Comparative Management Practices in Reforming the Health Sector in Tanzania

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Introduction

Tanzania has made significant investments in health-related infrastructure in the past, and great improvements were realized in terms of access to health care services. The number of heath facilities in the country can explain the outcome of these efforts. At independence in 1961 there were 98 government hospitals, and by 1994 they had increased to 174. Between 1961 and 1964 the number of dispensaries rose from 875 to 3924, an increase of 266%. An even more significant improvement is on rural health centres, which increased from 22 in 1961 to 276 in 1994.

This investment in public health infrastructure has enabled the majority of Tanzanians to have relatively easy access to health care services. Indeed, about 72% of the population now lives within 5km of a health facility, and 93% live within 10km of a health facility. These facilities, accessible as they were, started to face problems during Tanzania's economic downturn in the 1980s. There were shortages of essential drugs, and the quality of services deteriorated. The government could no longer continue being the principal financier and provider of health care services.

The ongoing political, economic, and social reforms have necessitated the need to review the health care delivery system in Tanzania. The Ministry of Health has acknowledged the apparent decline in the health service delivery system. The government admits in the Health Sector Reform Strategy document that,

> … the health sector is full of examples of ineffective policy implementation initiatives such as dependence on donor funding for basic programs, poor distribution of staff, inadequate supplies (particularly drugs), poor management, lack of supervision and lack of motivation, and the growing gap in knowledge between the community and public health providers… (Ministry of Health, 1994).

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The under-funding of public health services is also reflected in the inadequate and unreliable supply of drugs; inadequate maintenance of buildings; a high proportion of equipment awaiting repair, spare parts or replacement; and overcrowding in government hospitals, among others. Workers are demoralized and are thus not customer-oriented. This further undermines the quality of health care services delivery in public facilities. The inability of the government to provide quality health care has prompted many people to seek alternative health care, a choice that has been made possible by the liberalization of the health sector in 1991.

Health care in Tanzania is mostly provided through health facilities owned and managed either by the government or private dealers, both commercial and non-profit. Traditional healers and herbalists also play an important role in health care provision. All along, the focus of the government has been to provide primary health care (PHC) to as many people as possible. PHC is considered to be the "…first point of contact between clients and a facility in the health system. In most African countries, health care at this level is provided at a health dispensary, clinic, or health centre"(Shaw & Griffin, 1995). The government introduced the PHC strategy to mitigate the expensive nature of secondary and tertiary health care. However, due to various reasons, it has been unable to provide adequate primary health care, and thus has been forced to allow private dealers to provider this service.

Secondary health care takes place at referral hospitals, mostly located at district headquarters. Such district hospitals are supposed to deal with complicated cases that lower level hospitals are unable to handle. On the other hand, tertiary level health care takes place at higher referral hospitals mostly at regional and national hospitals, which are also often designated as teaching hospitals such as Muhimbili Medical Center in Dar es Salaam, Bugando in Mwanza, and KCMC in Kilimanjaro region. Fewer people can manage to get to this level, hence the strategy of the government to serve most people at the first point of contact with modern medical services.

The main objective of this article is to find out how various ownership categories make decisions in their health facilities. The article sets to determine which institutions are more efficient in providing health services and for what reasons, as well as the differences that exist in the management styles of public and private health care providers.

To realize the above objective, it is imperative to extract information and describe the various management systems found in different ownership categories. This information will be useful in recommending lessons to be drawn as the health sector continues to undergo reform.

The general question addressed in this article is: does an NGO and/or private health providers manage a health facility (hospital, health centre, or dispensary) better than the government (MOH/Local Government) and why? Two basic research questions are derived from this general question, namely:

(a) Are there any differences in the way NGOs and the government manage health facilities?
(b) What lessons (policy significance) for decentralization can be drawn from the differences in management styles between these health providers?

Conceptual Framework

One of the central issues in this article is why patients opt for private health care that is expensive, instead of public health services that are subsidized, and hence comparatively cheaper. The government has a significant number of facilities and human resources, but it has failed to provide satisfactory services to its citizens. It may therefore not necessarily be an issue of capability, but rather one of managerial style. A decentralised managerial style requires that key decisions be made at the facility level, rather than at the central level. Furthermore, health services can only be perceived as satisfactory if they are patient-oriented. To become patient-oriented, health managers at the facility level have to be able to respond quickly to patient demands. To do this, first hand authority is required to make prompt decisions as the situation dictates, without prior reference to headquarters or subjection to other bureaucratic delays.

It is hypothesized that the closer the owner of a facility is to the health service delivery unit, the higher the chances of responding promptly to a patient's demands. Timely response to patients' needs is an indicator of effective management, and this may lead to patient satisfaction; which may itself be indicative of the quality of the health services provided. It is also envisaged that localized management is more effective because health facilities are given financial and administrative autonomy, with executive authority vested in a facility manager. To be effective, the facility manager has to be in

a position to make managerial decisions regarding personnel, supplies, equipment and patient treatment. All hospital activities should be determined at the facility level, hence making it easier to make patient-related decisions without delay.

It is also acknowledged that the "perceived quality of service is one of the most important determinants of patients' choice of provider and willingness to pay" (McPake & Hanson, 1991). In this article, therefore, patients' choice in picking providers will be used as indicator of better services provided by the health facility. Lower utilization is, on the other hand, perceived as a proxy indicator of dissatisfaction with a health facility where choices exist. Patients often weigh the advantages and disadvantages of getting their health care from one health facility compared to another. In making decisions, patients have to consider their needs and weigh them against the available choices of health providers. When deciding which health facility to use, patients take into consideration their perceived quality of health care as indicated by drug availability, attitudes of health workers, and the physical environment of the health facility.

Effective management at the health facility level is critical for ensuring patient satisfaction with the services provided. This demands substantial managerial autonomy at the facility level to enable managers to ensure accountability and closer supervision and control of their workers. Here, we agree with Drucker (1982) that patient satisfaction is not possible except where managers institutions "think through priorities of concentration which enable them to select targets, to set standards of accomplishment and performance, i.e., define the minimum acceptable results, set dead-lines, work on results and make someone accountable for *them*."

Managers of public health facilities have to base their activities on performance and results. However, this can only be achieved if these health facilities are given not only more powers and authority (autonomy) to set their own performance targets, but also the ability to supervise their attainment. Decentralisation by means of devolving managerial powers to health facility managers can help bring patient satisfaction within the services provided by public health facilities. In turn, this will help the government realize its primary health care objectives.

It is further assumed that the level of centralisation of policy and decision-making varies with the type of ownership. This study examines the

contention that government-owned health facilities experience more traits of bureaucratic centralism than private health care providers. The reasons attributed to poor performance of a centralized health system (government-owned health facilities) include: managerial delays, lack of supervision, indecision and non-accountability. It is therefore proposed that in order to deal with this problem, one needs to untie the knots of centralized management practices.

We need to examine critically the assumption that the knots of bureaucratic centralism are not as tight in private health facilities as they are presumed to be in public-owned health facilities. It is also imperative to compare the ownership of categories to determine whether levels of privatisation and decentralization of management contribute to the performance of health facilities in terms of patient satisfaction.

Bureaucratic centralism is here perceived to possess negative behavioural traits. According to Heady, such traits make bureaucracies "dysfunctional, pathological, or self-defeating, tending to frustrate the realization of the goals toward which the bureaucracy is supposed to be working" (Heady, 1979). For Merton, such managerial behaviour produces "inefficiency in specific instances and also leads to a concern with strict adherence to regulations, which induces timidity and conservatism" (Merton, 1940). Bureaucratic tendencies may easily lead to poor health services, which inevitably discourage patients and force them to seek alternative health care from private dealers.

The negative behaviour of bureaucratic management includes "buck passing, red tape, rigidity and inflexibility, excessive impersonality, over-secretiveness, unwillingness to delegate, and reluctance to exercise discretion" (Heady, 1979). Government health facilities exhibit such tendencies, and that is why people complain of poor services and corruption. Public health providers could make a big difference if they operated like private dealers. In this case "they need people who do the managerial job systematically and who focus themselves and their institution purposefully on performance and results" (Drucker, 1974). It is hereby reiterated that decentralization of functions, responsibility and authority in public health units can help to improve the quality of health care in line with the PHC strategy.

Findings

Patient Satisfaction

Patient satisfaction is contingent upon the quality of services offered. Health services are deemed to be of good quality if drugs are available, and equipment is constantly in good working condition. The quality of health services is also measured in terms of available good-natured (caring, patient-friendly) and qualified medical personnel. In addition, patients' perceptions of quality are also influenced by the convenience of operating hours, time taken before a patient is able to see a doctor, and distance to the nearest health facility. It is these factors that tend to influence a patient's choice of a health facility.

To find out why patients chose certain facilities and their satisfaction of the facility chosen, a total of 1342 patients from 132 health facilities were randomly selected as they left health facilities and interviewed. The study covered ten districts in five regions. Detailed information on patient perceptions and choices, and management styles was gathered. The facilities covered were as follows: Dar es Salaam 39, Arusha 30, Kilimanjaro 21, Mwanza 21, and Shinyanga 21. In terms of ownership, 44 government facilities, 48 NGOs and 52 commercial private facilities were covered.

Out of 1342 patients interviewed on why they chose certain facilities and their satisfaction of the facility chosen, only 16.8% indicated they consulted traditional healers where they were sick. This indicates that more people in urban and semi-urban settings now appreciate the importance of using modern medicine. The findings also show that of those patients interviewed, only 2.5% attended health facilities in search of preventive care, while about 63.5% attended health facilities seek treatment for various ailments.

It is also interesting to note that where the interview took place, most of the patients were not first-comers to the health facility, as only 28% said it was their first time to visit the facility. Under normal circumstances, a frequent visit to a health facility would be construed as a sign of satisfaction with services offered by the facility. A patient who is not satisfied with the services provided in a certain facility is likely to seek an alternative amenity. However, this assumes that patients have a variety of health facilities from which they can choose the one that would meet their demands. This is a prerequisite for rational patient choice based on perceived satisfaction of services provided. The factors that are likely to influence choice include easy accessibility (proximity) to the facility, quality of services offered in terms of

qualified staff who are patient-friendly, as well as the cost of the services which further determines patients' ability to afford treatment.

Unfortunately, in many rural areas in Tanzania most people do not have much of a choice. Quite often there is only one government dispensary or mission facility available. The government owns all health centres in rural areas. The lack of facility choice in rural Tanzania may help explain why about 58.8% of those interviewed had visited the same facility more than twice, and 88.8% even more frequently. Indeed, when patients were specifically asked whether they had a choice of an alternative facility they could have used, about 500 patients (38.3%) said that they did have a choice. The rest said they did not have any alternative. Here, the lack of choice was more a factor of the availability of an alternate health facility, rather than the quality of services offered. In urban areas, however, perceived quality of service is an important and critical consideration in choosing a health facility because of the availability of a number of health facilities from which one can choose.

Of the 1242 patients asked to indicate their preferences between government, mission, and private hospitals, about 74.7% said they had no other alternative than to use government district hospitals, compared to 20% who were treated in private hospitals, and 5.5% in mission hospitals. When probed further, many patients said they did so because government hospitals were cheaper. However, when they fail to get drugs and government medical practitioners mistreat them, by the use of foul language, long queues to see a doctor, dirty beds and poorly ventilated waiting rooms, they then decide to visit other facilities.

The utilization of dispensaries was a different story. Out of the 1242 patients who agreed to answer a question on utilization, only 21.5% said they were treated in government dispensaries compared to 53.0% who preferred private dispensaries and 25.5% who preferred the use of mission dispensaries. This means that about 78.5% of those interviewed opted for private health facilities instead of government ones. Given the limited number government health centres, very few people (only 8%) said they visited them compared to 3.5% who said they visited mission ones. The private sector does not own any health centres. (See table 1 below)

Table 1: Patient choice of a health facility

Type of facility	Owner of facility chosen by patient					
	Government		*Mission*		*Private*	
	No.	%	No.	%	No.	%
Hospital	925	74.5	68	5.5	249	20.0
Dispensary	267	21.5	317	25.5	658	53.0
Health centre	99	8.0	43	3.5	-	-

For any rational patient who has a choice of available health facilities "perceived quality of service is one of the most important determinants of patients' choice of provider" (McPake, Hanson, and Mills 1992). In most instances, the perception of quality of health care services is often associated with the availability of drugs and the behaviour of facility workers, especially doctors and nurses. Thus, when drugs are not available patients complain of poor services. Likewise, when nurses or doctors are rude to patients, services are also perceived to be poor. This study confirms that whenever choice of facility exists, patients will tend to choose those facilities that they believe have drugs and whose staff attitudes are not negative. In this study it was found out that at least 61% of those who went to private dispensaries did so because of availability of drugs and positive (friendly) personnel attitudes.

It can also be discerned from Table 2 that out of the 1342 patients who agreed to answer the question on why they picked one facility instead of another, 61% said they did so because of availability of drugs. Another 55.6% said they were influenced by perceived presence of competent and qualified health personnel, while the rest, 45.6%, were influenced by close proximity of the health facility to their residences.

Table 2: Reasons for choosing a health facility

Reason	No. of patients	%
Drug availability	819	61.0
Friendly personnel	416	31.0
Competent/qualified personnel	738	55.6
Lower treatment cost	539	40.2
Closeness to residence	612	45.6

Convenient opening hours	93	6.8

The physical environment of the health facility was also considered important. Over 70% of those interviewed said they chose private dispensaries because of their general cleanliness. It was suggested that in most NGO and private health facilities, drugs, running tap water and toilets were available and accessible to patients in satisfactory conditions. The reverse was the case in government owned health facilities. Indeed, even government health workers seem to concur with the assessment made by patients regarding the appalling conditions in government health facilities.

Over 75% of personnel in government facilities who were interviewed complained of government neglect of buildings, equipment and personnel. Most of them said they were demoralized because their working conditions were appalling. This may also help to explain why patients were dissatisfied with the way they were treated by government employees in public health facilities. These personnel were said to be rude to patients and less caring compared to those in private health facilities.

In addition to the presence of disgruntled employees and lack of drugs in government owned health facilities, it is also clear from the study findings that most of them lack working medical equipment and operate in dilapidated structures. There is also a reported tendency for pilferage of public property due to inadequate security in government facilities. Medical journals are also lacking in most government health facilities.

It appears from the above findings that people in rural areas, are still dependent on public facilities as only a few private health facilities exist there. In urban areas, people tend to visit public facilities not necessarily because of lack of alternatives, but rather because of other reasons, including the fact that they are cheaper.

Management Style

Management styles also affect the provision of health services. In this article management style is viewed in terms of decision making and supervision. Hence, the article compares decision-making in government and private dispensaries. It also compares the extent of service supervision in both public and private health facilities. From the findings, it can generally be observed

that the vast majority of commercial private health facilities in Tanzania are small-scale dispensaries owned by a physician and staffed by one or more medical assistants, most of whom are permitted to prescribe most drugs. These individual owners have the authority to make critical managerial decisions as the need arises. On the other-hand, managers in government dispensaries, health centres and hospitals lack such authority as evidenced in the following sections below.

Decision-Making

The importance of prompt decision-making cannot be over-emphasized. Efficiency, which is critical for the provision of quality services, can be undermined by the way decisions are made in an organization. As intimated earlier, government owned facilities are said to experience more traits of bureaucratic centralism than are the NGO and the commercial private health facilities. The poor services decried by patients in the first part of this study can be attributed to the centralization of decision-making in public health facilities. The explanations presumably attributed to poor performance of a centralized system are managerial delays in making critical decisions, lack of proper supervision, indecision and non-accountability of personnel. In order to deal with the problem of rooted bureaucratic decision-making and do away with poor health services in public facilities, it is proposed that the knots of centralized management practices be loosened up.

Health facilities should be given discretionary powers on the determination of service prices as well as on the expenditure of their revenues. Facility managers should be able to use their revenues to ensure prompt availability of drugs and carry out necessary repairs and maintenance of equipment and buildings. Health facility managers should also be given supervisory powers and should be able to hire and fire staff as the need arises to enforce discipline among health personnel.

It is often said that one of the virtues of NGO and private dealers is that they make decisions promptly. On the other-hand, government providers are assumed to be bogged down by a bureaucratic maze in their decision-making process. These assumptions appear to be confirmed in this study as will be shown below.

To find out whether the bureaucratic management style indeed dominates public health facilities compared to private ones, this study has attempted to compare the ownership categories in terms of how they make their decisions.

It is noted in this study that, although the Ministry of Health has issued expenditure and planning guidelines to be used by public health facilities, decision-making appears to remain problematic in most government owned health facilities. The guidelines emphasize that facilities can make expenditures on drugs, essential hospital supplies and equipment, and repairs and maintenance of equipment and buildings.

These guidelines appear to unwittingly promote in-built features of bureaucratic centralism. This is mainly because the Ministry of Health guidelines emphasizes that health facility management teams make expenditure decisions and that local advisory committees must approve such decisions. Facility managers are therefore not given power and authority to make decisions on their own. Making decisions through the committee system denies facility managers of these public institutions flexibility and speed in making critical managerial decisions. Although the intention was both to avoid hasty decisions and to ensure a democratic decision-making process in government institutions, as well as accountability, the consequences are equally serious. Indecision and delays are now the norms. Meanwhile, the quality of services provided by the government suffers.

Under such conditions, it is not surprising that 77.8% of the government employees interviewed observed that in government facilities, simple decisions on prices were made by committees. Similarly, decisions regarding exemption of payment for service are bureaucratically made. Study findings further indicate that government facilities cannot make independent decisions regarding patients unable to pay fees under cost sharing. About 84% of the government employees interviewed said that decisions regarding exemptions are made at the Ministry of Health headquarters.

On the other hand, 83.3% of those interviewed in NGO facilities and 71.4% of private dealers confirmed that similar decisions were made by owners of the facilities or by administrators entrusted to do so by the facility owners. This means that it takes much longer for decisions to be made in government facilities than in privately owned units.

Table 3: Decision-making in government facilities

Type of decision	Committee	Clinician in charge	MOH (owner)
Prices of services	56.5%	6.0%	37.5%
Reviewing service fees	71.4%	-	28.6
Exempting poor patients	-	15.8%	84.2%

About 72% of those interviewed in NGO facilities said decisions regarding exemptions in NGO facilities are made by the clinician in charge. Similarly, about 67% of the workers in private clinics said owners who are always present in these facilities make decisions regarding exemptions. As a result of the centralization of decision-making regarding exemptions, poor patients in public facilities do not get prompt responses.

Table 4: Decision-making in NGO facilities

Type of decision	Committee	Clinician in charge	Headquarter (owner)
Prices of services	54.5%	18.2%	27.3%
Reviewing service fees	44.7%	4.3	51.0%
Exempting poor patients	-	72.4%	27.6%

At least 84% of those interviewed said that patients unable to pay cost sharing fees are referred back to the exemption system since no decisions can be made at the government facility level. Meanwhile, about 72% said that patients in private facilities are excluded from service access since the owners are only interested in making profits. It is only in NGO facilities that about 57% of the workers interviewed said that poor patients are allowed treatment on deferred payment compared to 14% in private facilities and 8% in government owned health units. See table 5 below.

Table 5: Decision-making in private facilities

Type of decision	Committee	Clinician in charge	Headquarter (owner)
Prices of services	6.0%	10.0%	84%
Reviewing service fees	18.0%	3.0%	79%
Exempting poor patients	-	10.5%	89.5%

Decisions on revenue expenditure are also made differently at different health facilities. The findings indicate that decisions on repairs or restocking of drugs and supplies in government owned facilities are made by the government itself at the national or district level. About 66.7% of government

employees interviewed said that such decisions are made centrally. On the other hand, about 86% of those interviewed in private facilities said that such decisions were made by the facility owners or by the unit's administrator while in the case of NGO owned facilities about 61% said that such decisions were made by the unit's top leadership. This situation is prompted by the fact that private facilities depend on incomes generated by these facilities including the sale of drugs and consultations with facility physicians. Restocking is very important and decisions have to be prompt in order to retain the confidence of their patients. Government facilities are run on subsidies from the central government and decisions regarding restocking are also done by the same central government. See table 6 below.

Table 6: Decisions on restocking of drugs and supplies

Who makes decision	Government facility	NGO facility	Commercial Private facility
Central or district bosses/owner	66.7%	11.0%	86.0%
Units top leadership	4.0%	61.0%	14.0%
Facility management committee	29.3%	28.0%	-

The above findings indicate that decisions are promptly made and with less hassle in privately owned units when compared to the government facilities where delays are a common practice. Since the management in government facilities has to convene committees, decisions are usually delayed. When a decision is about prices or exemptions, poor patients suffer the most. Inefficiency and inconveniences to patients become the norm rather than the exception. As a consequence, patients become unhappy with the services rendered by government facilities.

Managers of government owned health facilities avoid making decisions regarding prices and exemptions by referring them to government headquarters and to the respective committees. We reiterate that lost time leads to lost revenue and results in low patient satisfaction. Some patients interviewed in this study complained that at some government owned units they were kept waiting for a long time and sometimes attended to by junior staff because the qualified and more senior staff were in committee meetings.

Service Supervision

The quality of services provided depends on close supervision of workers in health facilities. Workers have to be disciplined and be able to listen and

attend to patients promptly. The study reveals that NGO and private health service providers tend to supervise their staff more closely than the government ones. For example, owners of private dispensaries review the performance of their facilities on a daily basis. Moreover, while private owners spend time to listen to complaints raised by patients and change their staff and services accordingly, government facilities appear to be less concerned. Government facilities appear to be more like units owned and run by absentee landlords who do not give much power, authority or an enabling environment to the resident managers. This is a consequence of the fact that major staff decisions have to be referred to apex organizations. Even minor staff problems in district and village government dispensaries and health centres have to be referred to the district headquarters and/or the Ministry of Health in the case of district hospitals and regional hospitals. Government facility managers do not have the authority to hire and fire their employees. Only the Ministry or district headquarters can do so. A committee has to discuss disciplinary action, which is mostly limited to reprimand to employees who are rude to patients or negligent. This encourages inefficiency and poor services in government health facilities.

The study findings also indicate that 90.3% of NGO and 80.6% of commercial private dealers make service reviews on a frequent basis. In government facilities, although the presence of frequent service reviews was confirmed by 77.8% of government workers interviewed in this study, the major difference is that in 92.9% of these facilities such reviews are made by committees or apex organizations (regional/district health boards or Ministry of Health headquarters).

Close supervision by facility owners and/or owner representatives in NGO and private facilities makes for prompt decisions and actions as and when required. In some instances, owners of commercial private facilities or their representatives maintain official hours and take turns to oversee the performance of their staff on a twenty four-hour basis. Private owners of health facilities check with patients to find out areas of satisfaction or dissatisfaction and reconcile prescription records, purchases etc. with revenue receipts on a daily basis. Discrepancies are rectified on time. All workers in NGO and commercial private facilities are paid for hours worked. Patients' complaints may constitute an adequate reason to fire workers in private facilities unlike the public facilities where such workers may only transferred to other facilities.

In the case of very sick patients, government dispensaries tend to refer patients to government facilities at higher levels at least in 92.3% of the cases. This is perhaps due to the fact that lower levels do not have sophisticated equipment, qualified personnel and supplies. However, 81.7% of NGO and about 86.1% of commercial private facilities refer terminally ill patients to government hospitals. One explanation given by both employees and patients is that commercial private dealers do not want patients to die in their facilities, as it is said to give a negative image of their facility and may scare away patients. However, another plausible explanation could be that they try their very best before a referral decision is made. After all, every referral of a patient is lost revenue on their part.

The Dynamics of the Private Sector Health Service Provision

For almost three decades since independence, health service delivery has mostly been the domain of the state in Tanzania. Only a limited number of commercial private services were provided in major towns of the country. Meanwhile, various NGOs, mostly Christian church organizations, provided services in rural areas across the country.

The nationalization of some private health care facilities (mostly mission hospitals) in 1970 was followed by a long period of mistrust and lack of confidence by the remaining private health facility owners. This retarded the expansion of a complementary health care system in Tanzania. In 1977 commercial private health service was banned under the Private Hospitals (Regulation) Act. In essence, the practice of medicine and dentistry was prohibited as a commercial service.

It is a fact that the Private Hospitals (Regulation) Act had negative implications on health care delivery services in the country. The nationalization and its accompanying legislative moves "slowed down the opening up of new facilities" (Munishi, 1995). Consequently, government health facilities became congested and the quality of health care suffered. Most public facilities lacked drugs and were never properly maintained due to lack of funds and mismanagement. With the introduction of political and economic liberalization policies in 1986, the importance of the private sector in health care delivery was recognized once again. The Private Hospitals (Regulation) Act, 1977 was amended by the introduction of the Private Hospitals (Regulation) Amendment Act, 1991. Following this legislation, individual qualified medical practitioners and dentists were allowed to manage hospitals, with the approval of the Ministry of Health. Private health services could now be provided on a commercial basis.

The Health Sector Reform document shows that the private health sector currently owns 40% of all health service points (8-10% commercial and 30% non-profit). The remaining 60% of health facilities belong to the public sector, Government or parastatal. However, table 7 below shows that NGOs (voluntary agencies) together with commercial private health providers own more hospitals than the government and provide almost half of all hospital beds. The government is still dominant in health centres (97%) and dispensaries (80%).

Table 7. Public and Private Ownership of Health Units in 1991

	Public	NGOs	Commercial Private	Total
Hospitals	49%	48%	3%	174
Hospital beds	52%	47%	1%	24130
Health centres	97%	3%	-	276
Dispensaries	80%	19%	1%	3014

Source: Ministry of Health, 1993

The World Bank estimates that since re-legalization, approximately 500 organizations and individuals have registered with the Ministry of Health as private dealers. The bank also notes that "the growth of health units in Dar es Salaam has been extremely rapid: in early January 1992, there were 136 health units in the city and by late September 1993 there were 253 health units" (World Bank Aide Memoir, 1993).

It is obvious that NGO and private health care providers significantly supplement the public sector in health service provision. The increase in NGO and commercial private dealers means that consumers of health services in Tanzania now have both a wider choice and increased access to health services. This is especially the case where NGO (mission-run voluntary agencies) facilities provide a set of services similar to those offered by government ones. Here we have in mind services such as basic curative care (in and out patient services) and preventive services, e.g. maternal and child health care.

The proliferation of NGOs in the provision of health services is both a result of the failure of the state to deliver as well as the realization by the Tanzanian state that co-operation with these institutions could prove beneficial.

Particularly since the shrinking of the state capacity has limited its ability to provide adequate quality health care services free of charge.

Bitter complaints about poor health services, particularly by an impoverished rural majority, pose a persistent threat to the legitimacy of the state. Provision of health services by NGOs and commercial private dealers alleviates the harsh conditions of the poor in the rural villages. This in a way affords the beleaguered state breathing space to cater for other critical developmental and managerial issues as dictated by the political and economic reforms. Moreover, this may help to "broaden channels through which resources or benefits reach groups that may otherwise feel disenfranchised with consequent discontent and instability" (Fowler, 1991), that may otherwise undermine regime legitimacy. The state recognizes that any type of instability that puts the legitimacy of the state in question has the potential to undermine political and economic recovery programs.

Moreover, donors put conditions on the government mainly in the form of finance, political and economic reforms. The majority tends to mistrust the state bureaucracy, which they consider to be corrupt and inept. Thus, for the donor community, the failure of the government to reach the poor either because of organizational rigidities and/or lack of human capacities of both central, regional and local government bureaucracies, makes NGOs and private individual providers a better alternative. Indeed, as Tim Broadhead further observes, "donor governments and multilateral institutions now routinely pay tribute to their presumed capacity to reach the poor, and to the qualities of innovation and flexibility which are supposed to characterize NGO work." Under such conditions it is "hardly surprising that NGOs, with their human face and public support, their history of targeting the poorest and their programs and their relatively low cost management style seem an attractive alternative" (Broadhead, 1987).

NGOs are mostly preferred because they are conceived as "flexible, imaginative, useful and boost government efforts" (Hanlon, 1991) as well as their "presumed effectiveness in program delivery meeting the needs of the poor" (Broadhead, 1987). In addition, NGOs seem to perform better than the government institutions, not only because of bureaucratic procedures associated with government institutions but also because the financial survival of NGOs is not as guaranteed as that of government institutions. The survival of NGOs and other private dealers of health care services

depend on their ability to retain their customers by providing them with value for money in health services.

Furthermore, the emergence of NGOs and other private dealers of health care services have complemented government efforts in the provision of health services. As mentioned earlier, the government has created a lot of health infrastructures but has not succeeded in providing adequate and quality health care. These private dealers fill the gap left by the government. They also help to widen consumer choice of health services.

The tendency of the government to nationalize and dominate in the financing and provision of health care services was a systematic centralization process. As far as health care services are concerned, major decisions to finance, locate and provide these services had to cautiously anticipate the government's decisions. On that score, a policy to liberalize or privatize the health sector is a move in the direction of decentralization. The NGO and commercial private health providers can now make various decisions on what to provide, where, when, how and to whom, provided that they do not contravene existing laws or regulations.

Policy Significance

It is apparent from the above findings that the much talked about decentralization of health care provision in Tanzania is more a form of privatization of health care and financing than of functional decentralization in the public sector. Government facilities still refer most managerial decisions such as staff remuneration, hiring and disciplining of staff to the central government, particularly in the case of district hospitals, health centres and dispensaries in rural Tanzania. Moreover, the bureaucratic form of decision-making is still intact as evidenced by the tendency to refer crucial decisions to committees rather than to a trusted facility administrator as is the case in private owned health facilities.

The decentralization policy with regard to management style may mean a deconcentration of specific functions from the national headquarters to lower administrative units (region, district or village functional unit or management boards and teams). One needs to clearly understand what has actually been deconcentrated and what has not. This subject is being tackled in another study. Secondly, one would also wish to know which enabling factors, i.e., laws, regulations, amenities, supplies, sanctions, etc. have been deconcentrated in line with the functions.

Decentralization could also mean a transfer of responsibilities, authority and power to autonomous lower level units such as district hospitals, health centres and village government dispensaries. The study indicates that private owned health facilities have the power to make critical managerial decisions as compared to the public owned health facilities. Since patients appear to be more satisfied with privately owned health facilities than those owned and managed by the government, this could imply that giving facility manager's power to make decisions about drug supplies, repairs and staff discipline can make a difference in the quality of services provided. The government should consider giving district hospitals, health centres and other government dispensaries similar managerial powers as are given in private facilities, i.e., the power to discipline employees, including hiring and firing them. In addition, government owned health facilities should be given powers to spend cost sharing revenues on drug replenishment, supplies and maintenance of their worn out structures.

Conclusion

The findings in this study indicate that many people, especially in rural Tanzania, still rely on government health services. It is also clear from the findings that where choice exists, there is more consumer satisfaction with NGOs and commercial private dealers than with the government providers. Patients perceive services in NGO and commercial private facilities to be better than those offered by the government. This is in part due to close supervision provided by the facility managers of these health units. Also, the management style of privately owned health facilities enables them to make fast decisions regarding service prices, exemptions as well as decisions on drug purchases and repairs. Facility managers of government owned health facilities lack these powers, as they either have to refer major decisions to facility committees or to some other central decision-maker at the district and national levels. This makes decision-making cumbersome and demoralizing both to the workers as well as to the patients. Delays in making decisions undermine the services provided in government owned health facilities. It is therefore imperative for the government to give more decision-making powers to the facility level and encourage more facility autonomy akin to that of private dealers.

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