceptions that we know of. In a very low income context, the ability to pay is low, and all facilities struggle for financial viability. The private sector is no exception. In current research, interviews with doctors/clinical officers in-charge of some of the private health facilities we visited emphasised resource constraints and need for government support to address this constraint. It was made clear that it is hard to pay for competent staff, and in recent years better pay in the public sector has made the pressure on the private sector greater.

Medical/clinical officers in-charge did not hide the problem of shortage of qualified staff. This was also evident from our interviews with staff in charge of maternal health care including deliveries. Nursing assistants and medical attendants were delivering most of maternal health care including deliveries, work which is supposed to be done by trained nurse midwives. To some of the facility in-charges, use of unqualified staff was a coping mechanism to enable them stay open:

The problem is not finding qualified staff, but inability to pay them. (Medical Officer in-charge of for-profit private dispensary doing deliveries)

On the same issue of using unqualified staff another doctor at a for-profit dispensary in a rural district said:

Nurse midwives are expensive. The government pays more....

- The need for subsidy and support

The implication is that all sectors rely on subsidy of some kind, and those non-government facilities that do not obtain some subsidy tend to go out of business, or to provide extremely poor quality services. A medical officer in-charge expressed the need for government subsidy to support, for example, staff that do home visits and counselling, and HIV/TB training. He had received support from the Association of Private Health Facilities in Tanzania (APHFTA) for training of staff in HIV/AIDS counselling. There is a well documented shortage of funding for investment at manageable rates of interest, and a need for subsidised financing. A doctor in-charge of one for profit dispensary said he had plans to open a health centre but financing was a problem because it was difficult to get a loan from banks.

Government support furthermore is perceived as recognition of complementarity of services and partnership. Thus an administrator of a faith-based dispensary doing deliveries, and with plans to turn into a health centre, did not mince words about the rationale for government support:

We are providing service to Tanzanians who must be healthy to be able to serve this nation well. Yet we are given no support. It is like we are providing service to our family members. You ask to be given staff you do not get. Yet at the end of the month they ask for reports.

- The ‘emptying middle’

The quotes of some facility in-charges in the private sector about shortage of qualified staff presented above are indications of the pressure in the private sector to keep costs low and stay in business. Some of our earlier work indeed shows how competitive pressure to attract patients was leading to a trend we called ‘the emptying middle’ (Mackintosh and Tibandebage, 2002). Competition was driving private health facilities in two different directions – towards lower priced but lower quality care on one hand, and towards higher priced, more complex and more exclusionary provision on the other hand. It was found that private facilities that were able to resist the two dominant market incentives were those showing clear professional commitment and with a source of financial subsidy in addition to fee income. Others went bankrupt or faced threatened bankruptcy, and the turnover within the private sector identified in the 1990s (Tibandebage et al 2001) remains high.

- The ‘race to the bottom’

Kida (2009) has further studied this phenomenon of the emptying middle in a case study of a Dar es Salaam ward. As financial and pricing pressures intensify, decent quality private care for those on low and even middle income tends to be squeezed out. There is a bifurcation of provision, with a relatively small part of the private sector seeking to raise prices, restrict its provision to a small well off group, and compete on quality. Elsewhere, competition on price drives quality into a downward spiral to a shocking level of low priced, incompetent and dangerous provision.

- Public sector quality influences private sector quality

Conversely however, if the public sector is reasonably competent and accessible, it effectively places a 'floor' under the quality of the private sector. This happens because the two sectors compete, and given the search by users for value for money, a competent public sector will force up private sector quality. There is good evidence for this effect, which we have called 'beneficial competition' (Mackintosh and Tibandebage 2002), from cross-country comparison in Asia, where Sri Lanka's universalist and low cost public sector is associated with a better quality private sector than elsewhere (O'Donnell et al 2005). Kida (2009) found related evidence in Dar es Salaam: the population in a low income area with a very poor quality public dispensary were shown to use the private sector more intensively than a similar population with access to a better public dispensary, showing active judgement about the better of the available quality options.

- Culture and management are key

Qualitative results in all our fieldwork strongly suggest that organisational culture and management competence are key to effective provision in all sectors. The extreme divergences in quality found in the public and faith-based sectors, which have a larger subsidy than the private sector, appear to be closely dependent on these factors. Current research is exploring this in detail, in terms of its impact on maternal survival.

- Mutual hostility undermines quality of care

While competition can be beneficial in some circumstances, there are many aspects of health system where cooperation is essential. One is referral. The referral process in Tanzania in general works poorly, not least because people have to pay at each level. A further problem is hostility between public and private sectors that can compromise efficiency in health care delivery.

For example, a doctor in-charge of a for-profit dispensary in a rural district said when he started work, patients whom he referred to the district hospital were being mistreated just because they had gone to a private facility first. He had also initially opened a nursing home for deliveries in partnership with his wife who has many years of experience as nurse midwife. However, women who went there were being threatened by staff at a district hospital, telling them that they should not go to the hospital if something goes wrong. Such hostility and mistrust is harmful to good informal working relationships between sectors. Conversely, effective cooperative relationships can help to regulate interactions in the health care market and therefore have an important role to play, together with conventional methods of regulation such as formal rules and procedures (Hancher and Moran, 1989; Mackintosh and Tibandebage, 2002).

6. Directions of transformation: Designing effective PPP.

The aspiration in Tanzanian government policy – and among competent and committed non-government providers – to achieve an integrated system of health care which allows the different providers to play competent roles is very important. Without a more integrated system achieving value for money for both users and taxpayers, funds will continue to be wasted, and those in need of care continue to face neglect and abuse. The concept of PPP as a system within which different types of providers play complementary roles an essential objective. At present it is very far from being attained, and indeed the system appears to be moving in the opposite direction.

The overview of the public – private interface presented in the preceding sections reveals a set of issues that need to be addressed if the partnership is to effectively contribute to bringing about transformation for sustained poverty reduction. These include, among others, the following:

- A fee paying public health care system that continues to exclude those with no ability to pay because of ineffective exemption and waivers system.
- Payment for service in all sectors where those paying often do not get value for money.
- Inadequate government support to the private sector as partner in pursuit of one common objective for the health system.

We suggest in this section some approaches to designing policy for a more transformational PPP process in health that can improve value for money, access and quality of care across the system. The central argument is that changes in the public-private interface at the *system* level are needed to support and incentivise better individual public-private partnerships on the supply side at *local* level.

System-wide PPP issues

The core problem identified above in the operation of the public-private interface within the health system is the perverse market dynamics generated by reliance on fee-for-service out-of-pocket payments from really poor people. The effects in terms of exclusion and impoverishment are well known. Less well discussed are the effects of the resultant price-based competition in terms of reliance on incompetent and deteriorating service from some of the private dispensaries in very low income communities. It feeds a culture of informal payments in the public sector and generates reliance on private shops that are incompetent to provide medical advice. It is hard for individual facilities to resist these perverse dynamics.

As a result, people on very low incomes are contributing large sums in private out of pocket payments – official figures suggest a quarter of all health system funding which, as noted above, is likely to be an underestimate. In return they are receiving very poor value of money – much of this painfully saved funding is poorly used in terms of providing suitable care.

The current structure of private payment has thus produced an undesirable structure of private sector firms: predominantly small scale, poorly financed, struggling to stay in

business. The result is a pattern of private sector for-profit provision within the health system that is perverse. Instead of serving the better off, as a complement to a public sector that serves those with little ability to pay, the private dispensaries have become a major supplier, often the only option, of frequently poor health services for the urban poor. We concluded the following from our case studies of individual private facilities in the late 1990s, and do not believe the situation has changed:

...good primary health care needs to be routinely available, physically and financially accessible, reliable and stable; it also needs to be trusted in terms of basic quality indicators such as cleanliness and use of reputable medicines and trained staff, and to do effective preventative care. However, *there were no market incentives driving this health system in this direction.* (Mackintosh and Tibandebage 2008, emphasis in original)

Facing this kind of financial and market situation, welcome initiatives such as the quality improvement programme of the Association of Private Health Facilities in Tanzania (APHFTA) is a struggle against heavy odds.

A further outcome is poorly applied public subsidies that also do not deliver value for money to the taxpayer. The public sector continues to provide essential primary health services in rural areas, but it failing to provide an effective service to much of the urban poor. Faith-based dispensaries in the areas we have studied cannot fill this gap, and also struggle, like the private sector, with little subsidy. Most of the subsidy to faith-based organisations goes to hospitals, with some above-average quality. But the faith-based sector cannot resolve the problems of the currently perverse dynamics in the public-private interface.

Scope for transformational action

We suggest that this structural problem with the pattern of private payments – rather than simply lack of will or understanding between sectors – is creating difficulties for policy efforts to promote local level PPPs. Individual efforts to cooperate founder on the need for more efficient and effective use of available funds. What would a more transformational approach look like, and how might policy work towards it?

One possible starting point would be to decide what type of private sector is desirable. What types of private firms, serving what parts of the population, should be encouraged and supported? A possible answer is that policy makers should seek to work towards a situation where the private sector is *not* the first resort of the very poor. In other words, one aim might be to push the private sector up-market, where is served as a competent alternative for those with higher ability to pay, rather than a very low quality resort of the urban poor.

To do this requires, unequivocally, a very low cost or free– that is, very heavily subsidised – service for the poor. It is possible that this could be provided by contracting with private providers – but the small scale, quite informalised providers currently operating will be hard to upgrade. It is more likely that this needs to be done predominantly by the public and non-profit sectors which have in principle the organisational competence to achieve it.

But this in turn requires a change in the way in which the public sector in particular uses people's hard-saved payments for fees and charges. If people are buying supplies

and medicines in private shops there is no reason in principle why they should not buy them at little more than cost price in public facilities, returning the funds to public health care. It is a matter of organisation to ensure that fees and charges go back into the provision of health services, rather than into private pockets. At present far too many supplies are going missing: we found public health centres in one region that has received few or no supplies of gloves, which are essential for deliveries, for six months. Meanwhile the private shops had gloves.

However, improving this situation requires action from the national level. There should be more policy and management effort put into the sourcing and management of supplies at local level, especially in areas such as maternal health care, where provision in the public sector is formally free. Strikingly, many facilities do not retain the fees and charges they do collect, removing all incentive for collection. As a result, some public health centres interviewed in 2011 had *zero* cash for expenses and supplies. It is not possible to run a busy health centre on that basis, and the situation contributed to observable demoralisation and loss of commitment to saving lives.

We *propose* that modalities should be developed for the use of fees and charges collected at health facility level that make the funds much more formal and transparent. Such modalities should be clear on the proportion to be retained at the health facility level, and why. A clear process should be developed for feeding these funds back into provision of health care in the public sector. The aim could be to shift progressively the substantial fees and charges into a formal fund, well audited at local level, that contributed to public sector procurement and allowed management flexibility in response to local needs and emergencies.

This can only be done if management is sharply improved. The strength of those faith-based facilities that provide above average quality of service is observed to lie in autonomy and quality of management, including financial management. The same is true of above-average public hospitals. Yet policy puts insufficient emphasis on generating, supporting and celebrating good management. We *propose* that policy makers should focus much more strongly than is at present the case on policy and management effort on quality of care in all sectors, with particular emphasis on improvements in the public sector. The management focus should include distinguishing good and bad care and its roots in management practices, and working harder on supporting good care and penalizing bad care in all sectors. Much could be learned from successful management of charging in some NGO facilities, feeding that back into demonstration projects in the public sector.

Taxpayers also cannot know whether they are receiving value for money when their taxes are used for public subsidies to other sectors, since these subsidies are poorly recorded and evaluated. We *propose* that more effort should be put into making the public subsidies and their benefits in all sectors more transparent. In this way they can be easily traced, and therefore likely to be used more effectively.

There is a clear need for increased government support to the private sector to enhance its capacity to effectively complement the public sector through provision of more affordable quality health care. However, this should be done on a targeted basis, to develop appropriate types of private provision, and monitored for effectiveness. There is an acute shortage of affordable and accessible business

finance, associated with a lack of support for effective business development. It may be that the best use of public support is to help to support effective private for-profit development is in fact at the higher end of the income distribution – to assist, for example, competent private and non-governmental non-profit providers to play a larger role in maternal care.

A further possible target for government support might be non-governmental restructuring. Collaboration is unlikely to work between very fragmented and struggling small scale providers. It is more likely to work in organised collaborative networks within which patients can be referred and different requirements handled. There are quite a number of more or less formal collaborative efforts documented at local level. Encouragement of more formalised collaborative networks that share services and support may improve both access and value for money.

What would this direction of change imply for the concept of complementarity between sectors, and the role of PPP in supporting access to competent care? It would imply, we think, a major effort to change the current public-private interface, to shift away from small scale informalised fee-for-service care for the very poor, while ensuring that payments that continue to be made are formal and feed into the provision of care. If private provision for out-of-pocket payment can be shifted predominantly up-market, it is easier to replace it progressively with pre-payment. Selective subsidy, especially to deal with market failures such as those in business finance, can support the process. Meanwhile, policy at the lower income levels can focus on strengthening formalisation, direct delivery in a largely non-profit mode, and the progressive reduction of the perverse effects of fees and charges.

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Appendix 1: A note on sources.

The illustrative evidence used in this paper primarily derives from fieldwork for a research project on “Ethics, Payments and Maternal Survival in Tanzania”, which is funded by the Wellcome Trust (see Acknowledgements). Fieldwork for this project was undertaken in four districts of Tanzania, in two contrasting regions. In each region, the research included one urban and one rural district. The field work comprised household and health care facilities interviews. Fifty nine (59) health care facilities interviews took place from the selected four districts at different levels (hospitals, health centres and dispensaries), that is 11 hospitals, 16 health centres and 32 dispensaries. The health care facilities covered in the survey are from both public and private (including not for profit/religious) sectors.

Households to interview were selected purposively: wards and then streets were chosen to display contrasting economic circumstances, and then households were selected randomly along those streets. Households where no women had given birth in the last five years were replaced. Interviews in 240 households covered some basic data on household social and economic conditions, and interviews with women in the households who had given birth in the last five years and/or were currently pregnant. In total, interviews with 248 women included experience of antenatal care, care at birth and post-natal care, including payments made and experience and opinions of the quality of care received. The paper also draws on evidence in some of earlier work by the authors, listed in the references.