PUBLIC PRIVATE PARTNERSHIP IN UTILIZATION OF FUNDS IN THE HEALTH SECTOR IN TANZANIA

AN ANALYSIS OF KEY FINANCING MECHANISMS

BY

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DECLARATION

I Henry Kamau Kuria, declare that this work is a result of my own effort and has never been submitted for any award in any other university or institution of learning

Signed:_____
Henry Kamau Kuria

Date 30-10-07

APPROVAL

This work has been done under my supervision as a university supervisor, and submitted with my approval

Signed:_____

Wilber Bateisibwa

Date 30th October, 2007

DEDICATION

This thesis is dedicated with love and gratitude to my family: my dear wife, Cecilia and children – Kevin, Mary, Sylvia and Immaculate whose abundant love, support, extreme tolerance and deep understanding have sustained me through the course of the study.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ACRONYMS

AAD	Alma Ata Declaration
AAR	Africa Air Rescue
AD	Abuja Declaration
BFC	Basket Fund Committee
BI	Bamako Initiative
CHF	Community Health Fund
DAC	Development Assistance Committee.
GOT	Government of Tanzania
HICs	Heavily Indebted Countries Initiative
HSR	Health Sector Reform
IMF	International Monetary Fund
IPPPH	Initiative on Public Private Partnerships in Health
LICs	Low Income Countries
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
OC	Other Charges (in the health budget)
OECD	Organization for Economic Cooperation and Development
PE	Personnel Emoluments
PEPFAR	Presidential Emergency Plan for Aids Relief
PHC	Primary Health Care
PRSP	Poverty Reduction Strategy Paper
PRSP	Poverty Reduction Strategy Paper.
RALG	Regional Administration and Local Government
SAP	Structural Adjustment Program
SWAp	Sector Wide Approach
THs	Traditional healers
USD	United States Dollars

ABSTRACT

Purpose

As a result of donor apathy, there has been notable decrease in the amount of donor funding to the social sector in recent years. Results of recent studies conducted on the impact of previous donor funding efforts have led to development workers to query if foreign aid works. Noting the importance of the health sector in a country's pathway to development, the purpose of this study is to analyse the key financing mechanisms in the republic of Tanzania with a view to informing the policy makers on the need to design more efficient, equitable and sustainable financing mechanisms.

Methodology

This study used two main strategies to ensure sufficient collection of secondary and primary data. This included a detailed review of related literature obtained from internet searches, publications and related papers and journals from all over the world but with specific focus on Tanzania. The source of primary data was mainly from interviews with key stakeholders, that is, representatives from donor agencies, leading NGOs, faith based organizations and government departments.

Findings.

The study notes that public private partnerships in delivery of health services are not new in the republic of Tanzania. The earlier public partnership between the district hospitals and the private not for profit faith based organizations was more focused than the public private partnership between the transnational drug companies and the central government today.

Implications.

There is need to redefine the objectives of public private partnerships to ensure that partnerships are initiated where they exist in pursuit of a common objective. Policies and legislation are required to ensure where viable partnerships are identified, the ventures are appropriately monitored to ensure the set goals are achieved in an efficient manner

CHAPTER ONE
INTRODUCTION

1.1 Background

A review of recent literature on poverty eradication programs (Wagstaff, 2002), (Gwatin,2002), (Simm, 2001, (Lavergne, 2002) indicates that ill health, vulnerability and poverty are intertwined. Indeed, a close analysis of the Millennium Development Goals (MDGs) reflects that poverty reduction and health improvement are closely related, reflecting the close relationships between ill-health, vulnerability and poverty. Furthermore it is considered that sickness and disability can affect the productivity of individuals, households and communities (WHO, 2001), making it more likely they will fall into poverty or be unable to escape poverty for long periods. The strategies governments use to respond to the health risks, either curative or preventative may be pivotal to the enhancing the country's pathways to achieving its poverty eradication targets.

Many countries have formulated poverty reduction strategies (PRSs) to ensure that government, local stakeholders and development partners coordinate their efforts. Measures to improve health are an important aspect of a strategy to reduce poverty and pro-poor health strategies give priority to common problems for which cost-effective interventions exist. Implementing these interventions can be difficult in certain locations, particularly where technical capacity, government administration and governance are weak. Innovative efforts to overcome these problems must be provided and partnership between the government and the civil society has recently been suggested as a panacea. Donors have also increased the funding to the health sector, for example in the US, president Bush has urged the congress to provide USD 30 billion for the Presidential emergency plan for Aids relief (PEPFAR) program in the first five years after he leaves office in 2008 (The Daily Nation, 31 March 2007). The move will double the global HIV/AIDS

funding because to date the PEPFAR has approved USD 15 billion since the launch of the program in 2003.

In Africa, just like any other part of the third world, infectious diseases cause untold suffering and claims millions of lives every year including malaria, respiratory infections, bilharzias diarrhea related diseases. Malaria itself claims a million African lives every year and available statistics indicate that the figure could double in the next twenty years. Africa also has the highest infant mortality rates in the world. Other indicators of poor health in Africa include low life expectancy.

Every year more than 10 million children die of preventable diseases, that is, about 30,000 lives a day. More than 500,000 women die in pregnancy and child birth. With such a death a 100 times more likely in sub Saharan Africa than in high income countries. Around the World 42 million are living with HIV/AIDS with 39 million (93%) in developing countries (UNAIDS, 2001). Such statistics about the health situation are shameful given that many of these deaths could be avoided with more widespread use of bed nets, midwives, affordable antibiotics, basic hygiene and treatment approaches. Most of the diseases do not need hi-tech solutions yet they could save millions of lives every year. However, the facilities and services have remained out of reach because there is limited funding for health facilities and services, lack of equity in what the systems provide, and lack of efficiency in how services are provided. Health services in East Africa especially Tanzania are severely under funded and recently suffered constraints introduced through cost sharing model administered by the structural adjustment programs.

High income countries spend not less than 5% of GDP on public health services whereas in East Africa the spending rarely exceeds 2-3% which means that the sector is under funded. Consequently in poor countries it is basically possible to pay international prices for live saving medicines and

almost criminal to expect the poor to do so. A good example is the former president of Zaire (now DRC) who could afford expensive treatment abroad yet the poor in the capital Kinshasa could hardily access simple pain killers.

With small and inadequate budgets, poor people in East African countries, for example Tanzania, are likely to lose out. In most countries the poorest 20% of the households benefit from less than 20% of the health spending yet more equitable health spending is known to lead to better health outcomes. Countries with higher allocations to poor households have lower child mortality rates.

Rural urban disparities are another example of unfair spending – rural areas get much less and the lack of resources has a corrosive effect on health systems because shortcomings in one area feeds into others for example when clinics have no drugs patients are discouraged from going to them for treatment, that leads to higher absenteeism from the staff, further eroding the effectiveness of these systems. Because the community is unlikely to find the health systems worthwhile it does not monitor the system and consequently the services become less.

1.2 Background to the Study

Overall, Tanzania has a well developed health care system. Prior to independence the Tanzania health system was concentrated in the urban areas and services were essentially curative in nature (GOT, 2001). In 1967 the Arusha declaration stated that the government would provide free medical care to all its citizens and by 1978, a clinic was located within 10 kilometers for 90 per cent of the population (Benson, 2001). In line with its free health for all policy, private for profit health services were banned in 1971. Private not for profit, health facilities operated by non governmental organizations, however, continues to provide large share of health services in the country with subsidies from the government. Despite inadequate revenues, the

government adhered to these policies throughout the 1970s and 1980s. Under funding led to shortages in supplies of drugs deterioration of facilities, low staff morale and poor quality of health care in the country with subsidies from the government (MOH, 1998).

The importance of a private sector in health service delivery and the move towards market based economic reforms resulted in the re-establishment of private medical and dental services with the approval of the Ministry of health in 1991 (GOT,2002). In July 1993 under the pressure of the World Bank and the International Monetary Fund (IMF), the government started a phased implementation of the user fees for certain health centers in its referral, regional and district hospitals. To ensure that the poor and those who needed care most would not be barred from assessing health care because of inability to pay, the Ministry of Health developed waiver and exemption guidelines (Quijada, 2000)

The pressure for quality health services to improve the health status of the population led to the development of the health sector reform (HSR) in 1994 and a health sector reform strategy – HSR Plan of Action for 1996-1999 was approved by the government in 1996. The action plan had six strategies: decentralization, improvement of central health systems, health management, financing, human resources and public private partnership. In 1999 the HSR program of work 1999 -2002 and action plan was developed and increased the strategies from six to eight to enable the HSR plans to explore new options for health financing such as the sector wide approach (SWAp) framework, a national insurance scheme, community funding and cost sharing.

1.3 Statement of the Problem

Efforts to tackle the major diseases affecting developing countries have been poorly co-coordinated and financed, resulting in fragmented programs at country level. As a result anti-microbial resistance is increasing, while

research and development into new drugs has remained inadequate. The eradication of these diseases can be defined as a global public good – where prevention and control activities have substantial cross border benefits.

The effects of globalization - growing international migration and economic interdependence - mean that the major diseases of poverty are becoming global priorities. In response, new global initiatives, involving new public and private sector partners, have been set up to provide strong international co-ordination and to mobilize additional finance and skills. International bodies such as the World Bank, USAID, DFID, DANIDA and Irish Aid have stepped up investments in these areas. New private sector allies have entered the field – especially the philanthropic foundations and pharmaceutical companies.

Stakeholders are forming new international public-private sector partnerships to finance a wide range of activities, such as research and development of health products, distributing donated or subsidized products, strengthening health service delivery and access to drugs, educating the public, and co-coordinating disease control with national partners. By 2002, there were over 100 international private-public partnerships, with a combined investment of several billion dollars (HAI, 2001) New types of mechanisms are needed to co-ordinate and maximize the benefits of the new partnerships and funding streams.

Both multi lateral and bilateral agencies have long been interested in what benefits were to recipients of grants and loans dispensed to poor countries, with the plain question, "Does Aid Work? (Cassen, 1986) and drew much attention to the aspect of aid coordination. As a result of the assessments the Development Assistance Committee (DAC) of the OECD was formed in 1990s and developed principles and guidelines for improving aid coordination. Most of the recent literature resulting from analysis of bilateral and multi lateral aid (Cassen, 1986, Barry, 1987, Diallo et al, 1991, Johnson, 1993) concluded that aid does not always achieve its goals, in part because of lack of coordination

between donors and donor and between donors and recipients (Buse and Watt, 1997)

This study seeks to identify and analyze the current challenges in health sector financing with a view to reinforcing current efforts in public private partnership that are geared towards efficient utilization of available resources.

1.4 Research Questions

This study was guided by the following research questions:

1. What are the roles of the various stakeholders in provision of health services
2. What finance mechanisms exist in the health sector?
3. What are the weaknesses existing in the donor financing mechanisms in the health sector?
4. To what extent have donor funds in the health sector been adequately utilized?

1.5 Objectives of the Study

This study had the following objectives:

1. Examine the role of the various stakeholders in financing of health services.
2. To establish the donor financing mechanisms in the health sector
3. Identify the weaknesses existing in the donor financing mechanisms in the health sector.
4. Assess the adequacy with which donor funds are utilized.

The study explored the trend in health sector financing for all types of funding including but not limited to donor funding, private for profit and not for profit

entities, and the public sector. The study analysed the trends in health sector financing in the republic of Tanzania with a view to informing the partnership between various financiers especially bilateral donors and other key stakeholders.

1.6 Scope of the Study

This section provides highlights of the geographical, period and content scope of the study.

1.6.1 Geographical Scope

The scope of the study was geographically focused on the United Republic of Tanzania. The republic of Tanzania has witnessed major changes from the period of Arusha declaration making free medical care to all citizens a responsibility of the government with initial remarkable success. Private for profit health facilities were forbidden. However, this was followed by a period of untold suffering by many Tanzanians occasioned by under funding to the health sector with the government sticking to its policies despite the shortcoming. However, in 1991 the government made a full circle by re introducing the private for profit health facilities through the establishment of Private Hospitals Amendment Act of 1991 which re establishment of private medical and dental services with the approval of the Ministry of health in 1991 (Wyss et al, 2000, URT,2002). The trend in health sector financing in the united republic of Tanzania makes an important case study of key financing mechanisms in the health sector.

1.6.2 Period Scope

The study covered the period between the Arusha declarations (1967) through the millennium but specifically focus on 1990-2005. This period focuses on major policy shifts ranging from the nationalization of private

enterprises of the late 60s to the liberalization and privatization policies of the mid eighties which the government had to adopt to comply with the IMFs Structural Adjustment Programs (SAPs) to date.

1.6.3 Content Scope

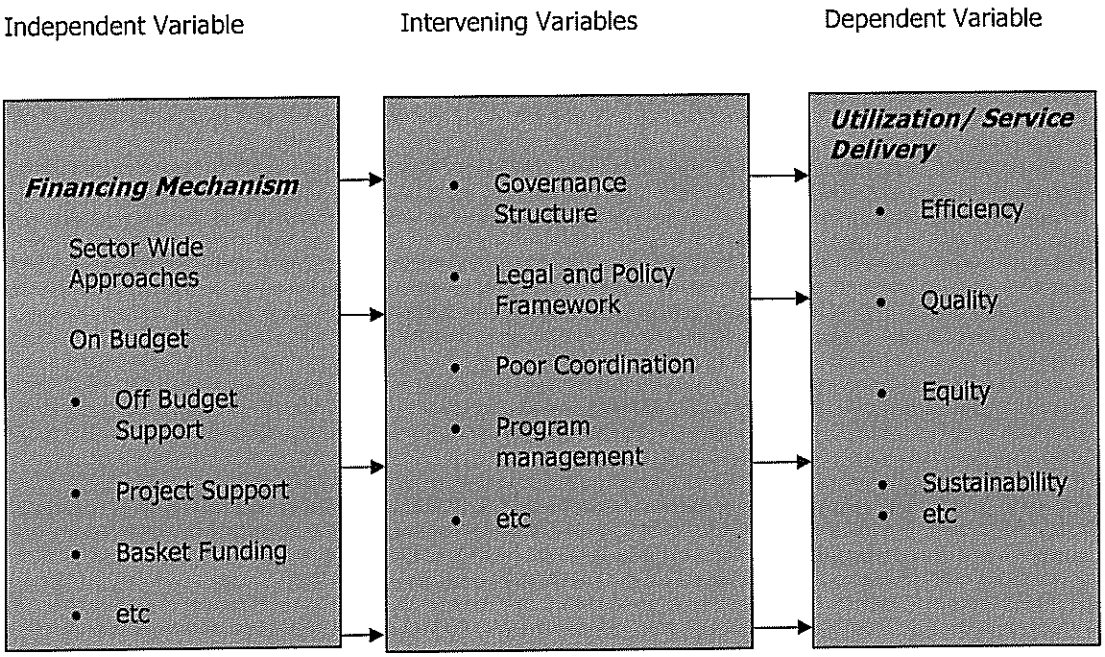
The study focused on public` private partnerships in health sector financing ranging from tax based financing, social insurance, community health insurance schemes, user fees (cost sharing approaches introduced by the SAPs, as well as bilateral and multi lateral donor funding within both sector wide and on and off budget support approaches. Emphasis of the study was on the contribution of the public private partnership between bilateral and multi lateral agencies, governments and Trans national corporations in ensuring that the benefits of the health sector financing are sustained.

1.7 Significance of the Study

The study expected to provide the stakeholders in Tanzania and East African region as a whole including the donor community with an insight of how funds are currently allocated and utilized in the health sector. This will increase awareness among the policy makers on the need to come up with more efficient, equitable and sustainable health financing policies especially targeting those in critical need. The study expected to promote and stimulate the academicians who would like to carry out further research in the same area and also policy related issues for academic purposes. In so doing the study provides knowledge to the researchers who will be pursuing their further studies in the related field in order to enhance the utilization of the funds allocated to the health sector.

1.8 Conceptual Framework

This section covers the conceptual framework of the study by highlighting the linkages between the independent variable (financing mechanism), the intervening variable (coordinating mechanism) and the independent variable (utilization of resources/quality and equitable service delivery) and shows the linkages among the variables. The synergies derived from the comparative advantages of the diverse stakeholders in the public private partnerships are expected to increase efficiency, quality and equity in the health service delivery.



1.9 Definition of Key Concepts

This section provides a working definition of the common concepts used in this study.

The Social Sector

According to the website of the Ministry of Gender, Labor and Social Development {(MGLSD, Uganda), (www.mglsd.go.ug)}the Social Sector, encompasses services such as water and sanitation, health, housing, community empowerment and education. In Uganda, many of these services have attained independent sector status, however, a major gap was identified regarding the needs and rights of persons disadvantaged by physical disabilities, age, gender and other socio-economic characteristics. This gap constitutes the concept of social sector concerns.

Health

Health is defined as the complete physical, mental and social well being. (WHO, 1947). Health is conceptualized within this paper as public good and as a right to which all human beings are entitled. (Cook et al, 2003) argue that the right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health. The right to health contains both freedoms and entitlements: freedoms would include the right to control one's health and body, including sexual and reproductive freedom and entitlements would include the right to system of health protection that provides equality of opportunity for people to enjoy the highest levels of health.

Partnerships

The Wikipedia defines a partnership as a type of business entity in which partners share with each other the profits or losses of the business undertaking in which all have invested. A partnership is a relationship that subsists between two or more people in pursuit of a common objective.

Partnerships can be distinguished from joint ventures which are relationships formed to execute a specific short term objective and are wound up after the accomplishment of the objective. It is also different from a consortium which is defined by Longman Active Study Dictionary as a number of organizations working together to achieve a certain objective. On the other hand, partnerships can also be distinguished from alliances which are defined by the same dictionary as an agreement between countries or groups of people to work together or to support each other.

Partnership working is popular today because partnerships boost capacity of individuals and organizations to deliver services to communities. It also helps the individuals and organizations to fulfil the community leadership role, bringing organisations together and agreeing shared local ambitions and priorities. Partnerships help to engage communities and users more effectively through shared area structures and joint consultations. The more one understands the community's needs and have pooled the resources, the more integrated and efficient the drive to improve quality of life will be. Successful partnerships are forged by sharing finance, assets, people, information, influence, skills, expertise and intellectual capital, and using these to deliver joint solutions to common problems.

Utilization.

Longman's dictionary defines utilization as to use something (Longman Dictionary) or to turn to practical use of account (Webster's, Dictionary) It can also be defined as to put into action or service for example we must *utilize* all the tools at our disposal (Webster's, Thesaurus) Utilize is first recorded in English in the early nineteenth century, though it didn't become common until the middle of the nineteenth century. It is a borrowing from French (Maven's word of the day). Whereas all the dictionaries define utilize as synonymous to "use" the Dictionary of English emphatically defines "utilize" as to put

something to unusual or practical use, and it is this version that the researcher will adopt in this thesis.

The Public Sector

Public as compared to private implies that something is provided for everyone to use for example public health services. The term public also relates to the government and the services it provides (Longman Dictionary). Public sector in the provision of health services includes the central government, local government, municipalities and parastatal bodies, for example the national Health Insurance Fund.

The Private Sector

Private is the opposite of public and refers to exclusive, restricted and privileged. Something private is for use by one person or group, not for everyone, or not owned by paid for by the government (Longman Dictionary). Private sector in the provision of health services in Tanzania can range from traditional healers, informal drug vendors and private for profit providers to non governmental organizations and community groups. Private sector providers are often chosen by people of all socio-economic backgrounds for reasons that range from offer of lower cost, the provision of higher quality care, or a greater sensitivity to patients mistrustful of public institutions.

CHAPTER TWO
REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter presents a review of literature on the challenges in the health sector financing from a global standpoint with a specific focus on Tanzania as documented in relevant books, internet searches, journals and reports.

Many low income countries suffer from ill resourced health systems and staffing levels far below international minimum standards. A massive effort is needed to achieve the health related millennium development goals (MDGs) in time. This chapter seeks to highlight the role of stakeholders, which include the Governments, Local Government, Urban councils, Private Sector, Traditional Healers, and bilateral and multi lateral donors for example WHO, UNICEF, UNFPA, IMF, WB. The study includes a review of the financing mechanisms and concludes it with the challenges and weaknesses that face the health sector financing. Then the general conclusion will follow giving streamlined synthesis about what has been studied.

Most governments through the Ministries of Health have over time influenced the pattern of government expenditure, which strongly favors curative care but at a low spending levels. It should be noted that the study presents an analysis of the positions of different stakeholders in health sector, their actions and impact, in order to draw lessons that will enhance the success of the ongoing health sector reforms. As noted in the study, many countries have started implementing intensive reforms in their health sectors in order to improve performance of health system functions (Gesami, 1999).

2.2 The Role of Stakeholders in the Health Sector

Stakeholders are defined as actors who have interest in the matter under consideration (Varvasovszky, 2002) or who are affected by the issue or who

because of their position have or could have an active or passive influence on the decision making and implementation process. Stakeholders in the health sector include public private partnerships, bilateral and multilateral donors, the private sector as well as the users of the health services and the government itself. In some countries it will be noted that bilateral and multi lateral stakeholders have exerted more influence than the governments of the host countries.

Stake holders have four components depending on interests – there are those whose interests are on design of financing mechanism others on policy formulation while others have interests in implementation and/or evaluation. In design formulation both the host country and the donors both multilateral and bilateral have strong interests. In the policy formulation and decision making both the legislators and donors must reach a consensus especially on checks and balances. The implementation stage mostly involves the host government and in most cases delegates the powers to handle this to the local governments, urban councils, and the private partners. The evaluation process is of particular interest to all stakeholders especially on issues of best practices and lessons learned which may be used to inform future processes.

2.2.1 Public Private Partnerships (PPPs)

Public private partnership is a collaboration between the public and the private sector organizations [private for profit, and private not for profit (faith based or NGOs)]. Collaboration could be in form of institutional arrangements ranging from simple collaboration, joint venture, direct contract, lease and concession. According to Itika et al (2006) continuum of PPPs models exist at various extremes; in one extreme situation where the private sector is fully passive to another extreme where the public role becomes fully passive but in between the two extremes, there are many models including joint venture, direct contract, lease and concession. Itika, (2006) continues to comment that

.... "In appreciation of the fluid nature of PPPs the types of partnerships that have emerged most often in developing countries contain many variations not found in conventional definition". Collaboration between the government and private sector is expected to create a window of opportunity for addressing problems of government and market failures in social service provision. The expected advantage of the public private partnership in the health sector service delivery is to establish functional integration and to support the sustained operation of a pluralistic health care delivery system by optimizing the equitable use of available resources and investing in comparative advantages of the partners.

Although both the public and the private sector in the health service delivery exist to ensure provision of quality health service to all, nevertheless, there are some strong myths about the private sector which strengthen the case of the public private partnerships. One of the myth is that the private sector exists for the rich and the public sector for the poor (Malek, 2004). A review of the budgets of most African countries has proved that the public sector finances less than half of the total health expenditures. In most African countries the private sector plays a more significant role than the government especially when compared to the OECD countries where public financing provides the majority of the resources. It has also been proved that the private sector is not very developed in African countries while in actual fact the private sector provides a third of most health services (Malek, 2005). Despite this reality most governments and aid organizations focus on public health delivery of health services and how to engage the private sector has been a challenge. (Mac Donagh, 2003)

In a study conducted in 10 East and Central African countries, it was noted that about half of the health expenditures in East Africa are private (M Makinen et al, 2000) Although there is not systematic data available across countries, evidence shows that a lot of services in Africa are provided by the

private sector. For example in Kenya the private sector delivers 49% of health services and half of these are given by religious and NGO facilities and the other half by small and medium sized commercial health enterprises (KAPH, 2004)

Despite all the evidence showing the significant amount of money spent by populations on services from the private sector, most governments and aid organizations still focus quasi exclusively on public delivery of health services and by doing so did not account for a large portion of health expenditures and service providers. However, with the arrival of HIV/AIDS recognition grew that all potential service providers must be mobilized and harmonized to cope with the epidemic. Now the concerns are more on deciding what services can be best provided, by whom, and how so that the public health goals are reached. (Malek, 2005). In addition, the quality of services by private providers could often be improved. For example data from Uganda shows that only 19% of private health facilities correctly managed simple malaria, a mere 6% of them did so for simple diarrhea without blood and 36% did so for pneumonia (MOH/IMCI Unit, Uganda, 1999).

According to the World Bank Group, (World Development Indicator Database, 2003) it will be difficult for Africa to come close to reaching the MDGs if it continues with business as usual attitude in the health sector. Although it is important to continue to strengthen the capacity of MOHs it is equally important to start paying attention to where people actually go for services and ensure that their money as well as public money is used efficiently for quality health care. Furthermore, according to the World Development Report, 2004 there is need to consider different type of service delivery arrangements depending on the country. Four out of the eight suggested service delivery arrangements suggested involve contracting with private sector.

How does the state retain its role as regulator, pace setter and strategic purchase? With emergence of the private sector as a key player in the health sector and health service delivery, the government will be required to provide insights into the different types of policies and interventions as a government can choose to influence the private sector to reach the public health goals. The government can influence the private sector through various means which include:

a) Financing the private sector to make it more efficient or targeted (financial support for health insurance programs and demand side promotion such as community health manuals or vouchers).
b) Legislative/regulatory reforms resulting in enabling environments
c) Formal partnerships with the private sector to
d) encourage the delivery of certain types of services.

Despite inadequacies in the current regulatory framework, the emerging evidence (Itika, 2003) shows that PPP in health service provision is the right choice because of several deliverables. The partnership reduces the distance to the health centers, service time and service costs. Furthermore, it increases capacity to deliver services, information sharing and service reliability.

There are different categories of PPPs. The main category include country level cooperation between public body and a private sector one and those occurring at global level between for example the United Nations Organizations and commercial enterprises or their representatives (Watt, 2001). There are three main types of partnerships:

i. Product development partnerships initiated by the pubic sector in response to the market
ii. Systems/Issues partnerships such as Roll Back Malaria initiative which involves coordination of different groups and

iii. Product based partnerships such as donation programs which are often initiated by the public sector.

According to Health Action International (2001) the shift towards public private partnerships on health is the result of increased global integration due to the scope and pace of goods moving across boarders, the lack of geographical boundaries for infectious diseases, the increased possibility for rapid communication (internet), the spread of idea as well as world-wide products and marketing. These developments have reduced state sovereignty. Decreasing government control means that there is need to collaborate with a strong corporate sector. However, it has been noted that there are hidden risks of partnering with the private sector (HAI, 2003). Ideally the private sector (for profit) is motivated by profit maximization goals, and it has been claimed that companies are moving away from simply selling products to selling brand image. Ironically, the partnerships are forged to help identify a certain product or company with well known public health company.

2.2.2 The Central Government

The government through the Ministry of Health helps in shaping the operating environment through guidelines and policies especially in the macro economic context of liberalized and market oriented economy. Overall governments aim to re-orient central governments role towards policy making, regulation monitoring and performance assessment. Apart from the Ministry of Health, there is also regional and local administration in the decentralized environment. The Tanzanian health system and especially the Governments referral system assumes a pyramidal pattern of a referral system recommended by health planners, that is from Dispensary to Consultant Hospital (Better Health In Africa, 1993).

The population of Tanzania is estimated at 33 million (1999) with a growth rate of 2.8%. The country is governed as a republic divided into 20 regions (mainland) and 5 isles and 116 districts. The districts are further divided into divisions, and wards (2354) and villages (9094). It has been the intention of the government to have one dispensary per village. The country has an estimated per capita of USD 100 which is far below the average of USD 640 for Sub Saharan Africa. Majority of the population live in the rural areas and only 32% live in the urban centers (Brown, 2002) According to the MOH website, the structure of health services at various levels in the country is as follows:

Village Health Service : This is the lowest level of health care delivery in the country. They essentially provide preventive services which can be offered in homes. Usually each village health post has two village health workers chosen by the village government amongst the villagers and be given a short training before they start providing services.

Dispensary Health Service: This is the second stage of health services. The dispensaries cater for between 6,000 to 10,000 people and supervise all the village health posts in its ward. Staff in the dispensaries have some minimum formal training in health service.

Health Care Center Service:. A Health Centre is expected to cater for 50,000 people which is approximately the population of one administrative division. The health centers are supervised by fairly trained paramedical staff usually a clinical officer.

District Hospitals: The district is a very important level in the provision of health services in the country each district is supposed to have a district hospital. The Government normally negotiates with faith based organizations to designate voluntary hospitals which provide support to the district hospitals

for example the St Luke's dispensary in Mpwapwa district. Supervision of district hospitals is usually under a qualified medical officer of health.

Regional Hospitals:Every region is supposed to have a hospital. Regional Hospital offer similar services like those agreed at district level, however regional hospitals have specialists in various fields and offer additional services which are not provided at district hospitals.

Referral/Consultant Hospitals:This is the highest level of hospital services in the country presently there are four referral hospitals namely, the Muhimbili National Hospital which caters for the eastern zone; Kilimanjaro Christian Medical Centre (KCMC) which caters for the northern zone, Bugando Hospital which caters for the western zone; and Mbeya Hospital which serves the Southern Highlands.

Treatment Abroad:. Other Diseases and cases require special treatment whose facilities and equipment are not available in the country. Depending on the foreign exchange position, some patients have to be sent for treatment abroad.

Public Education: Public Health Education mainly is concerned with identifying prevailing health problems and disseminating to the public methods of preventing and controlling them. This is an integral part of community involvement in Primary Health Care (PHC). It is assumed that, the health of an individual, the family and community at large is dependent upon factors as environment, social cultural traditions and life styles, hence public health education focuses to strengthen and address issues related to agricultural development, child up-bringing, environmental sanitation and development in general. For instance school children are special target group for health education through the school health program. Public health education is provided by a variety of methods including mass media,

continuous development and dissemination of health education materials and through dialogue with communities.

Health Professional Training: There several medical training schools for various medical cadres. The aim of the government is to train adequate, qualified and motivated medical personnel at all levels of the health care system.

Reproductive Health: The Government formally started providing Family Planning Services as one of the MCH components in the mid seventies. The Family Planning Unit (FPU) was operational in 1986, and has been gradually strengthened to its present capacity. This FPU is responsible for initiating and developing Family Planning standards and guideline on service provision, training and other aspects of quality care.

As stated earlier, the role of government is to set the vision and direction for the health system outline priorities and create policies to achieve its vision. The governments' oversight role covers the whole system; including the public and private sectors and interface between the two the government role also extends to functions such as purchasing and services delivery that must be carried out in accordance with overall policy. In countries where external assistance plays a significant role in the health system, priority-setting and oversight may have an important dimension. One option for co-coordinating programs is the sector wide approach that is designed to eliminate the inefficiencies and wastage with multiple and parallel projects financed by different donors.

The government as a stakeholder gets involved to change laws and regulations thus it plays a role in regulating the health sector. Useful legal and regulatory reforms include the development of new clinical protocols and standards for service delivery, as well as the dissemination of existing

standards, reforms might also include eliminating overly restrictive laws and regulations such as those that prevent practitioners from providing family planning services for example, Morocco, Tunisia and Turkey are exploring or implement ways to allow midwives and nurses to provide certain types of obstetric care that were previously provided only by physicians.

2.2.3 The Local Government

Perhaps the most common organizational change under health sector reform has been decentralization or the transfer of decision making authority and management from high levels of government typically from central agencies to agencies at the regional, provincial or local levels. (Brinkhoff, 2001), (Leighton, 2002). At the local level a number of responsibilities may be transferred, including planning, finance, human resources, and service delivery operations maintenance.

The primary justification for the decentralization is that local organizations are in the best position to respond to service users' needs as client-centered care demands making the delivery of services part of local administration responsibilities, can also allow greater flexibility between the stakeholders at lower local level, efficiency and accountability in resource use. Furthermore, local control enhances the potential for community participation and involvement in financing of health care, which ultimately expand the resource base. However, experience with decentralization has been mixed and the principal lesson has been that local councils require time and patience. Using an example of Sri Lanka success Langet (2001) provided one example of a country that localized health services as early as 1952 when it transferred a limited number of responsibilities to districts and only in 1992 (40 years later) did the central government hand over full health care, to the districts. The success of the Sri Lankan problem is associated with the gradual setting up of

gradual support teams that provide technical support to the districts within the decentralized structure.

A number of issues often arise in decentralizing the health sector. For example many local entities lack technical managerial and financial skills needed to deal with their new responsibilities, for example in Senegal local leaders had participated in developing a district health plan and only about one in five officials had received any training before the transfer of power. Cases studies in Bangladesh Indonesia, Mexico, South Africa and Tanzania also found that human resources at the local level were poorly developed and unable to provide effective health services (Wilson, 2000). In Uganda where local government involved all sectors in the district administration it was initially believed that health services were already well funded, so the central government allocated money to other services, which caused a major problem is service delivery. The central government Ministry of Health responded to the problem by establishing district grants to ensure that priority programs were adequately funded and donors supplemented the grants with funding for key health programs. This response particularly helped Uganda to effectively cope with HIV/AIDS crisis.

Equity may also be considered a casualty of decentralization, since some locals jurisdictions are likely to have more resources than others, as was the case in Mexico. To ensure that certain services are available to the vulnerable populations, the local government can set aside or ear mark funds for health when transferring central funds to the localities, or it can use weighted formula to grant more funds to districts with higher concentrations of "at risk" or poor populations (Akin et al, 2001).

One of the most notable cases of equitable health service delivery is available in Cuba. The case of Cuba is unique when population health indicators are considered in relation to per capita Gross Domestic Product, for example Cuba's under 5 mortality rate of 11 for males and 8 for females is only

comparable to what is being achieved in developed countries like US (9,7) and Canada (6,7). The other unique case about Cuba is that the country has sustained and improved on these achievements in the face of economic crisis especially when the IMF advocated for reduction in public spending in the public sector to check on the rising budget deficits. It is a fact that Cuba was a main beneficiary of substantial economic assistance from the Soviet Union, but what makes it different is that Cuba invested heavily in the training of human resources to meet its health needs, and has today achieved the world' greatest physician to population ratio. According to the Harvard Public Health Review, (2002) another unique aspect of the Cuban health sector is the formal use of alternative and herbal medicine which can be accessible and affordable to majority of the people. The Cuban health systems also invests heavily on maternal and child health. There is also a strong emphasis on preventative as compared to curative methods of disease control.

2.2.4 Traditional Healers

Traditional healer services refer to the application of knowledge, skills, and practices based on the experiences indigenous to different cultures. These services are directed towards the maintenance of health, as well as the prevention, diagnosis, and improvement of physical and mental illness. Examples of traditional health service providers include herbalists, faith healers, and practitioners.

Traditional Healers play a significant role in a health system. In most cases, Traditional healers are usually informal, unrecognized by the government, and do not interact with the rest of the health system. Yet they can be a formal part of a system. For instance, in Nepal, there is a formal training program and a department of Ayurvedic Medicine within the Ministry of Health. Moreover, in China, practitioners of Chinese medicine are formally recognized. Populations throughout Africa, Asia, and Latin America use traditional medicine to help meet this primary health care needs. In Africa,

up to 80% of the population uses traditional medicine to help meet health care needs. In China, traditional medicine accounts for about 40% of all health care delivered. WHO: Traditional_Medicine (2003) notes that traditional healers are especially significant in developing countries because they are more accessible and affordable. In addition, they are more socially accepted as compared to formally trained health workers from the urban areas. In Uganda, the prevalence of traditional healers is 50-100 times more than that of allopathic providers.

The traditional healers are more affordable, especially for the poor. For example, in Ghana and Kenya a course of pyrimethamine/sulfodoxine anti malarials can cost several dollars, but herbal medicine for treating malaria is considerably cheaper, and the cost is often adjusted to the wealth of the patient. THs have also been shown to have greater leverage in treating illnesses where behavior change is needed (ie STDs) because they are often integrated and accepted in a community. Particularly, they are influential in reaching and changing the behavior of low-status, stigmatized patients, who often avoid public providers or are neglected by the public health system.

2.2.5. Multi Lateral Agencies

These are formed by more than one nation and include World Health Organization, UNICEF, UNFPA, IMF and World Bank.

2.2.5.1. World Health Organization (WHO) According to the official WHO website, the World Health Organization (WHO), headquartered in Geneva, Switzerland, is an international group of one hundred and ninety-one member states devoted to the maintenance and improvement of the health of all people throughout the world. Member states are divided into six geographic regions: Southeast Asia, the Eastern Mediterranean, the Americas, Africa, the Western Pacific, and Europe. The Director General of the organization

oversees the mission to preserve, maintain, and improve health through education, nutritional support, health activities, management of disease outbreaks, response to emergencies, and funding programs. It has had huge experience all over the world in seeking to ensure that the maximum number of people is able to access the services they need that is the availability of high-quality services. In the health sector reform WHO aims to assist in its member states to improve the health and quality of life of people. WHO promotes an effective health dimension to social economic environmental and development policy through dialogue with senior government officials, bi-lateral and multi-lateral agencies and advocate health as an integral part of development?

2.2.5.2. United Nations Children Emergency Fund (UNICEF)

Established by the United Nations General Assembly on December 11, 1946 and originally known as the United Nations International Children's Emergency Fund (UNICEF), the UN Children's Fund has employed three approaches in pursuit of its mandate - the emergency needs approach, the long range benefits approach, as well as a future agent for economic and social change. During the post war period UNICEF was providing food, clothing in addition to the health needs of the children and continued with this emergency approach as well conducting campaigns major diseases like malaria, leprosy and tuberculosis (Helborne, 2000). Today, UNICEF has adopted an approach of linking children issues to the overall development of the nation. In the past 5 years UNICEF has shifted its focus from service delivery to the provision of technical assistance, supplies and other resources. As a stakeholder it has offered new opportunities in the provision of administration of health programs. In Zimbambwe, UNICEF is facilitating a coordinated effort to the HIV/AIDS response by providing a basket funding mechanism for all the participating donors funding the civil society.

2.2.5.3. United Nations Fund for Population Activities (UNFPA)

The UNFPA is the UN lead agency for promoting and coordinating the population activities reproductive sexual health; maternal mortality; and adolescents' reproductive health needs. UNFPA plays an important role in coordinating in mainstreaming of health issues in national development agenda, for example in Mozambique UNFPA participated in the common county assessment (CCA) exercise initiated in December 1996 UNFPA played a vital role in ensuring incorporation of demographic and reproductive health issues into the analysis of the socio-economic situation in the country.

2.2.5.4. International Monetary Fund (IMF)

IMF is one of the most influential multilateral agency in the health sector financing. The institution provides funds in form of grants and loans with the condition that the recipient country meets requirements set out in the economic recovery, structural adjustment and poverty reduction strategy programs that it endorses. Such conditions include economic reform that either directly affect health care or indirectly affect health through the effect of economic change or welfare.

The IMF has endorsed the call by the UN secretary general for this global campaign in the fight against HIV/AIDS and is collaborating with other organs, most notably the World Bank, to expand country level HIV prevention aid treatment programs. Such programs are important components of many poverty reduction strategy papers which are prepared by low income country government in collaboration with civil society and development partners. PRSPs provide the operational basis for subsidized lending by the fund and Bank and for debt relief under the heavily indebted poor countries (HIPC) initiative. The IMF, in cooperation with the World Bank, is also helping poor countries to improve their public expenditure management systems and ensure that funds including those for all health programs, are used efficiently

and transparently. The IMF does not directly determine how much of a governments budget will be allocated to health, but it indirectly plays a role by imposing ceiling or the overall budget via its macro-economic policy conditions that promote restrictive rather than expansion of public expenditure, by its definition of what are on non discretionary, and discretionary expenditure.

2.2.5.5 World Bank

According the World Bank website, the original purpose of the World Bank was to organize development projects for reconstructing much of Europe after the war. But as Europe recovered, the organization turned its skills and attention to other countries needing development – mainly Latin America and Africa. With its overriding mission to eliminate poverty worldwide, the World Bank has exploded into a developmental powerhouse that supports a myriad of projects in countries all over the world. The World Bank is owned by 182 member countries and divides its responsibilities among five divisions. The main thrust of the Bank's work comes from the International Bank for Reconstruction and Development (IBRD). The IBRD provides loans and grants to middle and low income countries. The second division – The International Development Assistance (IDA) – focuses only on the world's poorest countries that are ineligible to borrow from the IBRD. Technical assistance and interest free loans are used to fight poverty. The International Finance Corporation (IFC) is tasked with promoting growth in developing countries. This arm of the Bank works closely with private business and investors to infuse developing economies with much needed private sector funds. The Multilateral Investment Guarantee Agency (MIGA) is the newest area of the Bank, having been created in 1988. MIGA supports the IFC by creating a security net for investors seeking to invest in high-risk developing countries. Knowing that some of their investment will be guaranteed by MIGA, investors are more willing to venture into these risky, but needy markets. Finally, the International Centre for Settlement of Investment Disputes (ICSID) seeks to

negotiate disagreements between foreign investors and developing countries. The ICSID is technically autonomous from the World Bank.

2.2.6. Bilateral Agencies

The key bilateral agencies in the health sector include USAID, DANIDA, GTZ and SIDA

2.2.6.1. US Agency for International Development (USAID)

USAID was established in 1961 and became the first U.S. foreign assistance organization whose primary emphasis was on long-range economic and social development assistance efforts. Freed from political and military functions that plagued its predecessor organizations, USAID was expected to offer direct support to the developing nations of the world.

The agency has overtime unified already existing U.S. aid efforts, combining the economic and technical assistance operations of the International Cooperation Agency, the loan activities of the Development Loan Fund, the local currency functions of the Export-Import Bank, and the agricultural surplus distribution activities of the Food for Peace program of the Department of Agriculture.

While some could argue that the creation of USAID simply represented a bureaucratic reshuffling, the agency, and the legislation creating it, represented a recommitment to the very purposes of overseas development. USAID was established to unify assistance efforts, to provide a new focus on the needs of a changing world, and to assist other countries in maintaining their independence and become self-supporting.

USAID health program helps create a better environment for countries through support community family and individual action while strengthening services and scaling up key public health interventions , activities concentrate

on five major areas; malaria prevention and maternal health and health systems strengthening; significant expansion of HIV/AIDS prevention, and treatment activities with resources.

The world's governments adopted a program for action under the auspices of the United Nations–Agenda 21, (Earth Summit, 1992) which included an Official Development Assistance (ODA) aid target of 0.7% of gross national product (GNP). However, US levels for foreign aid fall short of this goal (the US currently ranks last among the world's wealthiest countries at about 0.1 percent of GNP.) However, in absolute amounts, the United States is currently the world's top donor of economic aid.

2.2.6.2. Danish International Development Agency (DANIDA)

Danish International Development Agency (DANIDA), is a Danish organization inside the Ministry of Foreign Affairs of Denmark, set up to provide humanitarian help and assistance in developing countries. Since 1995 DANIDA has played a central role in the transition to decentralized system in Kenya in the development of the health policy framework implementation and action plan issued in February 1996. Although Danida is strengthening capacity to implement the health sector reform at the district level in three northern districts, most mechanisms for managing and financing the health sector are being transformed or finding their own local modalities. Financial irregularities in some components of the health sector reform have led to delays or to a general freeze in disbursements to the detriment of overall progress.

2.2.6.3. Swedish International Agency (SIDA)

According to SIDA website the overall goal of Swedish development cooperation is to contribute to making it possible for poor people to improve their living conditions. By reducing injustices and poverty throughout the

world, better opportunities are created for development, peace and security for all people and nations. In an increasingly globalized world we are all dependent on, and affected by, each other. Not all Swedish ODA is channeled via Sida. Of Sweden's total budget for development cooperation in 2005, SEK 14 billion, or 55%, was channeled via Sida. Other major Swedish actors in the field of international development cooperation are the Ministry for Foreign Affairs and the Export Credits Guarantee Board. Sida works on behalf of Sweden's Parliament and Government to reduce poverty in the world. Its activities range over many areas. Sida has more than 120 partner countries in Africa, Asia, Latin America, Eastern Europe and Central Asia. Sida has in-depth programs of cooperation with some 50 of these countries.

Projects implemented by SIDA are in the fields of education, health, private sector development, and housing, rule of law, research, infrastructure and trade. There is a large budget for emergency assistance for people affected by wars or other disasters. Poverty has many aspects and requires different solutions.

2.2.6.4. German Society for Technical Cooperation (GTZ)

The GTZ is an international cooperation enterprise for sustainable development with worldwide operations. GTZ promotes complex reforms and change processes, often working under difficult conditions. Its corporate objective is to improve people's living conditions on a sustainable basis. As an international cooperation enterprise for sustainable development with worldwide operations, the federally owned Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH supports the German Government in achieving its development-policy objectives. It provides viable, forward looking solutions for political, economic, ecological and social development in a globalized world. Working under difficult conditions, GTZ promotes complex reforms and change processes. Its corporate objective is to improve people's living conditions on a sustainable basis.

GTZ contributes to human resource development in diverse ways ranging from support for strategic human resources planning as part of a health system's approach, to capacity building and technical assistance in many related areas such as which health cadres it makes most sense to invest in, to supporting closer collaboration between public and private health providers. The later may seem an unlikely area for an important contribution to HRD to be identified. However, in many countries where the German Development Cooperation supports the health sector up to 50% of service provision and a significant proportion of health staff training may be undertaken by non-state actors – religious associations, non-governmental organizations, foundations or private practitioners/colleges. By facilitating improved communication between private and public actors a contribution to the streamlining of wages and conditions is made. This can, in turn, result in a stronger, complementary effort towards wider health care provision.

2.3 Financing Mechanisms in the Health Sector

This section explores the various types of financing mechanisms in the health sector and highlights the strengths and shortfalls of on and off budget support including sector wide approaches (SWAPs) and basket funding, taxation and central government resource allocations as well as private schemes that range from user fees, national insurance schemes and community health financing mechanisms (WHO, 2000) and (Ravindran, 2002)

Despite demonstrated efforts to increase allocations to health as part of the priority sectors, world's financing of the health system remains far from the sectors needs. External resources remain in order, and there is need to further consider alternative sources of funding. Indeed the current status of user fees remain marginal, and unhappily in almost all the less developed countries, donor support to health sector equals governments own efforts.

Secondly despite a sharp increase in donor support the health sector financing gap remains significant. Total allocations to the health sector is less than the mandatory 15% (Abuja Declaration, April 2000)

2.3.1 On Budget Support.

Budget, which is an estimate of an entity's revenues and expenditures in a given period is an important tool of decision making and management control. Entities both in private and public conduct budgeting sessions as an annual ritual and the government is no exception. Ideally, all revenues of a particular entity including the central and local government should be reflected in the annual budget.

On budget support (also referred to as basket funding) is a form of quick-disbursing program aid which is channeled directly to partner governments, uses local accounting systems and is linked to sector or national policies rather than specific project activities. It aims to promote pro-poor growth through encouraging fiscal stability and more equitable and efficient allocation and use of public funds. It offers the potential to address key cross cutting issues such as public sector reform, gender, and the environment in ways that aid instrument, and also seeks to make maximum use of local capacity. However the budget support in most countries it is by world fronted by influential agencies like Word Bank, International Monetary Fund (IMF) and the experience has not been very popular due to the alien finance discipline regimes that go with the support. Some key bilateral donors like USAID are not able to channel their financing efforts through budget support citing strict home office rules and regulations that preclude them. Despite the proven advantages of budget support it appears the host governments require to embark on financial management practices that promote transparency and accountability in the utilization of available resources to ensure that all the expected advantages of on budget support are realized.

2.3.2 Off Budget Support

This support is provided parallel to the government accounting system mostly by donors who prefer to allocate the resources to the projects rather than putting it in the basket funds. It is usually an option for the donors whose home office precludes them from participating in basket funding mechanisms perhaps due to doubts raised on the transparency of the government procedures and accounting systems. In some cases this funding comes after signing of Memorandum of Understanding that spell clearly the areas of support and reporting procedures. In most cases the funds may be disbursed to the civil society.

2.3.3. Sector Wide Approach (SWAPs)

In countries where donors have agreed to pool their resources for a specific sector this process is often guided by a so-called sector wide approach (SWAPS) which are expected to address problems of duplication and fragmentation of funding efforts with a view increasing aid effectiveness, and establish greater coherence between policies, programs and budgets.
SWAP is first and foremost a policy co-coordinating mechanism and not a financial mechanism, thus in principle SWAP applies to budget as well as project funding arrangements even if they many times seen as primary a management tool for disbursement and accounting funds. SWAP covers public funding for the sector including project type aid, technical assistance earmarked funds and pooled funds.

According to studies by WHO (2003), SWAPS provide an improved diagnosis of barriers to service utilization and improvement, including better understanding of corruption and incentives problems, SWAPS also help to create common procedures for planning, disbursement accounting, audit and review which can help reduce the costs of dealing with donors, and increase

coherence of programs; also studies by UNFPA indicate that SWAPS place government squarely transparency of resources use, improve accountability, and achieve more value for money. (EC, 2003)

2.3.4 Private Insurance.

The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, early health insurance was actually disability insurance, in the sense that it covered only the cost of emergency care for injuries that could lead to a disability. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance. Patients were expected to pay all other health care costs out of their own pockets, under what is known as the fee-for-service business model. During the middle of late 20th century, traditional disability insurance evolved into modern health insurance programs. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this was not always the case.

Private health insurance in Canada cannot cover health coverage provided by the universal Medicare provided by the government. Private Health Insurance in Canada covers for example semi private or private rooms in hospital which is not covered by Medicare. Private health insurance provides drug plans. Private health care cannot cover Physician fees which are covered by Medicare. Private sector services not paid for by the government accounted for nearly 30 percent of total health care spending [Canadian Institute for Health Information: National Health Expenditure Trends, 1975-2003, (2003)].

The most successful private insurance company in East African region is the Africa Air Rescue (AAR). Many argue that AAR is a paradox of private insurance because in most cases the patient is required to attend AAR

designated clinics, which may offer quality below the expectations of most clients.

2.3.5 National Health Insurance Fund (NHIF)

A national health insurance scheme refers to a medical scheme offering universal coverage to all the citizens. Although countries like Kenya and Tanzania have the NHIF scheme in practice the universal coverage is not available for people living in poverty. The link between sickness and poverty cannot be broken.

Japan is one of the developed countries that has a national health insurance scheme that is publicly managed. The case is of Japan is unique because the system was developed before Japan entered a period of advanced economic growth, therefore, the example is useful to developing countries. There are several preconditions towards the successful implementation of the universal insurance scheme and three of them are: strong political will to provide universal health care, the second is the wholesale merger of the municipal governments that took place during the Showa era of 1926 -1989, and finally the incremental approach that took 23 years to fully accomplish universal coverage.

2.3.6 Community Health Insurance

Community Health Funds CHF's as a form of community based health insurance CHF's or community Based Health Insurance Schemes CBHI are often mentioned as the solution for the problems generated by use fees.

Community based health schemes where they have been operated successfully have offered benefits to the poor. However the very poor require special arrangements to enable them the access benefits under the scheme e.g. subsidies from the government or higher income scheme members a few

schemes have effectively implemented these arrangements to a recent study (Bennet, 2004) emphasize that there is actually very little understanding of how community based health schemes interact with other elements of Health Care financing scheme.

2.3.7 User Fees

User fees and cost recovery systems are one of the outcomes of the IMF and WB sponsored structural adjustment programs. Under this method, health ceases to be a basic right and becomes a commodity to be traded which can be denied to others who cannot raise the user fees required.

2.4 Challenges and Weaknesses in Donor Financing Mechanisms

This section provides an overview of the main challenges and weaknesses in donor financing mechanisms including the system of drug donations which have faced unique problems because they provide a short term solution to the drugs shortages and is not a sustainable mode (Alain Guillox, MSF, 2001). Drug donations also ten to distort rational drug use and hamper the growth of the generics industry. MSF believes that there is crucial need to convince policy makers to focus on policies towards more sustainable solutions.

2.4.1 On Budget Support

Issues related to transparency in disbursement and reporting are the main obstacles hinder the donor funding for the health sector under the budget support mechanism. Another challenge relates to the allocation between service delivery and administration. In most cases donor funds provided through the budget support may end up being guzzled by the high administrative costs and salary payments. This is a common situation when the health sector is operating in a budget deficit. Funds channeled through the budget support will likely end up meeting the outstanding bills.

Bureaucracy within the government system is also cited as an obstacle by donors who shun the budget support mechanism.

2.4.2 Off Budget Support

As highlighted earlier in this study the main shortcoming of this mechanism is that it will most likely result in duplication and fragmentation of funded activities especially if the central coordinating mechanism is weak.

2.4.3 Sector Wide Approaches (SWAPs)

(Janorsky, 1998) have identified challenges and concerns in relation to SWAPS from the perspective of donors, particularly those related to finding recurrent expenditure and in certain instances risk being associated with corrupt and unproductive spending. For governments, the increased transparency inherent in a SWAP can decrease their ability to accommodate political pressure to spend outside an agreed program. They also highlight that separate donor funding has traditional been seen as the best way of protecting spending on programs that address major causes of ill health such as malaria, HIV/AIDS and Tuberculosis, SWAP could serve to compromise, the priority given to these activities or the technical quality of the programs (Jeppson , 2002).

One of the shortcomings raised by donors in relation to the SWAp approach is that it diminishes their capacity fund sectors of their preference, and in other circumstances some of the less influential bilateral partners find themselves funding sectors which fit the agenda of the more influential partners.

2.4.4 Private Insurance

One of the most commonly advanced shortcomings of the private insurance schemes is that they discriminate against the poor. For instance policy holders are still required to pay a deductible before they can claim any expenses from the insurance company. Usually there is also a maximum out of pocket payment for any single year.

The private insurance also has a disadvantage of adverse selection and ex post moral hazard. This relates to the facts that only the unhealthy will opt to take the private insurance due to the strict regimes, while the moral hazard refers to the state of mind and change in behavior that results from a persons knowledge that if something wrong would happen, the out of pocket expenses would be mitigated by the insurance policy, which in actual fact provides reduced prices for the medical care.

2.4.5 National Health Insurance Fund (NHIF)

These also have proven to be insufficiently providing the services. A key concern moving towards social Health Insurance is that it creates a two – tier Health insurance. Kutzin (1998) argues that given the small size and relative privilege of those in the formal sector in African countries compared to the majority of the population health insurance systems would serve to enhance inequalities. He points out in Burundi, a compulsory social insurance scheme for civil servants, members of the armed forces, employees of parastatals and Universities and their dependants was the cause of great inequalities in the use of Government subsidies for health.

2.4.6 Community Health Financing (CHF)

The Community Health Insurance system is a health insurance system which facilitates the households to build reserves for meeting their health needs

when they can afford especially during the time of harvests. CHFs are often mentioned as the solution for the problems generated by user fees (Munga et al, 2004). CHFs schemes, where they have been operated successfully, have offered benefits to the poor, however, the poor require arrangements like subsidies to fully benefit from the schemes.

It is expected that CHFs will enhance equity in the modern health sector and thus will contribute significantly to quality improvements in areas such as the availability of drugs. Effective implementation of payments schemes requires a strong decentralized structure. A recent paper on CHFs (Bennet, 2004) emphasizes that there is limited understanding on how the schemes interact with other elements of health care financing schemes. CHF schemes differ markedly in terms of their ownership structures benefit package composition and membership and it has been aid that some countries have multiple risk pooling schemes meaning that the CHF runs parallel with other social security schemes.

2.4.7 User Fees

Two broad based models of user fees systems have been implemented in the African countries: the standard model and the "Bamako Initiative (BI) model" (Gilson, 1997). There is a wide range of different user fees payment systems: flat fee or differentiated fee; fee per episode or fee per item of service; prepayment or payment per time of use (Price, 2002).

One of the glaring weaknesses in the user fees model is the breakdown in the system of waivers and exemptions. In the user fees financing mechanism there is also the weakness in design of standard costing, accounting and exemption procedures. The degree to which the financing system is pro –poor depends on how the different mechanisms interact (Gilson , 2001). Systems appear to represent weak mechanisms for improving the efficiency of utilization, and may rather promote inefficiencies in providing behavior. Also

revenue generation from any fee system is unlikely to be adequate in addressing the large and growing gap causing nationwide quality shortfalls that exist in most African counties. Fees need to be complimented by a broader range of actions, if they are to enhance the sustainability of health systems (Gilson 1997.

Most of the reviewed literature [(Gilson, 2001), (Turbat, 1995), (Kutzin, 1999)] expresses a strong concern that safety nets tend to protect the poor insufficiently from the adverse impacts of user fees case studies in Kenya indicate that in 1999 waivers rarely exceeded two persons per month while 42% of the population was living below the poverty line. It was found out that 80% on in patients and 86% of out patients were not aware of waivers and exemptions (Owino, 1998 and 1999). Also according to UNICEF and Barton the performance of exemption and waivers is seldom evaluated. This is considered as a major weakness as the consequences cannot be assessed and policies cannot be adjusted.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction.

This chapter outlines the strategies and techniques that have been used in the gathering of the information and interpretation of data and reaching at conclusions. It lays down the procedures, tools and techniques that have been used to establish main constraints. This chapter therefore, takes into account the assumptions and values that have served as a rationale for this study, and also provide details that have enabled an independent validation of the chosen criteria as well as the established data.

3.2 Research Design.

Efforts to tackle the major diseases affecting developing countries like Tanzania have been poorly co-coordinated and financed, resulting in fragmented programs at country level. The most appropriate research strategy to study the challenges in health sector financing are a combination of literature search and in depth interviews with representatives from key stakeholders in the public private partnership, that is the government both at the central and local level, the private sector, both the private for profit and private not for profit, as well as donor agencies and respective international and national NGOs. The perspective from the vulnerable groups also needs to be considered. The literature study included a review of key publications in the field of health sector financing especially from multi lateral agencies like World Health Organization, World Bank and IMF. This included an extensive review of diverse experiences in countries all over the world as well as a review of specific experiences in Tanzania. The study also employed a situation analysis involving document analysis of previous case studies conducted in the republic of Tanzania. However, this strategy was

strengthened by interviews with key informants especially in the government and the NGO sector.

This study relied basically on qualitative and descriptive research design which, sought to explain and expose the problem that hinder public private partnership in the utilization of resources in the health sector in Tanzania. This is indeed essential in analyzing the financing mechanisms vis-avis the problem in resource allocation as well utilization. The methodology is historical and analytical - historical in the sense that it looks at historical evolution of donor financing trends from the 60s through the millennium. The methodology is analytical in the sense that it exposed the issues specific to individual donor ideologies and interests which contribute to the problem of allocation and utilization of funds in the health sector. Lastly, the methodology was deductive in that it construed the meaning and applicability of issues from the available facts. Conclusions and recommendations were then made on the various financing mechanisms

3.3 Study Population

Stake holders in financing mechanisms have four components depending on interests – there are those whose interests are on design of financing mechanism others on policy formulation while others have interests in implementation and/or evaluation. The survey population is drawn from the central government and donors (representing stakeholders in design and policy formulation) local government and NGOs (representing the implementers) while evaluation process involved all the stakeholders because they all have an interest on issues of best practices and lessons learned which may be used to inform future processes.

3.4 Sample Size

This ideal practice is to obtain information from the entire population to ensure maximum coverage of the population concerned in the research. (Kakoza, 1996: 11) states, "Ideally the whole population should be used to get information for the research". However, due to resource limitation the entire population of this research could not be covered and a sample population of 120 people was considered appropriate to carry out the study. According to Bailly (1987:83), a "sample can be highly accurate if done with care". Considering the limited resources in terms of finance and time because of the geographical scope of the study, data was collected from the selected sample of 120 respondents which comprised the total sample of the population under study. According to Duttolphy et al. (1986:138), "if the sample is selected properly, the information collected about the sample may be used to make statements about the whole population". Therefore, a reasonable sample of 120 respondents was selected to represent the whole population.

3.5 Selection of Respondents

The population was clustered along the three key stakeholder interests namely donors and host government (representing design and policy formulation cluster), NGOs and Local Governments (representing implementation cluster) and all the four, that is donors, central government and local government officials and NGOs representing policy evaluation cluster. A sample of 40 was selected from each cluster based on the researcher's own discretion. The selection of the NGOs was done from the directory published by the government, which is considered as an official record of all the NGOs operating in the country.

3.6 Data Collection Methods

There were two levels of data collection; mainly through literature searches and interviews conducted through a standard questionnaire. Data collection involved examination of historical and other records and documents for obtaining secondary data. This was obtained from libraries, internet sources and key publications from the Ministry of Health, Tanzania. This provided the information that was required in the study.

The questionnaire was the main device for collecting primary data and formulation of the questionnaire was focused on the four key financing mechanisms – Tax Financing, National Insurance Schemes, Private Insurance Schemes, and User Fees.

3.7 Data Analysis and Presentation.

Data collected from different categories of respondents was placed in different files and assigned identification mark for ease of analysis. Editing and coding was also done to segregate items misunderstood by respondents or to monitor the accuracy of responses. Editing was done with care to avoid distortion of data from the respondents. . The data was then calculated in percentage form and tabulated for clear presentation and further analyses. The criteria for the interpretation of results included the conceptual framework as detailed in the research questions and objectives.

CHAPTER FOUR
DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

By drawing reference to the literature review relating to the rest of the world as well the primary results of the study in the republic of Tanzania this chapter provides an analysis and interpretation of the data. The analysis is structured along the specific research questions and therefore focuses on the role of the stakeholders in financing the health services, the various financing mechanisms in the health sector, weaknesses in each of the finance mechanisms as well as an overall assessment of the adequacy in which the donor funds are utilized.

4.2. Role of Stakeholders in the Health Sector.

The key stakeholders in the health sector financing in the republic of Tanzania include the public-private partnerships, government, at central and the local government level, bilateral and multi lateral development agencies, private for profit (including practitioners) and not for profit (for example NGOs, FBOs), and national and international research agencies.

Due the major policy shifts during the period of the study, the stakeholders in the health sector in Tanzania have assumed different faces at different periods. For example, prior to independence, the health sector was dominated by the private sector and services, which were curative in nature, were concentrated in the urban areas. After the 1967 Arusha declaration, the government assumed overall responsibility for the provision of health services in partnership with the private not for profit. Private not for profit facilities were required to practice in partnership with private not for profit facilities. With the advent of the structural adjustment programs in the 80s the private sector became more emphasized after the introduction of the IMF and World

Bank Structural Adjustment Programs which were characterized by cost sharing schemes in form of user fees, national health insurance and community health insurance schemes. This bitter experience followed a period of severe under funding that had led to shortages in supplies and drugs, deterioration of facilities, low staff morale and poor quality of care (MOH, Tanzania, 1998). It is within this background that the Health Sector Reform was formulated and consequently the healthcare in Tanzania is today provided by a mixture of government, private for profit, private for profit including traditional healers and company hospitals and private not for profit (mission hospitals)

4.2.1 Public Private Partnerships (PPP)

As noted in the 3.1 above, the first formal public partnership evolved immediately after the Arusha declaration when the government partnered with the private not for profit to implement the new policy of free medical service for all. However, according to Itiku (2006), the PPP philosophy as well as policy framework in public service delivery appeared in the government policy in the mid 80s but more prominently in 1990s through 2000s as part of government reforms to improve public service delivery including health. The health service delivery in Tanzania is provided through a decentralized three tier pyramidal system, that is, national, regional and district levels (MOH, 2003). The central Ministry of Health is responsible for policy, governance and financing and quality assurance while the President's Office Regional Administration and Local Government is the implementer. At the national level, the executive boards manage the hospitals. At the regional and district levels there are regional and council Health Boards respectively where private health providers have representation.

The most recent study on PPP in health service delivery which was commissioned by the Ministry of Health and President's office Regional Administration and Local Government (MOH/PORALG), 2005 and the Tanzania Joint Annual Review, MOH, 2005 and both have jointly recommended many

areas that require thorough study under the umbrella PPP. The reports have indicated that so far there is inadequate knowledge on the extent to which stakeholders involved in PPPs in health service delivery have benefited or may have not benefited.

The PPP in Tanzania has evolved depending on the specific gaps identified. It may start as simple cooperation, between the government or government organ and the private sector for example when the government invites the business community to contribute to revision of bye laws to regulate service delivery mechanisms in a strictly advisory nature. In the case of joint ventures, the government and the private sector assume joint responsibility for overall delivery. The importance of private sector in health service delivery and the move towards market based economic reforms resulted in the establishment of Private Hospitals Amendment Act of 1991 which re establishment of private medical and dental services with the approval of the Ministry of health in 1991 (Wyss et al, 2000)

Performance indicators and outputs for assessing public private partnerships in health service delivery in the country were developed by the Ministry of Health (MOH) in the year 2000. The performance of PPPs was expected to go through the following timeline:

a) Policy and Legal Review to be completed by 2001

b) Mechanisms for promoting PPPs discipline by 2002

c) Guidelines to enable private providers qualify for government support in place and operational by 2002

d) Mechanisms for Joint Inspection of health facilities in place by 2002

It has been argued that health problems in Tanzania today require global solutions but little is known about the effectiveness of the partnerships. According to the literature reviewed (IPPPH, 2002), some of the areas that require attention include:

i. Roles and responsibilities of all partners involved should be specified in the very earliest stages of the program.

ii. Realistic goals and commitments should be specified to ensure program is likely to have an impact.

iii. To ensure transparency and adherence to national program objectives, partnerships should be strengthened or integrated within existing government frameworks.

iv. Regular communication is essential between all players at all levels in order to hold partners accountable for their actions and improve program performance.

4.2.2 Central Government

According to the Ministry of Health Statistics Abstract, (1999) the government provides more than 60 per cent of the facilities Health service network and coverage is better in Tanzania than in any other sub Saharan African country. However, the quality of services and therefore use is very low (Shiner, 2003). The infrastructure is poorly developed and the intended system of referral is often bypassed. A regular supply of the drugs available is at government health facilities remains a problem. **Table 4.1** highlights the trend in allocation and budget execution to the health sector. Apart from the recurrent expenditure, associated to referral abroad, the budget shows an increasing trend in line with the government's commitment to improve the funding allocation to the health sector.

Table 4.1 Tanzania: Health Government Budget Execution

Budget Allocations Between Recurrent and Development

Tsh billion	1997/98		1998/99		1999/00		2000/01
	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Recurrent	46.89	46.82	62.21	62.18	6073	57.99	75.79
Development	2.88	2.56	2.16	0.92	3.86	1.94	4.18
Total	49.77	49.38	64.37	63.1	64.1	59.93	79.97

Source: MOH/SDC 2001, Public Expenditure Review Health Sector in Tanzania.

However a further breakdown of the recurrent expenditure between personnel emoluments and (PE) and other charges (OC) over the last three years conforms the weight of the 67,000 workers wage bill which absorbs at least two thirds of the total recurrent expenditures as demonstrated by **Table 4.2**

Table 4.2 Tanzania: Health Government Expenditure breakdown

Period and Allocation Between PE and OC												
Tshs	**1997/98**				**1998/99**				**1999/00**			
Billion	PE	OC	Total	%	PE	OC	Total	%	PE	OC	Total	%
MOH	1.96	1.06	3.02	7	1.97	1.74	3.71	6	2.61	1.25	3.86	7
Hospitals	19.45	8.74	28.19	60	21.68	17.12	35.8	62	23.93	10.69	34.62	60
PHC	9.9	5.71	15.61	33	11.79	7.88	19.67	32	11.89	7.62	19.51	33
Total Recurrent	31.31	15.51	46.82	100	35.44	26.74	62.18	100	38.43	19.56	57.99	100

Key:

PE – Personal Emoluments OC – Other Charges PHC – Primary Health Care

Source: MOH/SDC 2001, Public Expenditure Review Health Sector in Tanzania.

4.2.3 Local Government

Tanzania's decentralization model is unique due to the socialist historical background and subsequent reforms carried out to date. Since the reintroduction of a system of local government in 1982 local government has played an important role in the delivery of services, providing such key government services such as primary education, basic health care and other government services that are generally considered to be typical "local"

services. However a main concern in the assignment of expenditure responsibilities in Tanzania is the limited level of discretion that local government have in implementing their responsibilities; local governments are substantially constrained in responding to local needs due to the presence of inflexible central government

4.2.4 Urban Councils

Although the health system in the urban centers is more developed than in the rural areas, it should be observed that health problems in the urban centers are tremendous. For example the rapid urbanization in Dar es salaam is a typical example of the rapid urbanization in Africa and reflects the epidemiologic transition, with the emergence of chronic diseases as well as the prevailing problem related to the infectious diseases arising from declining levels of public health for example poor sanitation an unavailability of clean water. The urban councils are in charge of delivery of service at the ward level, and emphasis is put on decision making or local initiatives are of greater importance because they help in the provision of drugs to the people at the lowest levels. They also have responsibility of implementing council decision and the day to day running of affairs not only this but also mandated to see how hospitals, clinics, ambulances, maternity and child welfare, prevention of air and land water pollution public private partnership.

4.2.5 Bilateral Agencies

The most prominent bilateral agencies in the health sector in the republic of Tanzania include USAID, DANIDA, CIDA and GTZ.

4.2.5.1. US Agency for International Development (USAID)

USAID/Tanzania's Health Program is improving the health of Tanzanian families by reducing infant and child mortality, improving reproductive health

standards for women, and accelerating the downward trends in fertility. USAID is involved in:

USAID supports the Tanzanian Government in defining a basic healthcare package and establishing quality standards for health service delivery and training. By promoting partnerships between non-governmental organizations, community based organizations and district councils, programs strengthen the quality of child and prenatal healthcare services. Tanzanians are learning what to expect from service providers, how to demand quality services, and the importance of rewarding good service.

4.2.5.2. Danish International Development Agency (DANIDA)

Denmark under DANIDA has supported Tanzania's health sector for several decades since 1996 as sector program support. In accordance with the government's decentralization reform and health sector strategy DANIDA is channeling an increasing proportion of funds as sector budget support through basket mechanisms The fight against HIV/AIDS, which is one of the biggest tasks for the health system, receives substantial support directly from a number of donors. The Danish-funded health sector program does not exclusively earmark funding for this, but contributes by strengthening key systems necessary for its success, such as drug delivery, hospital management and quality of district services. In addition, districts can access support for specific activities in this field under the demand driven sub-component.

4.2.5.3. Swedish International Development Agency (SIDA)

The agency has provided tremendous to Tanzania not only in providing funds but also by supporting the development of donor coordination mechanisms. SIDA supports the Tanzania HIV/AIDS Care and Treatment Plan (CTP), which is developing the country's health sector to give it the capacity to cope with the strain caused by the epidemic, and improving access to anti-retroviral

medicines to all poor people in need. SIDA also supports the Rapid Funding Envelop, a fund that makes contributions to local organizations active in HIV/AIDS prevention

4.2.5.4. German Society for Technical Cooperation GTZ)

Tanzania is a priority partner country for German Society for International Cooperation. Since 1975, GTZ has been active there on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ).

Among the country's most pressing problems are a weak public administration, corruption in many areas and underdeveloped civil society structures. Efforts are also being undertaken to strengthen the PRSP especially in the filed of the Health Sector Reform.

4.2.6 Multi Lateral Agencies

The most influential multilateral agencies are International Monetary Fund (IMF) and the World Bank. Other actors include WHO, UNICEF and UNIFPA.

4.2.6.1. IMF AND World Bank.

Despite the occasional rocky relationship that the Tanzania government has had with these institutions, the economic crisis of the 70s and the rising debt in the 1980s forced the country to accept the conditions they demand and embrace their agenda. When Benjamin Mkapa became president in 1995 he embraced the World Bank and IMF policies and opened the doors of the Tanzania economy and health sector to foreign investment and restructured the enterprises, most of which have now been privatized.

The World Bank finances several health sector policy projects in Tanzania: the funds provided are used to increase infrastructure, strengthen capacity to implement policy and enhance the role of the private sector. The World Bank was responsible for popularizing the user fees concept as it perceived them to

be the mainstay of health sector reform and a mechanism for other financing options such as health insurance. These two components therefore featured prominently in the structural adjustment programs and were introduced by the World Bank in Tanzania in 1993. However, they failed to raise the revenues and improve service quality and though still included in Tanzania poverty reduction strategy plan, the World Bank has acknowledged that user fees will probably worsen the welfare of most households (Mwabu, 1995). The World Bank is now funding projects that explore alternative financing mechanisms, including community health Fund and National health Insurance Fund. It also supports the private sector, a recent feature of the health sector reforms.

External organizations have driven most reforms in the health sector. Thus far, they have succeeded in creating an essentially market driven system with few safeguards for the poor, and inadequate population coverage of high quality medical services. The expansion of the private sector is progressing at an exceptional pace; an issue of concern since there is very little capacity to monitor and regulate its effect; and it seems likely to result in further inequity.

4.2.6.2. World Health Organization

The WHO Programme provides support and technical assistance to national control programs. A network has been established including donor countries, private foundations, NGOs, regional institutions, research centers and universities to participate in surveillance and control, and to undertake research projects for the development of new drugs and diagnostic tools. According to the WHO website in Tanzania, the objectives of the WHO Programme in Tanzania are to:

a) Strengthen and coordinate control measures and ensure field activities are sustained;

b) Strengthen existing surveillance systems;
c) Support monitoring of treatment and drug resistance through the network;
d) Develop information database and implement training activities.
e) Promote inter-agency collaboration with the Food and Agriculture Organization (FAO) and the International Atomic Energy Agency (IAEA). This agency is dealing with vector control through flies males made sterile by radiation. In addition there is a joint Programme Against African Trypanosomiasis (PAAT) including WHO (human health), FAO (animal health) and IAEA (vector control).

4.2.6.3. United Nations International Children Emergency Fund (UNICEF)

The Tanzanian government has developed a new national poverty-reduction strategy that reflects the UN Millennium Development Goals. UNICEF successfully advocated for an emphasis on the rights and participation of young people, gender equity and the fight against HIV/AIDS.

In the refugee camps, UNICEF helps care for more than 70,000 pregnant or breastfeeding mothers and more than 100,000 children under age 5, providing immunization and other medical care. UNICEF has also provided school supplies and teaching materials for more than 130,000 primary-school aged refugee children.

UNICEF supports the Ministry of Health's immunization program, which now reaches more than 90 per cent of Tanzanian children. Vitamin A supplementation and de-worming have been added to the biannual immunization program. Maternal neonatal tetanus has been nearly eliminated and the number of measles cases has dropped dramatically.

In two pilot districts, UNICEF has controlled malaria by distributing insecticide-treated bed nets to pregnant women and infants. The program's success has prompted the government to launch a similar effort

on a national scale. At least 85 per cent of households now use iodized salt in 2004, up from 68 per cent in 2002. A successful UNICEF-sponsored pilot program in preventing mother-to-child transmission of HIV has led to the development of national guidelines for medical care.

UNICEF has worked closely with the Tanzanian government to develop a national policy to protect orphans and other vulnerable children one can assert that UNICEF has improved the health sector in the united republic of Tanzania.

4.2.6.4. United Nations Population Fund for Population Activities (UNFPA)

UNFPA assistance to the Government of Tanzania dates back to 1971. The 2002-2006 Country Programs (CP), representing the fifth cycle of assistance to Tanzania, contributes to the following national outcomes: increased utilization of quality sexual and reproductive health services and information; effective implementation of population and development policies and programs; and the enhancement of gender equity and equality and the empowerment of women.

4.2.7 Private for Profit

For a period of almost thirty years, since the Arusha declaration, delivery of health services has been largely a prerogative of the state, only a limited number of private-for-profit health services were provided in major towns of the country. After independence, health care facilities were re-directed towards rural areas and free medical health services were introduced. In 1977 private health services for profit was banned under the Private Hospitals (Regulation) Act and the practice of medicine and dentistry prohibited as a commercial service. This Act had negative implications on health services in the country.

However, after a series of major economic and social changes, the government adopted a different approach to the role of private sector. New policies were developed that looked favorably on the role of the private sector. The importance of the private sector in health care delivery was further recognized with an amendment to the Private Hospitals (Regulatory) Act, 1977 which resulted into the establishment of the Private Hospitals (Regulation) (Amendment) Act, 1991. Following this act, individual qualified medical practitioners and dentists could now manage private – hospitals, with the approval of the Ministry of Health.

The private for profit sector makes approximately 18% of the health facilities in Tanzania. The distribution of Health Facilities has a heavy rural emphasis because more than 70% of the population lives in rural areas. Plans for the establishment of health facilities have in the past taken into consideration the facility/population ratio (in line with Arusha Declaration of 1967), but with time this has in some areas been seriously overtaken by the high population growth-rate.

4.2.8 Traditional Healers

Traditional healers in Tanzania are known as Waganga wa jadi ('traditional doctors") play a major social and medical role. The knowledge of traditional healers is passed on from one generation to another. The practitioners are consulted about a huge variety of problems. Some of the healers will treat as many as seventy different ailments (Ntemi, 1995) ranging from malaria to good luck medicines. Patients also receive scarification cuts into which medicines are placed for good luck or for curing the affected body. The traditional healers rely on the forest reserves to gather forest products and this indicates that they must be considered as stakeholders in the management of forest resources to ensure their resource base is sustained for them to keep on playing a key role on the provision of health services.

4.2.9. Private Not For Profit

The government has been the main provider of health services even before Tanzania became independence. However, the private sector has been in existence even before the colonial era. The traditional healers and birth attendants were the main providers of health care at that time. During the colonial era, the private providers of health services included the non-government organizations – mainly religious organizations and the voluntary agencies. These religious organizations were and are still categorized as "private not for profit" providers of health services. The other category of private providers of health services are those who provide health services for profit. This category of providers of health services have been in existence since the colonial period.

This arrangement in providing health services continued after Tanzania had become independence. After the Arusha declaration in 1967, there were reforms in the health sector. It was no longer accepted to trade/make profit using human health. The government was convinced that with the help from the "private not for profit" it could provide the required health services to all the people. In 1977, the private for profit were effectively banned from practicing. However, there was a provision that they could continue providing health services if they were operating under the umbrella of religious organizations belonging to the private not for profit category. Many of the "private for profit" providers of health services opted for this only alternative. Their hospitals and first line health facilities were then registered under the auspices of religious organization.

4.3 Financing Mechanisms in the Health Sector

The financing mechanisms in the republic of Tanzania can be classified into four main categories today: Budgetary funding (domestic and external), Private Insurance Schemes (eg AAR) and the Cost Sharing Mechanisms (National Health Insurance Fund, User Fees and Community Health Financing)

4.3.1 Budgetary Funding.

Domestic and external budget financing currently contributes most to the resource envelope for the health sector in Tanzania, with significant rise in 2004 and 2005. The per capita budget support 2004/5 was USD 7.45 while the allocation for the previous financial year was USD 5.71 both low in relation to costs of achieving service delivery targets (MOH, Tanzania Health Financing Workshop, and May 2005). Public spending in the health sector has increased in recent years, both nominal and in real terms. The allocation in priority items has increased notably to drugs and supplies and to preventative and district health services. However, as highlighted in the above pie chart, the government allocation of the health sector budget is 10%, (Budget Speech, 14 June 2007) still far short of the Abuja target of 15% (Abuja Declaration, 2003) of the government spending and lowers than in 2002.
The government remains the main financial source and dominant provider of health services in the republic of Tanzania. Currently the government and parastatals provide close to 60% of the health facilities.

The macro economic context of underdevelopment, a heavy growing tax burden and dictates of the structural adjustment programs do not favor tax spending on health systems in Tanzania. The government has been able to allocate very limited resources to the health sector resulting in the dismal per capita government spending on health. Thus in Tanzania like in any other

country in Africa within which resources are at a premium and health systems are burdened by high levels of disease and related health challenges, the efficient an equitable use of resources in critical to sustainable health care financing. Researchers in this field {(Braam, 2005), (Burki,2001), (Watt et al, 1999)} point out that the key ways in which resources can be optimized are by prioritizing public health resources for primary health care, (PHC), improving the efficiency of the public hospitals and relocating resources between geographical areas and user groups.

The colonial inheritance translated into health systems where vast majority of resources are consumed by hospitals (Braam, 2005). However, the burden of disease is primarily attributable to illness that is preventable and/or treatable through basic primary health care interventions. Thus a relative redistribution of limited government resources towards primary health care services could improve the health status of Tanzanians dramatically. Attention should also be paid to services that are provided at the primary care level and priority given to most cost effective services.

According to Tamara Braam (2005) improving of hospital efficiency is another way to ensure optimal utilization of existing resources base within the public sector and she has suggested two critical ways in which to do this as: (i) to ensure that patients receive care at appropriate levels of care and do not utilize hospitals which have a higher cost per unit, unnecessarily, and (ii) to ensure geographical efficiency within hospitals. According to the Economic Development Institute of the World bank, (1998) many hospitals in Southern African countries (Tanzania being no exception) are overcrowded and inappropriately used, particularly where, particularly where they fill the gap created by the poor, or non existent PHC services. However, the urban hospital centers and curative bias of most health systems in Africa has proved hard to redefine, while restructuring or closing down a hospital is financially and politically difficult. Furthermore, there is need to redistribute the health services to promote equity and ensure that those with greatest need for

health care and least ability to pay receive the benefit of government funded services.

4.3.2 Bilateral Donor Funding.

Donor funding are a significant source of revenue in Tanzania. The donor community contributes up to 50% of the health sector budget beating only a few other African countries namely Eritrea (52%) and Chad (63%). While donor funding is essential for maintenance of basic health services in many African countries, it has been observed (Braam, 2003) that donors fund areas that they are interested in which may not necessarily be the most pressing health problems. For example launching the Voluntary Sector health Program in Coast region in Tanzania in 2001(VSHP, 2001) the lead agency was put to task to explain why the USD 15 million project was focusing the funding effort on HIV/AIDS (60%), while Malaria was the top killer disease in the region. In some cases, donors have been accused of concentrating their efforts on most accessible geographical areas which may not be necessarily be in most need.

4.3.2.1 Sector Wide Approach (SWAp)

In an effort to reduce fragmentation of bilateral and multi lateral donor funds and maximize the benefit of donor funding the Sector Wide Approach (SWAp) has been introduced as a vehicle to prioritize the use of funds from external agencies. SWAp in Tanzania evolved from Sector Investment Programs promoted by the World Bank in the 1980s. The mechanism is also referred to as basket funding and the donors to the mechanism are called basket partners..

According to the MOH Program of Work (1999-2002) the overall objective of the health sector policy is to improve the health being of all Tanzanians with a focus of those at risk and to encourage health system to be more responsive to the need of the people. From a number of underlying and specific

objectives, the Ministry of Health elaborated eight strategies for the reforms implementation, which constituted the framework of the health Sector reform Program of Work 1999-2002. This framework was based on a number of assumptions (Burki, 2001) which included availability and efficient use of resources, clear priority setting and monitoring, decentralized management, staff motivation, and availability of drugs and essential supplies. Together with the Plan of Action 1999-2000, listing the intended activities for the first year of implementation, the program of work provided the basis to operationalise the government program in the health sector in the context of sector wide approach. The program was submitted to a joint Ministry of health partners' appraisal in March 1999.

At that time the policy environment and framework for implementation were considered conducive, a number of issues (Burki, 2001) namely fragmentation, responsibility and performance remained subjects of concern. The absence of a comprehensive resource envelope indicating resource availability to the sector, sources of funding as well as related activities meant that there was an inherent risk that the sector program would duplicate resources and activities with ongoing programs and projects. Each strategy referred to as a key reform area was assigned to a Strategy Coordinator from the Ministry of Health. Although this model was not unique to Tanzania it , however, implied that each strategy was spread over several implementation bodies in the Ministry of Health, The Ministry of Regional Administration and local Government for District Services. The links between the activities and respective budgets were hard to establish. The function and scope of Strategy Coordinators remained unclear, since their status was subordinated to the Directors who ultimately decide on their priorities. The practice of management by objectives was a very new concept to Tanzania. Managers were used to plan the use of internal resources on an incremental basis (around 10% per year) and expectations to receive the planned amounts in full were low, which provided little incentive for planning. As for the external

resources in the traditional programs, the planning process involved substantial technical assistance and left little flexibility to the Ministry.

With partner's will to support the sector program using government systems and moving towards budget support, the Ministry was now invited to produce a plan linking substantial and unallocated resources to verifiable outputs and outcomes. With sources coming from a fragmented database and a poorly performing management information system, the plan was fairly comprehensive but the activities looked like a "wish list" (Burki, 2001) than a structured and prioritized interventions resulting from sectoral objectives. In addition, the question of activities to be funded remained open, since no financial management system existed to cater for an earmarked budget support for the sector.

a) Intense consultations were made within this background to give the Tanzanian SWAp its peculiar character thus: Based on estimated resources to be available, the sector program would be revised to a limited number of key priorities and milestones to be implemented by the directorate
b) Implementation would be incremental promoting learning by doing process, and focusing first on systematic issues like financial management system, procurement procedures and sector performance monitoring.

Some of the assumptions underlying this framework were evident from right from the onset. One – any assumption to embark on a full-fledged sector program was bound to fail by overloading the Ministry's capacity, and by virtual of impossibility to reach a consensus on every issue with all the stakeholders. Second and in order to ensure sustainability, government's systems were to be used albeit customized to partner's expectations in terms of accountability and transparency. The joint appraisal concluded with a side agreement between the government and supporting partners, which together

with a set of jointly agreed benchmark constituted the basis for the first year program of implementation.

4.3.3. Private Insurance

The main player in the private insurance sector in the republic of Tanzania is AAR. The sector is not yet well developed and it appears it is a preserve of the well to do in the society.

4.3.4. Cost Sharing Schemes

The main cost sharing schemes in the republic of Tanzania are the national health insurance fund (NHIF), community health insurance scheme and user fees. The implementation of the National Health Insurance Fund (NHIF) started in 2001 and the actual expenditure is still very low because the plan is still at its infancy. The plan is to start the implementation among the central government employees, then move to the local government before covering all the sectors. It therefore appears that the fund which is financed by government suffers from equity problems because it is currently subsidizing the health service to a selective class of citizens. The Community Health Insurance Fund has also been in operation since 2001 and financed by the World Bank up to 2008. Technical assistance is provided by the GTZ. The scheme aims to improve the financial sustainability on the health sector and increase access to the health services (Schewerzel, 2004). It is also designed to empower the communities, therefore the scheme has the potential of improving equity and access in the delivery of health services. User fees concept was introduced by the IMF and World Bank through he structural adjustment programs and treats health as a commodity which can be bought when people have money and avoided when people do not have the money

to buy the service. It is therefore the most unpopular cost sharing method ever implemented in the republic.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This section highlights the overall summary, conclusions and recommendations regarding the stakeholders and financing mechanisms in the health sector.

5.1 Role of the Various Stakeholders in the Health Sector

Although it has been acknowledged that there are many actors in the health sector in Tanzania, the main stakeholders in financing the health care system in Tanzania is the Central Government through the Ministry of Health, the regional administration and local government, the district and urban councils. The input of the development partners is also considered substantial. It is also considered that the input from the traditional healers is also significant. The private for profit sector is the least developed. However, the private not for profit sector is considered a key partner to the government in the provision of health services since the colonial era.

5.1.1. The Central Government

The central government's main role is to set the vision and direction in the health sector and this includes design, implementation of the health sector coordination mechanisms. These coordination mechanisms are necessary for eliminating inefficiencies and wastage with multiple and parallel projects. The government has the overall role of shaping the operating environment through guidelines and policies.

It has however, been noted in this study that the government as the regulator is not commanding adequate respect due to the bureaucratic layers and accompanying inefficiencies. Although the accounting systems are well documented, tested and elaborate they have been rendered meaningless by

the government's own servants. It appears like the only comparative advantage the government has is mandate from the people to lead the process. The government may also have a network through the decentralized structures in the districts which may be useful in the rapid mobilization of the people. This could be one of the main contributions the central government can make in the public private partnership

5.1.2 The Local Government

It can be concluded that the local government is a useful partner in the public private partnership because the local administration is near to service provision. Health service provision would be improved by being close to the clients and exploit the advantage of potential for flexibility of the systems and standards to suit the expectations of the clients. Delivery of the health services at the local level also encourages local control and opens potential for community contribution which is highly needed not only to augment the dearth for health sector funds but to reduce the percentage of funds contributed by donors, which currently is unsustainable. Service at the local government level also increases the level of accountability since the community is keen and capable of holding their local leaders to account than they can to the central government.

A number of issues, however, often arise in decentralizing the health sector. For example many local entities lack technical managerial and financial skills needed to deal with their new responsibilities. Equity may also be a casualty of decentralization, since some locals jurisdictions are likely to have more resources than others.

5.1.3 Private Sector

While it may appear the action by the Tanzanian government of abolishing the private medical practitioners in the early 70s was high handed and

illogical, nevertheless the private sector as stakeholder in the health service delivery seems to be endangered when one examines the precarious nature of the private insurance sector. For example, the AAR requires one to visit their clinics where services may be sub standard. This is restrictive and may deny the client the quality they may be worth if they had not entered into the insurance scheme.

5.1.4 Public Private Partnerships (PPPs)

Public private partnership concept in the provision of health services in Tanzania is not new. It has been established that the first public private partnerships were established as early as in 1967 Arusha declaration. This partnership with the faith based organizations providing health services improved the access to the health service delivery especially in the rural areas because most health service seekers are attracted by the good services provided by the committed staff .

5.1.5 Multi Lateral and Bilateral Agencies.

Both multilateral and bilateral donor agencies provide significant funding to the health sector in the republic of Tanzania. The more popular ones include agencies include USAID, WHO, UNICEF, DANIDA and SIDA. Other well known international agencies include the World bank and IMF. A glaring shortcoming of the IMF macro economic approach to the health sector is the emphasis on reduction of state funding which has resulted in laying off of staff and also advocates for the introduction of user fees in hospitals. It has also been confirmed that although USAID provides significant amount of funding to the health sector, nevertheless, the agency's funding policies restrict it in participating in the basket funding mechanisms.

5.2 Funding Mechanisms:

The government has been considered as the main financier of the health sector in partnership with donor agencies however ,aid coordination has been identified as main stumbling block in creating efficiency in the utilization of available funds in the health sector. The most common coordinating mechanism is by setting a special unit at the Ministry of Health for coordination purposes. Other mechanisms include geographical zoning, donor agencies for example the UN system here in East Africa, which sets common procedures for management of external programs and /or operational guidelines including per diem rates payable to government staff for in country staff travel, and regular collective consultations between recipients and donors. In some countries some agencies have been referred to as lead agencies (SIDA) however, it was noted that this special relationships between SIDA and the government of Tanzania arose from the latter's decision to provide MOH with earmarked budget when the other agencies were bypassing the government in favor of the NGOs.

The Sector wide Approach (SWAp) has been introduced, particularly in Africa as a vehicle through which to co-ordinate and prioritize the use of funds from external agencies with the approaches in place the single health sector policy and expenditure program under government leadership and in partnership with donors. The aim here is to adopt common approaches across the sector and progress towards a situation in which all funds are disbursed by government. It has been argued that, the core advantage of the approach are that, it ensures greater efficiency and equity, decreases misappropriation and contribute towards the sustainability of health policy and health systems development.

5.3 Conclusions

This section makes the general conclusions on both the stakeholders and effectiveness of the various donor financing mechanisms

5.3.1 Stakeholders

The study has confirmed that the public private partnership concept (with the private not for profit) is not new in Tanzania and indeed the concept has proved to be an effective vehicle in promoting equity and efficiency in the utilization of the available resources. However, the public private partnership with the transnational corporations today is laden with ulterior motives and selfish interests. It is clear that while some of the multinational companies are eager to provide support to host less developed countries like Tanzania, they are mostly driven by the profit motive. The multi national companies are appear to be marketing their brands by supporting philanthropic initiatives. In other cases the motive is simply to block the market against penetration by affordable generic drugs. Worst of all the multi national companies may have obtained tax holidays from host countries like Tanzania denying the host countries the ability to raise their own revenues and support the health sector in a dignified manner.

Bilateral donors like IMF have also complicated the scenario because by advocating for cuts in staff bills the health sector is forced to operate with less human resources making the facilities unattractive to health service seekers.

5.3.2 Funding Mechanisms

The Tanzanian government has been able to allocate extremely limited resources to the health sector. Thus in the Tanzanian context where health systems are over burdened by high levels of disease and related health challenges, the efficient and equitable use of resources is critical to

sustainable health financing. Most recent health sector financing mechanisms for example user fees have been fronted a part of the broad health sector reform agenda. The stated intention of these reforms is to improve the performance of health services and systems and to increase access and equity. In practice, however, their practical application is not necessarily focused on responding to the needs of the populations but instead they are an integral part of a broader agenda of international financial institutions to achieve macro economic restructuring, particularly in relation to reducing the role of the government and expenditure levels.

It is evident that lack of coordination has an adverse effect on overall aid effectiveness due to the resulting inefficiencies and fragmentation. It is also arguable that effectiveness of aid coordination depends on those taking active part in the partnership arrangements. Ironically, it is the donors who have been at the forefront of advocating for the coordination mechanisms. It can be concluded that in some cases recipient MOH officials at times have benefited from the fragmented and uncoordinated funding streams.

SWAP arrangements requiring long term coordination commitments may be resisted by those who have benefited from fragmentation, mostly aid agencies and donors themselves but also sometimes the host recipient government officials. Coordination requires technical skills, stability and sustained leadership (with both the recipient and donor agencies) and commitment. In some cases the recipient government ministries may not have this capacity. It is necessary to put in place a long term capacity building strategy. Leadership changes will hurt the vested interests and is not health especially in SWAp.

Coordination is more successful when recipient governments do not feel they are hostage of powerful donors. The recipient authority needs to feel that the donor agencies understand the local picture and are willing to be flexible and support trials from resource coordination and management.

Blue prints are not useful because there is not particular recipe for managing donor resources. In Tanzania, donors have proved that on budget support is not the only mechanism for coordinating donor aid and appointment of a financial management agent to administer pooled resources can be a successful and accountable mechanism acceptable to the public private partners, comprising the government or government agency, NGOs and the donors.

5.4 Recommendations

5.4.1 Stakeholders in the Health Sector – Government.

1. The study recommends that health be conceptualized as a public good and a right to which all human beings are entitled. The study argues that a right to health is an inclusive right extending not only to timely and appropriate healthcare but also to underlying determinants of health. Therefore the right contains both freedoms and entitlements.
2. Based on the findings and conclusions made the study recommends that health service focuses on preventative rather than curative through public private partnership sharing similar goals (eg district hospitals and private not for profit) to promote equity and ensure that those with greatest need for the health care and least ability to pay receive the benefit of the government funded facilities.
3. In relation to availability and accessibility within the rights based approach, there is clear expectation that the responsibility for health service provision lies with the society as a whole and the government in particular. It is the responsibility of the government to ensure that there are functioning health care facilities and a sufficient quantity of services and essential drugs in order to promote health care availability.

4. To achieve the 2003 Abuja commitment of 15% government spending on health parliament can also responsible for promoting policies and budgets that mobilize improved health financing that do not burden the poorest through:

a) Moving away from out of pocket funding of public sector health especially user fees and actively pursuing other finding mechanisms

b) Increasing tax revenue through improved tax collection methods and more appropriate strategies for corporate and wealth creation

c) Exploring, evaluating and implementing national social health insurance mechanism to supplement tax revenue finance.

d) Actively managing donor funding to ensure that it contributes to achieving national health priorities, for example through sector wide approaches.

e) Ensuring that health resources are fairly allocated, particularly to the primary health care and district services that have greatest benefit to the poorest.

5.4.2 Public Private Partnership (PPPs)

a) The word partnership should be replaced with terms that more accurately describe the respective relationship for example the partnership between the district hospitals and the private not for profit service providers in the district are for a common objective and qualify to be referred as "partnership"
b) Guidelines on conflict of interest and clear baseline criteria need to be drawn up for each specific interaction to ensure that these public private interactions truly serve public interest.

c) Public – Private ventures must be based on contractual agreements, which are placed in public arena with a clause for termination of contract and possibility of negative publicity if corporations do not uphold their contractual agreement.

5.4.3 Funding Mechanisms

1. Sector Wide Approach (SWAp) has been recognized as an effective method of coordinating and optimizing donor support. However, the study has also concluded that donor support does not have to be necessarily channeled through the SWAp method. The Rapid Funding Envelop model in Tanzania has proved that coordination using the off budget support is possible.

2. It has also been noted that drug donations provide only short term solution and are hamper the growth of generic drugs. It is therefore recommended that:

a) Countries advocate for generic production for many drugs instead of resorting to single disease drug donations.
b) Increase research on the distortions caused by donations and the future of generics industry in the context of the intellectual property agreements.

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APPENDICES

Kampala International University

School of Post Graduate Studies

Research Questionnaire

APPENDIX 1.A : Interview Guide,

Dear Sir/ Madam

We are carrying out this study to find out how the health sector in the United republic of Tanzania is currently financed. The results of this study will help us to make recommendations to ensure the health sector is financed in a more equitable and sustainable manner.

Please answer the following questions as honestly as possible. All the information given will be treated with the highest confidentiality and used only for the purpose of this study.

Thank you for your cooperation.

Henry Kamau Kuria

Researcher

Instructions

1. Fill in the blank spaces.
2. Insert the appropriate numeral in the box provided.
3. Do not omit any item of information.

APPENDIX 1.B Research Questionaire

1:00 Identification (Optional)

1.01Name of respondent.....

1.02 Nationality

2:00 Socio Demographic Characteristics

2:01 Sex

Male.....1

Female.....2

2:02 Age

How old are you?.....

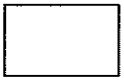
2:03 Marital Status

Single..... 1

Married.....2

Divorced.....3

Widowed.....4



2:04 Education Highest level of formal education

None.....1

Primary.....2

Post secondary.....3

University.....4

Other.....5

2:05 Occupation

Professional.....1

Clerical.....2

Artisan.....3

Civil servant.....4

Businessman.....5

3:00 Tax Financing

3:01 Do you think the government should provide health service free of charge to all?

Yes..... 1
No.....2

3:03 What measures has the government taken to improve the services in the health sector in Tanzania?

.....

.....

3:04 What are some of the weakness in the tax financing mechanism?

.....

.....

3.05 Are poor people/ specific categories of people excluded from public health services?

.....

.....

3.06 What recommendations would you propose to ensure the services reach those who need the health service most but are least able to pay?

.....

.....

3.07 What measures can the government take to improve the financing in the health sector?

.....

.....

4:00 National Health Insurance Fund (NHIF)

4:01 Do you know how the NHIF system operates?

Yes.....1

No.....2 ☐

4:02 Who benefits most from NHIF?

The poor.....1

The rich.....2 ☐

4:03 Are the poor people/specific people excluded from NHIF?

Yes.....1

No.....2 ☐

4:05 How can NHIF be improved?

.....

.....

4:06 Suggest ways to improve this NHIF on delivery of services?

.....

.....

5:00 Cost Sharing Schemes (eg User Fees)

5.01. What are the benefits/shortcomings of the user fees?

.....

.....

5.02. How has the user fees specifically affected the poor?

.....

.....

5.03 How can negative impact of user fees be mitigated?

.....

.....

6:00 Private Health Insurance Schemes (eg AAR)

6:01? Who currently benefits from the private health insurance schemes?

The poor.....1

The rich.....2

6:02 How can the poor benefit from private insurance?

.....

6:03? What are the key weaknesses of private insurance?

.....

6:04 What options are available for improving private health insurance

.....

6:05 Suggest ways to improve on its use in the health sector?

.....

7.00. Stakeholders

7:01 Who do you think are FOUR key stakeholders in the health sector?

.....

7:02 What is the specific role of any of two stakeholders you have mentioned?

.....

7:03 Do you think the private sector has a role in the health sector provision?

.....

7:04 What are the problems the current stakeholders encounter in the allocation or providing the services?

.....

7:05 Have the donors (both multi – bilateral Agents) done something to improve the financing in the health sector?

.....

7:06 What can donors do to improve the delivery of the health services?

.....