Considering Quality of Health Care Differences in Government Owned and Non-Governmental Services in Tanzania

by
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Introduction

Tanzania is currently in the implementation of structural Adjustment Program (ASP) which started in 1986. As far as health care is concerned, the SAP calls for a sectoral reform which includes, among other things, reduced government involvement in providing some kinds of care, and letting the private sector come in. The 1991 Health Sector policy initiates this turn-about policy. Since the health care sector is in dire need of resources, especially finances, the reform intends to invited and encourage (as much as possible) private capital to invest in health care services for sale. Even though the government had dominated the health care sector in financing and providing all sorts of health care services, there was (parallel to it) the church- sponsored voluntary agency units which constitute 48.6% of the hospitals while the government owns 77 hospitals (MOH 1994:6)

With SAP, user fees have been introduced in the government health care units where people have been used to getting free medical services. Even when the services were free at the government units, some people used to prefer to attend the units where they had to pay. Some patients many walk some kilometers past free-of-charge government health units on to a VA unit where they are prepared to pay for services. There must be a reason why people preferred to pay at the VA units instead of getting free services at the government owned units. A reasonable explanation is the QUALITY of care which is believed to be higher at the VA units than at the government

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units. The extent to which this is true is a concern of many, and an attempt to inquire further is a concern of this discussion.

Since people have been willing to pay at the VA, and perhaps paying for a superior quality, it is important to highlight on what does constitute that quality, especially according to the health care consumers themselves. The discussion will compare the government and the VA health care services at the dispensary level. If people are indeed paying for what they consider to be quality, the current health sector reform which calls for privatization and user fees has to hold quality as a major factor that will make consumers support the policy reforms. Yet there are no adequate comparative studies between the government's almost free services and the NGO's for-pay services.

What constitutes health services in Tanzania is a complex mix of the government owned hospitals, health centers, dispensaries and health posts; the Voluntary Agency owned units, the private-for profit unit and the traditional healers' practices.

The dominance of the government (until the liberalization policy) in the health care financing and provision in Tanzania resulted from an egalitarian and populist orientation which considered health care as a basic necessity and a right of every citizen irrespective of one's ability to pay for the services. Therefore health care services have been dominated and expanded by the government, and have been rendered free of charge until 1993 when user charges were introduced with a lot of caution and unwillingness.

Along with the government owned units there are the VA units which have been allowed to continue as approved organizations. They continue to receive a heavy subsidy from the government in terms of bed grants, subsidized drugs, trained personnel etc. Some have been, until 1991, under a complete financing by the government. This is especially so where there have been Designated Government District Hospitals (DDH).

There seems to be a tendency for scholars to evaluate health services as though the government's dominance is eternal, leaving out about 50% of the hospitals, and an extensive network of dispensaries owned by the VAs. Most evaluations, save for Abel-Smith 1992 Bloom et al 1992, and Munishi *et*

al 1992, make little or no comparative reference to the quality issues of the government and VA health care. A more recent evaluation (Munishi, Kanji and Kilima 1992) found out that there are some significant differences between the government owned and VA owned health care units in their services on the attributes of structures and personal interrelationships, and slightly in technical processes.

This paper tries to take up some highlights from that research conducted in Dar es Salaam region in 1992, combining it with another research conducted in several districts in Tanzania in 1990/1992. It is considered appropriate to briefly comment on the quality and methodology used to compare the government and VA subsystems in Tanzania. Secondly, some historical background will be briefly highlighted upon in order to understand the role of the VA and the government in health care provision. Thirdly, the comparisons are then made using data from the two studies. Concluding remarks are made in view of the current reforms in the context of the structural Adjustment Program (SAP) which requires more private participation in health care delivery than ever before.

For the purpose of this discussion, the comparison focuses on the curative care only. The part of private care focused upon is a complex of mainly dispensaries falling under the umbrella of missionary organizations, hereafter called Voluntary Agencies or VAs. The government units focused upon are dispensaries. All these (government and VA) units deliver curative, preventive care and other kinds of primary health care. The curative care aspect has been singled out for comparative purposes. Some VA units would not have the preventive services at the same scale as the government owned units.

2. Quality of Care Differences: the Conceptualization and Methodology

There are studies which have shown that people prefer the non-governmental health care services because they have a relatively higher quality of care (Anderson Brolin *et al* 1991:16-20). But what is it that constitute the quality of care? Quality of care is perceived differently by the users of services and providers of services (physicians and other technicians). an evaluation of health care services seeking to focus on quality is more informative when it examines the various dimensions and perceptions of quality. These attributes are mainly the structures which include the

buildings, the setting, space planning and utilization, human resources attributes by the level of training, motivation and number, equipment, organization and management (Peters and Becker 1991:273-286, Donabedian 1980). The assumption here is that given well planned structures, well trained personnel and good management, the quality of care will be improved significantly. Likewise, a chronic shortage of essential drugs and equipment, poor nursing behaviour, substandard techniques and a lack of effective control, supervision by management is likely to result into poor quality of services.

A major attribute of quality is the process which will tend to consider medical technology in place and its utilization, the process of clinical history examination, diagnostic competence, prescribing and dispensing. Process will also include what is known as "good" practice that predominantly exists at the facility. The assumption on the process attribute is that given adequate and proper procedures, some appreciably satisfying health services may be a result. It is unfortunate that this specific attribute is not fully incorporated in the studies referred to. It is also noted that "good health and good practice" are elusive terms that mean different things to different people. This is perhaps why many scholars do not oftenly focus their studies on this aspect.

The third attribute is the outcome which considers whether the process attributes have had any influence or whether the actual treatment (process level quality) can be attributed to an improvement in the health status of the individuals who receive health care at such units. This (Outcome attribute) is invariably called user perceived quality. The assumption here is that patients can make an aggregate judgment about where they usually get treatment that can be positively relate to their health recovery or restoration (Wouters 1991).

The measurement of health care quality becomes difficult given the various dimensional perceptions. Measurement health services quality indeed call for different methodologies. Neither the structural, the process nor the outcome perspective will be adequate in making a conclusive judgment that a government or a VA, or health care unit A or B is rendering higher quality health care services than the other. The attributes must be taken in total. However one can decide to emphasize a particular dimensional view, thereby using specific methods that will compare, say only

the structural attributes or the process attributes. Though this approach is partial, it does contribute to an understanding of why people are prepared to pay at a unit X and not at W.

Garner *et al* (1990) presented a method that mainly considers the structural elements assessment of health care facilities in Papua New Guinea. He development a checklist of the presence or absence of some essential equipment and medicines. However that methodology does not show how the processes are managed and how the service users rate the performance of the health care units. Perhaps a useful extension of the Garner et al work that includes the user-perception assessment will give more light. This was done in the Dar es Salaam region study (Munishi *et al* 1992). Additionally how the structures and processes are managed (comparing the government to the VA system) could explain why a relatively higher user-perceived service quality is associated with the VAs. This was done in the country-wide study (Munishi 1991). A combination of the two will presumably add more light on the qualitative differences between the government and the VA health care services in terms of quality. A future study is intended to be more comprehensive to detail the elements of the quality attributes. That methodological approach considers the dimension of centralization (from government dominance) to a move towards quality (Gross *et al.* 1992). In other words there is even a great need to further study the relationship between a health sector reform that introduces user fees as well as encouraging private capital participation and decreasing or increasing the quality of care. There is however a general assumption that quality will increase with privatization due to market competitions.

A further note on methodology is important here. The following discussion extracts data from two studies in which I was a principal researcher. The general perspective covering several districts in Tanzania was done in 1990/1991 during a wider study that covered various aspects including drugs delivery efficacy. Both the government and the VA dispensaries were receiving the drug kits. The study used a sample of facility users in the health-care-unit catchment areas. There were also areas of overlapping catchment areas, where the government and the VA unit overlapping areas were used for the comparative perspective. This is because these are the areas where researchers could readily get people who had treatment experiences from both the government and VA health care services. Such individuals were interviewed using instruments structured to

compare the government and the VA health care services. There are many places in Tanzania where government and VA units are located in close proximity. This made it easier to establish and get respondents from overlapping areas for our comparative study.

Focus group—discussions were conducted in the administrative posts closest to any health care units—one government and the other belonging to some VA in the districts of study. Researcher-facilitators directed a discussion which focused on comparing the quality of services, availability of equipment and drugs, management style etc. Researchers also held in-depth interviews with the dispensary personnel and patients found at the units which were visited. Facilitators used a checklist of issues for an open discussion. Finally they asked participants to rate the units according to their own experience in recent treatment encounter by a scale of very poor to very good. Some found some units to be rendering very good services, while others were rated poor or very poor.

The Dar es Salaam region more research or less used the Garner et al approach in examining and comparing the quality of structures and technical processes in government and Voluntary Agencies units. Structured interviews and focus group sessions were also used to collect comparative data. The process quality assessment was done by posting some medical assistants (as technicians in diagnosis, prescribing, dispensing etc.) at the prescribes' desks to assess history taking, examination, diagnosis and prescribing. This methodological procedure proved to have some limitations and confounding influences on objectivity. A substitute that was adopted was to interview patients found on site and others outside the sites, mainly at their households, provided that they had used the services of both the government and non governmental health care units. The focused group and general interviews mini surveys adopted the approach used in the country-wide study, i.e. getting respondents from the overlapping catchment areas of both the government and the VA units.

This discussion takes highlights from the findings of the two studies. It goes further to consider an important variable that has been rather neglected, that is the managerial quality-difference. The managerial factor is important because even if the structures, supplies of drugs and equipment and personnel were of the same level, the quality of service differences would be much attributed to the way these resources are utilized and directed

efficiently and effectively with a prime objective of improving performance or quality of care. In other words, it is assumed that close supervision, inspection managed autonomy and control are vital management instruments that may improve the quality of services if well utilized.

Information on management differences was gathered by interviews at the ministerial headquarters (MOH, Ministry of Local Government and the Prime Minister's Office). Regional and district headquarters were also visited in trying to study the management related roles and powers of the Regional Medical Officers and the District Medical Officers. Various organographs were studied. On the part of the VAs there were interviews held at their respective secretarial at the national, regional, district and parish levels. The units are mostly owned and supervised at the district or parish (religious mission) level.

The choice of districts in the countrywide study was random meaning non systematic, when a region had been established as having the requisite characteristics of mixture of government and VA units. The choice of respondents at the health care facility level as well as the choice of those in the overlapping catchment areas was randomized also by a game of chance. But one was interviewed when he/she or a member of the household had adequate experience (more than 3 contracts each) with (the use of) government and Voluntary Agency experiences. Experiences were those most recent by our respondents.

A final note on methodology is that readers need to realize that this is mainly a cross-sectional study that examines the current system. The only reason a historical background is necessary is to indicate the processes which have come to necessitate the current policy consideration that calls in the private sector to invest in health care delivery in a situation in which the government was increasingly becoming overloaded by a welfare budgetary crisis in conditions of recession and economic doldrums.

3. Historical Note on the Pattern of Public/Private Mix and Performance

What appears to be public dominance in the current public/private health care mix in Tanzania has historical antecedents. Church organizations which entered Tanzania before Tanzania mainland's independence in 1961 had two other major objectives in addition to religious propagation. These

other goals were education and health care delivery. The VA performance in health care delivery independence is quite remarkable. By December 1958 the church organizations owned 52.9% of all hospitals in the country and 88% of all the dispensaries (Tanganyika Territory Report 1958:350). Therefore the role of the VA during the colonial period,, and even after independence, was vital. Most of the VA units were located in the rural areas where the majority of the population resided. Current Tanzania's rural (peasant) population can be put at more than 80 percent.

After independence there were several government measures which seemed to tilt the balance. The first one was a deliberate government campaign to start new educational and health care structures to demonstrate that it was doing more and better than the colonial government. Secondly these populist inclinations encased in utopian socialist ideology culminated into the 1967 Arusha Declaration of "socialism and self reliance" (Nyerere 1968:1-32). In that declaration health care became one of the basic needs and the government committed itself to deliver it to all who needed it, and free-of-charge.

Out of the Arusha Declaration commitment came locally initiated efforts (self reliance) in which sub-district organizations led by politicians constructed dispensaries in anticipation of a government's take over full responsibility. The government provided equipment and personnel, and eventually taking over an entire management responsibility in many of locally constituted units. If the number of health care units is seen to be growing fast during the 1960s and 1970s, much can be attributed to the self-help projects of the pre-and-post-Arusha Declaration and an eventuality of the government taking over full responsibility.

Another step that made the government to appear heavily involved in health care delivery was its 1969 policy of taking over some responsibilities from the local district authorities in financing and managing health care units, as well as some of those which were previously owned by the VAs. The government took over 17 VA hospitals and titled them government-designated hospitals where medical care was delivered free of charge. The government also took over two VA-owned huge referral hospitals to make them its own zonal referral hospitals. These two huge VA hospitals have been returned back to the VA system in 1993 (in a slow and cautions manner to avoid negative consequences).

The above government centralization did make a significant difference in tilting the balance. Whereas the government owned only 19.2 per cent of the dispensaries at independence, its share had increased to 74.5 per cent in the 1990s. Whereas its hospitals constituted 47 per cent at independence, the number had grown but not so much as it constituted 45.9 per cent in 1990 as compared to the VA hospitals which constituted 47 per cent (see Table 1).

Table 1: ***Distribution of Health Care Facilities by Management and Unit Level (1992)***

Hospitals		Health Centers		Dispensaries
Number	*Beds*	*Numbers*	*Beds*	
77	14231	268	6008	2325
(44)	(53.1)	(96.1)	(97.7)	(74.50)
118	97	8	124	585
(48.6)	(44.4)	(2.9)	(2.0)	(18.7)
13	678	3	18	211
(7.4)	(2.5)	(1.0)	(.3)	(6.8)
175	**26806**	**280**	**6150**	**3121**
100	**100**	**100**	**100**	**100**

* *Others include those under parastatal organizations and some operating under VA licenses.*

Source: Mainland facilities are from Ministry of Health Statistics 1991, Planning Directorate. Zanzibar facilities are from "Priority Plan for Health Services, 1991/1992 - 1995/96" MOH, Zanzibar.

Note that there are no beds in dispensaries as admissions are structurally allowed from the Health center-level upwards.

By June 1994, the balance in the ownership of hospitals and dispensaries had almost reversed where the government is leading (see Table 2). As a result of the populist (egalitarian policy) private capital participation was rather discouraged. Even the religious (Voluntary Agency) organizations had to seek special approvals from the government for them to establish units.

Table 2: ***Number of Hospitals, Health Centers and Dispensaries by June, 1994.***

	Government %	*Voluntary %*	*Others %*	*Total*
Hospitals	77 (44.0)	85 (48.6)	13 (7.4)	175
Health Centers	265 (96.0)	8 (2.9)	2 (1.0)	276
Dispensaries	2218 (73.6)	585 (194)	211 (7.2)	3014

Source: MOH, Health Information System Unit.

* *Others do not include the recently established private dispensaries because at the time of writing the MOH was still verifying the list.*

What one sees in Table 2 is a situation in which the government primary level units were increasing while the VA development of units slowed down drastically. It is however notable that the VA hospitals are more (48.6%) than the government hospitals (44.0). This is a result of the government's policy to concentrate expansion on the primary units, and more so, a policy in favour of rural development. Note that by 1991, before the health sector liberalization policy, the government owned 73.6% of the dispensaries.

Under the category of "other" in Table 2 are included dispensaries and hospitals owned by parastatal organizations (211 dispensaries and 9 hospitals). These units (financed and managed by parastatals) render services free of charges to their families. Non employees are charged fees when they seek services from such units.

This brief background presents a situation where the government's role in health care financing, management and provision was systematically growing while its own resource base to support the established extensive network of health care provision was decreasing or remained constant owing to over commitment and growing demand for free medical services. The health care sector also systematically faced a problem of underfinancing

owing to the recession which hit the country in the 1970s and 1980s. The per capital recurrent expenditure in ECU units of expression was 0.8 (1986/87, 0.9 (1987/88) 1.1 (1988/89) and 0.8 (1992/93). The public commitment to provide free medical services was becoming difficult to sustain. Donor assistance has been very significant. About 47 per cent of the Ministry of Health expenditures in 1991/1992 were donor-funded (United Republic or Tanzania p. xiii). Donor contribution for 1994/1995 for the development budget (United Republic of Tanzania 1994:60).

With an entrenched commitment to provide free health care services, and with diminished capability to sustain them, there has grown a serious concern on the quality of services delivered at the government owned health care units. There are few data concerning the quality of care levels at both the government and VA-owned health care units. An assessment of the structural attributes of quality in VA and government health centers and dispensaries was carried out in Morogoro region. That survey found a wide variation in all aspects of attributes of structural quality. The variation was also between VAs attributes of structural quality. The variation was also between VA and government owned units (Gilson 1992). In an earlier study (Munishi 1991) a comparative exposition is made on the status of the building structures of the dispensaries which were visited (see Table 3). The summary carries agreement judgments by respondents found at the site of the units as well as some visited at their households.

Table 3: ***Comparison of structural quality at Government and VAs (in percentages)***

	Buildings		*Waiting place*		*Equipment*		*Toilets*	
	Govt.	VAs	Govt.	VAs	Govt.	VAs	Govt.	VAs
Very Poor	21.4	7.1	7.1	-	50.0	7.5	66.7	7.1
Poor	14.3	7.1	21.4	-	42-9	-	25.0	-
Fair	35.7	14.3	28.6	28.6	7.1	28.6	8.3	28.6
Good	21.4	21.4	42.9	35.7	-	28.6	-	28.6
Very Good	7.1	50.0	-	35.7	-	35.7	-	35.7

The responses put up a picture showing the government health care units to be generally in poor or very poor condition as far as the attributes of buildings, equipment and toilets are concerned. On the other hand the VA health care attributes are rated much superior- 71% saying that their buildings are good or very good. This level of rating also applied to the way the waiting place is rated at the VA units. Equipment and toilet facilities are in poor or very poor conditions (90 per cent of the responses) at the government owned facilities.

A study undertaken in Arusha region in 1990 showed that many dispensaries had cracked walls. Many had no storage places for equipment and drugs. Some of the dispensary stocks had to be stored in health workers' residences (Munishi 1991: 5-6). A more detailed account of the Dar es Salaam study is presented by quoting specific narrating cases that are mostly typical of many of the government dispensaries which were built in hurry, but have had no maintenance ever since. The briefs are extracts from focus-group discussions held at administrative posts closest to the health care unit premises. The constitution of the focus group included a researcher as a facilitator, village development committee members, some two or more facility users found at the place and a physical examination of the premises by the researchers to corroborate the notes. Extracts are those of Goba, Tuangoma and Kiwalani dispensaries as just a few of such cases. Goba and Tuangoma are in rural areas, while Kiwalani is in the city (urban area)

Case A: Goba dispensary (in Kinondoni District) is in a bad shape with old and cracked walls, dirty rooms etc. The roof leaks and patients have to wait outside because there is no adequate waiting space inside the dispensary. There is no water at the unit. Sick and expectant mothers are required to make arrangements to provide water for cleaning after delivery—usually relatives carry water to the dispensary. A bucket of water sells at Tshs 50 to Tshs 100. Dispensary workers use several hours in search of water. This may reduce their concentration on their professional duties.

Case B: Tuangoma dispensary (Temeke District) is small and unkept; the last repairs and painting were undertaken in 1975 and there is one unkept toilet. There is staff accommodation for only two of the dispensary's personnel. The rest usually report late most often after 11. a.m. instead of the usual 7.30, am as they stay in distant place. The Rural Medical Aid (RMA) in charge of the unit stays at Kimbiji, several kilometers away where

he has some residence and some small farm where, he, like many others, spends most of the time. He is said to be 50% of the time absent from the dispensary that he is supposed to manage. One would not want to assume that a trust in professional ethics (as taught at the medical schools) can be a close substitute for close supervision, inspection and control. Indeed on the continuum of unit's personnel's autonomy it is too much tilted in favor of the dispensary personnel's side. One observation is important, in that fact short of proficient management supervision and inspection, that autonomy is often abused and thereby reducing the quality of services rendered to the public at large.

Case C: Kiwalani dispensary (in Ilala District), is housed in a building which appears to be in ruins, and when there is no activity, it appears like an old deserted structure. It has no medical examination or consultation room. Examination and consultations are carried out in the patients waiting room—a very small space too. There are no toilet facilities, not even for the units' personnel. The Medical Assistant (in charge of the unit) argued that his transfer to the unit is a punishment and he is serving it with bitterness.

After this study report a lot of attention has now been paid to these dispensaries with the assistance of donor (mainly Swiss) funds, at least for the Dar es Salaam region.

For quality to be enhance, the management of human resources inputs is a major enabling attribute. Those who man the various processes have to be those who have the requisite training to handle them efficiently and effectively. Under the government regulations, dispensaries should be headed by Rural Medical Aids (RMAs) who will have had training in diagnosis and prescribing at that level. Units caring to meet quality standards are expected to have these categories of workers doing the diagnosis and prescribing. It seems that some dispensaries do not adhere to these technical requirements. This omission was pointed out by a survey conducted by Mnyika and Kilewo in 1990/1991 in government dispensaries (Mnyika and Kilewo 1991). Table 4 shows the caliber of personnel heading a health facility. The heads of dispensaries, namely Rural Medical Aids (RMAs) are by the MOH guidelines the persons responsible for examination, diagnosis and prescribing in addition to heading dispensaries. At some large dispensaries these roles are done by medical Assistants (MAs) who are a notch higher than the RMAs in qualification.

Table 4: *Health Care Personnel In-Charge of Health Facility at Government Dispensaries and Health Centers (N = 42)*

Cadre Type (in qualifications hierarchy)	*Number*	*Percentage*
Medical Assistants	3	7.1
Rural Medical Aids	5	11.9
Nurse Assistants	12	28.6
MCH Aids	2	4.8
Health Assistant	1	2.4
Health Orderly	2	4.8
Others	17	40.0

Source: IHPP Research Data Source, Dar es Salaam. Case of Kigoma Region.

Table 4 shows a situation in which least trained people get entrusted with intricate responsibilities, for example, Nurse Assistants (scheduled to keep cleanliness) being responsible for dispensaries (29%) or other low level cadres (50% of the time) is an indication of possible low quality. The qualified workers i.e. MAs and RMAs, were found to be working in few places i.e. 19% of the cases studied. This has some negative implications on the quality of health care and the trust the clients may have about units run and managed by unqualified personnel. There was an extreme cases in Kasulu District in which a Bwana Ndoro (tsetse fly assistant) was in charge of a dispensary. This goes to question Tanzania's government claim for a wide coverage by the public health provision. It may mean a lot in quantity but lower quality, and this is a significant tradeoff.

A comparison of how the consumers of health care services rate both the public and VA health care services (with a view of human resources) shows that the level of the qualified personnel (for diagnosis and prescribing processes) is better at the VA units than at the government owned units. While only 27 per cent rate those at the government's units as good or very good, the same respondents rate the VA at 82% unit's personnel as good or

very good as shown in Table 5. (Extracted from the Dar es Salaam region study).

Table 5: ***Quality of prescribers (MAs and RMA) Rated by Users on the Basis of Ability and their Availability at the Point of Consultation.***

	At Government Units		*At V.Agency Units*	
	Frequency	*Percent*	*Frequency*	*Percent*
Very Poor	20	13.0	1	0.6
Poor	51	33.1	2	1.2
Fair	56	36.4	12	15.6
Good	23	14.9	46	46.1
Very Good	4	2.5	36	36.4
	154	100 .0	154	100.0

Table 5 depicts relative higher levels of the quality of care by the MAs, RMAs, nurses and other workers at the units owned and run by the Voluntary Agencies. The respondents indicate that the MAs and RMAs are readily available at the Voluntary Agency unites but hardly available at the government owned units. The availability of MAs/RMAs at the government units is rated to be poor or very poor by 71 respondents or 46 per cent, respectively, but the Voluntary Agency units are rated to be poor or very poor on that count by 3 respondents or 2 per cent respectively.

The problem of non availability of key workers at their places of work is rampant. This negative personnel behaviour was also noted during the interviews and focus group discussion with the ward and village level leadership in the unit's catchment areas. The interviews depict that absenteeism is mainly caused by a lack of systematic supervision, control and inspection, low wages which force workers to engage in other petty

income generating activities and lack of staff housing units, which forces the workers to live in places very far from their places of work.

The group focus minutes did point out some extreme cases of unavailability of MAs and RMAs at their places of work. At Gezaulole, the RMA in charge lives on his small farm far from the unit, and during our intermittent visits, nursing assistants were in charge of diagnosing and prescribing. Workers other than MAs and RMAs were found to be doing the work of MAs and RMAs even though the regulations and training levels do not allow. Indeed such cases are likely to cause problems at the units in question, and most probably, lead to poor services.

The existence of adequate working equipment is another important element of the structural attribute of quality. In addition to these, some other structural back up facilities, such as means of communication, are important. Some of the dispensaries and health centers are located in remote distant places. These locations are sometimes inaccessible during the rainy seasons. In the country-wide study that was conducted in 1991, the case of Arusha region was quite informative of the differences between the government and the Voluntary Agency (VA) units.

For the purposes of sterilization, the MOH units are provided with kerosene on a monthly basis. Sometimes the kerosene runs out before getting new supplies, whereupon patients are asked to make contributions to purchase fuel. In the case of the distant remote VA dispensaries, there are solar power units in place. There were solar-energy units installed at the VA units, for example, Loliondo, Kiteto and Mto-wa-mbu dispensaries, while the neighboring, government units did not have any. Additionally, every head of station at some of the VA units —the Rural Medical Aid—is provided with a motorbike for quick errands and patient-case follow up or patient-extension visitations. All these attributes are absent at the government owned dispensaries in the same locations where the VA units are located. These differences mean a lot to the personnel at the unit in terms of enhancing workers motivation and quality. They also mean a lot to the service user, who may be influenced by the structural gear in place, and they may judge the VA units services to be superior to the government health care services.

On the status of the essential equipment at the dispensaries there are also significant differences between the VA and the government units.

The Dar es Salaam study shows that more than 62 per cent of those interviewed rate the availability of up-to-date working tools at the government units to be poor or very poor. The same respondents rate the status of equipment at the VA units to be good or very good (71%of them).

One wonders as to what can additionally account for the significant differences between the VA and government at their units. One of the explanations is management style as it will be shown later. But related to the management is a maintenance culture that is structurally in-built in the VA but almost non existent in the government system. Again, the Arusha region study show that the Northern Diocese of the Lutheran Church maintains a maintenance schedule for equipment located at various places in the dispensaries under their jurisdiction. The medical-equipment technician is located at the Diocesan headquarters. A calendar of maintenance is structure and closely followed for routine equipment check-up and repairs on sight. Major repairs are done at the Diocesan headquarters, and later on they are returned to the respective dispensaries or hospitals. Unscheduled repairs can also be requested in order to smoothen treatment processes

Another back-up facility to improve the quality of care at the VA is communication network. The 1990 Essential Drugs study in Tanzania (Munishi 1991) found out that packages of essential drugs were dispatched to remote distant locations 3 to 6 months in advance. This is because the government distributors feared that they might fail to supply remote distant dispensaries according to the schedule of monthly deliveries, especially during the bad weather.

There are several problems with this (advance) deliveries, including drug damages, pilferage and expiration of drugs shelf life before they are dispensed out to patients. Of course quite often some dispensaries got supplies which did not tally with the disease syndrome in their localities.

The Voluntary Agency dispensaries in Arusha did not have an overstock or hold buffer stocks. In the Lutheran Church dispensaries, for example, orders could be made by a radio call facility connecting them to the Diocesan headquarters (Diocesan Medical Store). They could order what was needed at the time, depending on the diseases prevailing during that season. The government facilities totally lacked communication that would enable them to report problems, or to order fresh supplies. These structural

difference count a lot more in comparing the government and VA services in terms of level of quality of management.

Transportation is a major handicap in the government health care facilities especially at the level of dispensaries and health centers. It has been noted above that some VA dispensaries are provided with motorcycle for simple errands to make work more efficient. Some more established dispensaries and hospitals under the VA system have vehicles at station for supplies-back up, and in case of emergencies that require referrals. The 1990 IHPP study found that the Tanga (Municipal) catholic dispensary had a four-wheel vehicle at station. The location of the VA dispensaries at the denominational parishes (church premises) means that they can also request to use the parish vehicle(s) whenever there is a need to, for instance, for emergency referrals.

4.2 Availability of Drugs and Quality of Service Assessment

In countries of the Western industrial world, drugs are not a rare commodity because they can easily be purchased at the drug stores with or without prescription. Of course this generalization assumes that one has the required cash. In most developing countries drugs are a very scarce and essential commodity. Their availability depends on several factors including the availability of foreign currencies and an efficient network of drug stores and transportation, factors which are major stumbling blocks to the availability of drugs in the government's supply system. In remote rural areas, drug stores may not exist; and where they exist they may not oftenly stock the essential drugs. In such circumstances a patient visiting a dispensary for treatment will consider the treatment as being adequate and qualitative if he/she can get the prescribed drugs at the premise, whether purchasing them or getting them free of charge. This is the situation in most rural and even some urban parts of Tanzania. An assessment of quality has to include drugs availability. With a privatization policy of post 1991, quality seems to be commensurate to the availability of drugs also.

Some hints have been made concerning the differences between the government and VA units in terms of structural endowment. Apparently the structural endowment is closely related to drugs management at the health care-facility level. Government dispensaries are normally supplied by a centralized program of essential drugs—the Essential Drugs program or EDP. Estimated supplies are delivered at the dispensaries each month, and

one such kit is expected to last for 30 days. The EDP study found out a lot of problems with the kit system. These problems included situations where some essential drugs such as antibiotics and injectable lasted for 25% of the month (Munishi 1991). The over-centralization of the EDP management is inefficient in responding to outbreaks of diseases, delivering to location-specific care-needs. The kits could not be distributed to go along with the changing diseases patterns. Drugs for water borne diseases were delivered in the same amounts as though there were no variations in weather and geographical factors. The government is presently abandoning the supply approach. The reorganization is adopting a requisition approach in which units will order what they require, say like the VA units (MHO 1993).

On the other hand the VA units are different in that they get their supplies at the district level as the demand arises. The VA unite keep a budget which enables them to ensure that most of the prescribed drugs are available at their dispensing counters. Government units do not keep budgets, as they vertically look up for government supplies. Perhaps as the user fees are introduced in the government system, health care units may keep some funds to replenish their emergency supplies. Short of this facility, treatment is more complete and more qualitative (in the perception of patients) at the VA units (by the criterion of drug availability) than at the government units. Service is incomplete and inefficient at the government units as patients are told that drugs are not available, and they have to purchase them from some distant and unsafe places. Again in remote rural areas drug stores are unavailable or ill-equipped; the government has hardly the resources for drugs inspection and control of usage to guarantee the quality of drugs purchased from street shops.

The Dar es Salaam region study compares the availability of essential drugs at the government and the VA units. It found out that drugs were available for less than 50 per cent of the (month) time (Table 6) at the government units.

What Table 6 shows is a general affair which sees one system (the government supplied side) being abstemiously graded in terms of quality almost equated to the availability of drugs. At least 130 of the respondents or 84.4 per cent view the availability of drugs at the government units to be very poor or poor. On the other side 139 respondents or 90.3 per cent view the availability of drugs at the Voluntary Agency units to be very good or

good. Only 3 (1.9%) out of 154 respondents indicate the availability of drugs at Voluntary Agency units to be poor or very poor; and only 8 (5.2%) of the 154 respondents indicated that the availability of drugs at the government units was good or very good.

Table 6.: ***Comparing the Availability of Drugs at Government and Voluntary Agency Units***

	At Government Units		*At Voluntary Agency Units*	
	Frequency	*Percent*	*Frequency*	*Percent*
Very poor	77	50	1	0.6
Poor	53	34.4	2	1.2
Fair	16	10.4	12	7.8
Good	7	4.6	50	32.5
Very good	1	0.6	89	57.8
	154	100.0	154	100.0

The differences in the availability of drugs, according to our probing interviews, made patients to travel long distances leaving behind government units in their neighborhood to go to distantly located Voluntary Agency units. At the Kawe Roman Catholic Dispensary (in Kinondoni District), our respondents had traveled across the city from Kibaha 40 kms away (in Coast Region), Kigamboni 15 kms (Temeke District) and the city center 9 km (Ilala District). When probed further to explain why they had traveled all the way leaving other units behind, they all said that it was because of the availability of drugs and personal touch they received from the Kawe Voluntary Agency dispensary personnel. In fact a government dispensary with free services is located 600 metes away across the road from Kawe Voluntary Agency dispensary but these were few patients there whenever we made comparative visits. The units' buildings and equipment were dilapidated and needed serious repairs.

At Msimbazi Roman Catholic dispensary, the researchers had to do interviews after the official closing time because of the long queues waiting to

be attended. Again the unit is almost overstocked with drugs and other supplies. The MA in charge explained that the unit donates some drugs to Ilala government hospital at a time when it is judged that certain kinds of drugs in stock will have their shelf life expiring without being used. This kind of high endowment repeats itself if one goes to other units such as Voluntary Agency dispensaries at Tegeta, Kiwalani and Temeke and many other places across the country. Whereas governments in Dar es Salaam, the VA dispensaries had diversified sources such as direct purchases, domestic and international purchases and donations.

4.3 Treatment Processes and Quality Differences

The above discussion has shown that there is a significant difference between the government and the VA health care facilities in terms of structural amenities and their maintenance, back-up services such as communication and transportation and the availability of the essential drugs. One would further seek to know the differences in how the processes of diagnosis and prescribing are handled. On this factor differences are not to be very significant because they (examiner/diagnostic personnel) are trained in the same schools which are under the government. Therefore differences may be the result of motivation and management variations. The VAs have some schools but the syllabi are the same as those of the government schools. In the Munishi-Kanji-Kilima study (1992) the process element of quality was captioned "technical quality".

The study found out that history taking was adequate in 63% of the sample consultations, and the Christian (VA) units performed better than the government units (Munishi *et al* 1992:17). VA units also performed better than the government units in the examination process. It has to be noted that these observations suffer from one major limitation. This is the fact that while examining or prescribing, some researcher sat by to observe the correctness of the procedures. The demonstration effect fear by the MA/RMA may question the reliability of the above conclusions as they are compounded. We had to have a technical person to examine technical processes, and this has its own limitations in terms of reliability. Due to this important confounding effect, conclusions are better reserved to what the users see (Table 5 above), and in any case, the earlier study shows that the processes are being handled by unqualified personnel even where such units have qualified people (Table 4 above).

What may make a lot of difference in terms of quality, while holding the process attributes constant, would be the structural attributes and the management mechanisms that ensure that structural emenities enable the workers to execute their duties efficiently and effectively. The process attributes can be held constant because both the VAs and the government draw their technical personnel from the same training pool. Presumably at the point of qualifying (passing written and practical examinations) all graduands are averagely the same, what would tend to make a significant difference is the conduct of management that controls for efficiency, supervision and accountability.

4.4 The Management Differences between VAs and the Government System

The management of public health services in Tanzania is divided among three major ministries. The Ministry of Health (MOH) is responsible for the technical aspects of health care, and it supervises all policy matters concerning creative, promotive, and preventive health programs. The prime Minister's office funds the regional district hospitals. The Ministry of Regional Administration and Local Government is responsible for the District councils, which are in turn responsible for the health centres and dispensaries under their jurisdiction. Therefore, the responsibility for public health care units falls under several authorities. This undermines the unity of command and accountability in the individual health care units, especially in as far as the government owned units are concerned.

At the national level the organization and implementation of health care programs seems to suffer from several problems. The health care management information system is not readily available for the purposes of control and inspection. Coordination of the three principal ministries involved—and there are others such as water, Education and Culture, and Agriculture—is very weak and intermittent. Financial management is poor, due to principally poor communication, coordination, supervision and systematic inspection.

The Tanzania government health care system is supposedly a decentralized one in principle. It was a deconcentration from the national headquarters to the regional and district headquarters. It is not a completely devolved system of management. The recent move (after 1993) to allow units to charge for services and related such funds may lead to effective

decentralization. Even with the policy, local units are still heavily dependent on the center. On the other hand the national level system is presently incapable to exercise serious control, supervision and inspection of what actually goes on at the level of the region, the district and sub-district in as much as health services delivery goes. Since 1989 there have been plans to revamp district level management. However, there are proposals toward this ideal, and the District Medical Officer will be equipped to be able to do some supervision. The government proposes to provided transport and supportive personnel. But the sector is still inadequately funded so far.

Given the fact that there are no funds available for inspection and supervision, these vital management functions are left to a game of chance. Occasionally, some units are visited by officials from the district or national headquarters. These unscheduled and unpredictable visits are very brief. At the level of the district there exists no inspectorate/supervisory personnel, transport, means of communication and funds to initiate systematic scheduled and unscheduled supervisory and inspection visits to health care units.

The organization pattern and management chart leaves no particular authority to be responsible for the maintenance of structural and technical aspects of quality at government owned health care units (see figure 1). With the cost sharing initiative started in the late 1993, it is hoped that funds will now be raised to supplement the meager government funding, especially if funds will be retained at the units level for undertaking simple repairs and maintenance of structures.

The Regional and District Medical Officers are persons responsible for medical services in the regions and districts respectively. However they do not report only to the MOH headquarters but also to their respective heads. i.e. the District Executive Development Director and Regional Development Director respectively. They are also answerable indirectly to the Prime Minister's Office and the Ministry of Local Government and Regional Administration. This creates a cumbersome network of answerability and responsibility. While the MOH can be held responsible for, say, poor diagnosis and prescription, the Prime Ministry's Officer could be answerable for lack of drugs at the regional hospitals, the MOH for lack of drugs at the dispensaries and the District Councils (under the Ministry of Local Government and Regional Administration) could be held responsible

for lack of funds to purchase drugs and equipment for government health centers and dispensaries. This cumbersome division of labour seems to be creating problems and lack of responsibility, let alone the absence of effective supervision and control.

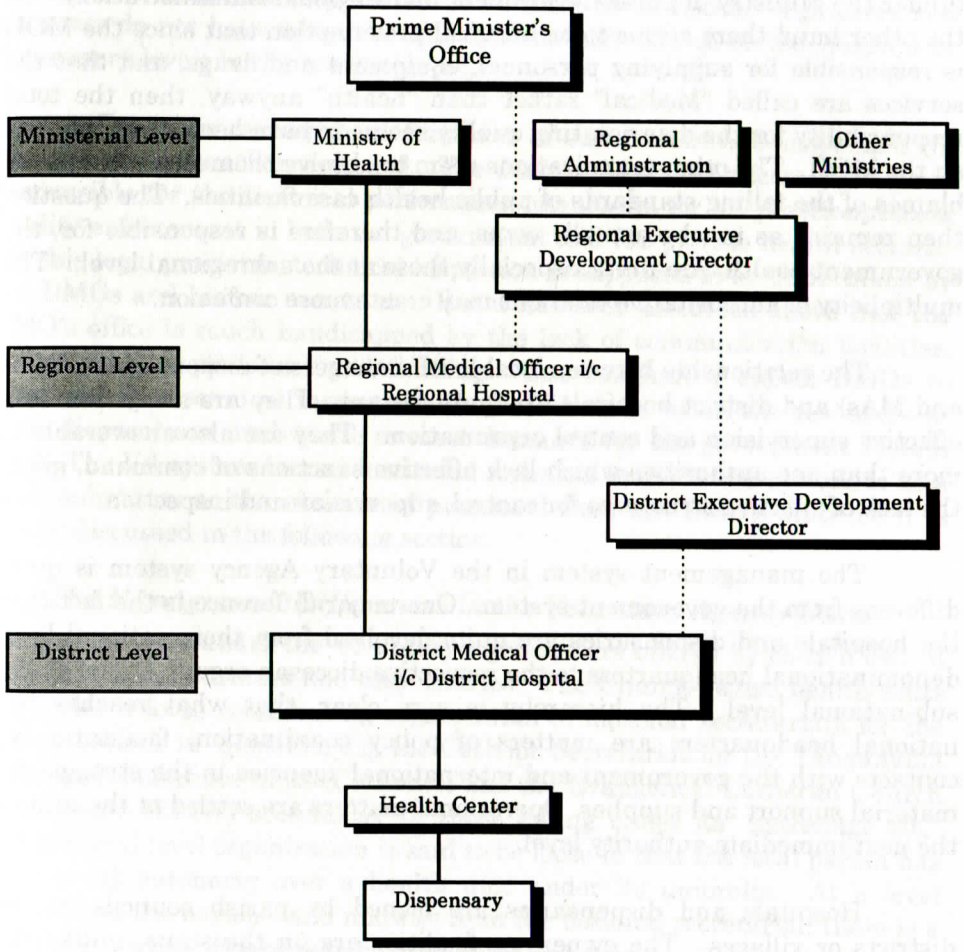

Figure 1: ***Supervisory Relations in Government Health Care System***

Note:

——— Administrative and Technical Communication

..... Administrative Communication.

The structural quality of the government health care units, especially buildings, has been said to be in deplorable conditions. The MOH is concerned more with the technical aspects of quality. The responsibility for the repair and maintenance of buildings lies with the District Councils (under the Ministry of Local Government and Regional Administration). On the other hand there seems to be a logical presumption that since the MOH is responsible for supplying personnel, equipment and drugs, and that the services are called "Medical" rather than "health" anyway, then the total responsibility for the deteriorating quality seems to have been easily blamed on the MOH. The other organizations seem to absolve themselves from such blames of the falling standards of public health care facilities. The question then remains as to who actually owns, and therefore is responsible for, the government health care units, especially those at the subregional level,. The multiplicity of authoritative relations may create more confusion.

The relationship between local level managers of dispensaries (RMAs and MAs) and district hospitals are quite distant. They are away from any effective supervision and control organization. They are also answerable to more than one authorities which lack effective sanctions of command, given the lack of effective structures for control, supervision and inspection.

The management system in the Voluntary Agency system is quite different from the government system. One major difference is the fact that the hospitals and dispensaries are quite devolved from their national level denominational headquarters to the respective diocesan organizations at the sub-national level. The hierarchy is very clear, that what reaches the national headquarters are matters of policy coordination, facilitation of contacts with the government and international agencies in the struggle for material support and supplies. Operational matters are settled at the unit or the next immediate authority level.

Hospitals and dispensaries are owned by parish councils in the districts or villages. The owners or facilities are on the scene, unlike the government system where the specific owner is either unknown, but definitely being quite far from the premises where the health care services are delivered, ownership, and responsibility are clearly shown for any prompt action where necessary.

With the VA units, the management functions of planning, organizing, directing and control are eased up, given the closeness between the managers and owners. These vital management functional in the government units are usually done globally at the headquarters of the regions and ministries responsible. Most often these distant organizers and planners do not have adequate and accurate information on the hospital or dispensary levels in the remote places.

The other management functions of supervision and inspection (in health care) are rather technical. The District Medical Officers (DMO) are responsible for the technical performance standards for all practice/process quality enforcement in both the government and the private health sectors. On this legal provision, technical inspection is supposed to be undertaken by the DMOs and his/her assistants. But it has been discussed above that the DMO's office is much handicapped by the lack of communication facilities, transportation, personnel and funding. One can hardly expect DMOs to carry out the technical inspections in the VA units when the resources at their disposal are inadequate to meet demands for the government system itself. The VA system has an instituted technical inspectorate system to be a close substitute to the absence of personnel from the DMO's office as it is briefly discussed in the following section.

4.5 The Management Differences in the Voluntary Agency Units

Medical services under the Voluntary Agencies are offered by church owned hospitals, health centers and dispensaries. The Church-owned health units are under a loose coordinating organization of national secretariats for the denominations in question, e.g. the Catholic Secretariat for the Tanganyika Episcopal conference units (Catholics) and the Evangelical Lutheran Church of Tanzania (ELCT) secretariat for those falling under its patronage etc. The national level organization is said to be loose in that the local parish has some great autonomy over a health unit under its umbrella. At a level higher than the parish—and midway from the national secretariat, there is a Diocesan Medical Board which coordinates operations and supplies as well as matters of policy on the management of the church-owned health units as shown in figure 2.

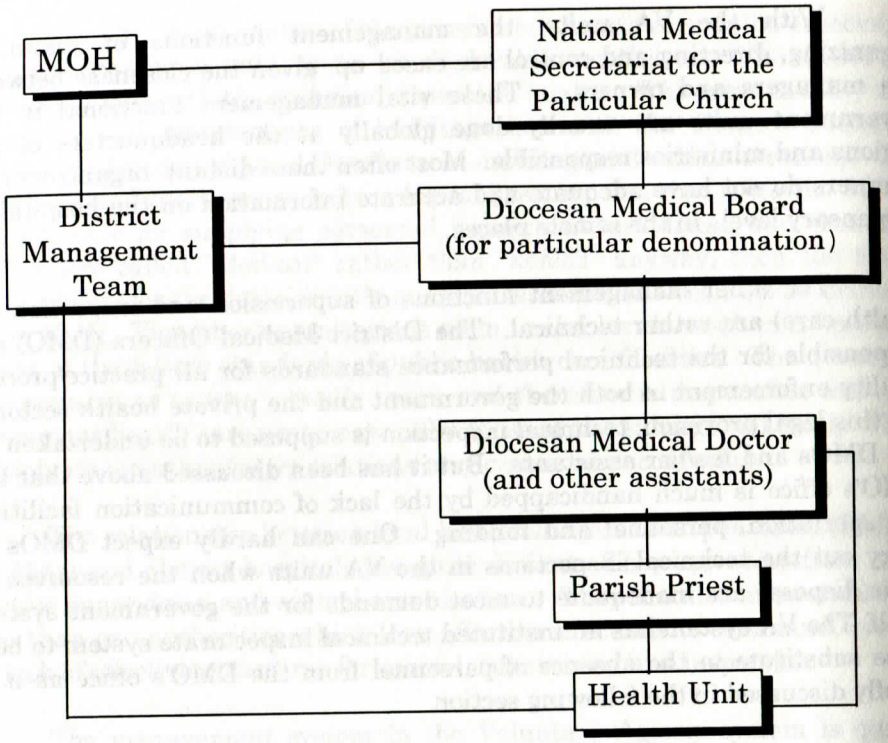

Figure 2: ***Organization of VA Health Units***

What can be noted from figure 2 (which is different from the government system) is the fact that there is a known responsible facility owner close to the unit itself. The VA health units belong to the parishes in which they are located or the diocesan bishop. The parish priest in charge supervises the day-to-day activities at the health unit in addition to the medical practitioner in charge of the unit in question.

VA units seem to be better supervised than the government owned units. In well established church health systems such as that operating in Morogoro, Arusha and Kilimanjaro regions, there is Diocesan Health Management Team composed of the Doctor in charge for the diocese, Medical Secretary, Storekeeper, Treasurer etc. Visits are made twice a year or more

by the team; and more frequently by the Doctor in charge. The team normally spend a day or two at a particular unit to examine medical procedures/practice/correctness of diagnosis and prescription; to inspect stocks, to appraise and write off or reallocate expiring drugs, to inspect buildings and equipment and to examine books of accounts at the unit. The Medical Doctor's visits becomes expertly and importantly consultative. Diocesan medical doctors serve as consultants (as they visit) to lower-level health units in their respective hospital catchment areas. This creates a qualitative difference in the clinical performance that can be closely related to the management difference.

There are other forms of supervision and control besides those undertaken by the visiting teams. These include visits by treasurers of the dioceses, technicians, storekeepers etc.; and sometimes visits by the District Medical Officer etc. There are also some surprise visits by members of the Diocesan Health Management Team.

4.6 Management of Human Relations: The Qualitative Differences between Government and VA Health Care Units

Most often the quality of reception of patients by the health units staff is underrated on its contribution to a patient's perception of the quality of care. The studies in Dar es Salaam and Arusha regions indicate different methods used to cultivate patients' or patrons' trust in the particular unit's services. Indeed when most patients were requested to compare the qualitative differences between they government and VA group of units they mostly referred to the way they were received and nursed; and whether there were drugs or not. Table 7 shows responds from a survey carried out in Dar es Salaam comparing quality of interpersonal relations between prescribers and patients at government and VA units.

What can be noted from Table 7 is a fact that the way prescribers handle patients at the government units is qualitatively different from the way they are handled at the Voluntary Agency health units. While the facility users rate the VA-unit service as high or as good or very good (89%), the rating is lower for the government units on the same level scale of good and very good (33%). The methods by facility personnel vary from simple mechanistic handling (pure procedures) at the government units, to a strategy of cultivating a sense of hope and belonging at the VA units

(Kibosho hospital in Moshi, Seliani Lutheran hospital in Arumeru and Tanga Municipal catholic dispensary).

Table 7: ***Quality of Interpersonal Relation (Patients to Prescribers) in Dar es Salaam Units***

Rating	*Government*		*Voluntary Agency Units*	
	Score	*Percent*	*Score*	*Percent*
Very Poor	13	9.3	1	0.7
Poor	23	16.4	0	0
Average	58	41.4	14	10
Good	29	20.7	48	34.3
Very Good	13	12.1	77	55.0
	140	**100.0**	**140**	**100.0**

Source: Dar es Salaam Urban Health Project Research.

At another level the quality of reception and nursing care would tend to make a significant qualitative difference in the manner in which facility users compare the government and the VA groups of health facility services. Again in the Dar es Salaam study, facility users who were found at site and away (but having an experience of using services from both VA and government providers) were requested to award scores. The summary is presented in Table 8.

Table 8 shows facility users who have experiences with both the government and Voluntary Agency health services give higher scores to the Voluntary Agency units services (76 per cent as being good or very good nursing and reception services). The government units score comparatively lower than the VA units (17 per cent for good to very good services). On the other extreme end of the users' rating scale, the VA services are given 5% for being poor or very poor; and the government health services score 49% for being poor or very poor. Rendering health services with a human touch makes a qualitative difference between government and VA health units.

The now mushrooming private units may hypothetically score more on quality, perhaps. But this hypothesis requires a more detailed comparative study.

Table 8: ***Quality of Nursing and Reception at Units***

Rating/Score	*Government Units*		*Voluntary Agency Units*	
	Frequency	*Percent*	*Frequency*	*Percent*
Very poor	29	20.7	2	1.4
Poor	40	28.6	5	3.6
Average	47	33.6	27	19.4
Good	21	15.0	54	38.6
Very Good	3	2.1	52	37.1
	140	**100.0**	**140**	**100.0**

5. Concluding Remarks: The Qualitative Differences under Structural Adjustment-Program-Induced Health Sector Reforms

The discussion finds that there are significant differences between the government owned and VA-owned health care unit-services in Tanzania. The fact that quality is found to be poorer in the governmental sector than in the NGO sector is a function of factors which could be attended to so as to improve the quality of services in the governmental sector. Such factors are mainly explained by the existence of a very loose or lax management in the governmental sector. Unit-level planning supervision, inspection and control are major management functions which govern the delivery of efficient and effective services in the VA system. These management functions are almost absent or they are loose and intermittent if not nonfunctional at the government health care units. One would tend to believe that given detailed and consistent management of resources at the disposal of the government health care units, there would not be significant difference between the NGO and governmental health care services. Of course the problem of multiple

accountability must also be straightened up as a management reforms strategy in the governmental sector.

The better performance by the NGO sector in the area of health care delivery, and the fact that people are willing to pay for such services instead of getting them free of charge at government health care units, must have influenced the government's decision to embark on health care sector reform under the SAP (Abel-Smith and Rawal 1992). What people are prepared to pay for is perhaps the perceived and structural quality of care. This implies that the proposed health care sector reform must be accompanied by a significant improvement in the quality of care at those units which are charging fees for services. Otherwise it may greatly alienate people and probably reduce utilization levels (assuming that the quality and prices in the private sector remain constant).

The above discussion also showed that the concept of quality is very slippery. If quality is perceived by providers as a major factor that attracts (commodity) service consumers, the providers will decide on what constitutes quality. The inputs will be such that they are cheap but attracting patients, but not necessarily adding significantly to the general state of a society's well being. Providers (especially private practitioners) may install expensive equipment to demonstrate prestigious and conspicuous elements that are not necessarily related to quality (in the technical sense) improvement. Such installations may just exploit the consumer ignorance, to make consumers believe that private care is more capable than the government unit in the treatment processes. This implies that with health sector reforms, under the SAP, the government system of laws and regulations must also adopt criteria for standard performance that apply to both the governmental and non-governmental sectors. If left alone, the private-for-profit- practitioners may over-invest in conspicuous-consumption aspects rather than in the actual improvement of treatment processes themselves. This defeats the purpose of the planned reforms which gear at the improvement of well being.

The VAs have had heavy subsidies from the government for them to (partly) maintain a superior quality of care than the government health care units. Subsidies have included bed and personnel grants, tax exemptions, etc. With the current health sector reforms a substantial part of the subsidy is likely to be withdrawn. The question is whether the VA units will be able to continue to maintain comparatively better qualities of health care delivery

at the current costs. On the other hand the desire to compete and maintain standard quality of care along with the for-profit private health care may force the VAs units to increase their service-prices. This may have effects on utilization and equity factors. These are also important issues to be studied in more detailed studies as the implementation of SAP progresses in Tanzania, with a view to establish its positive and negative impacts on the quality of health care delivery as a whole.

There are possibilities in the privatization movement that the VAs and other private health care and especially preventive health services providers will tend to invest in high-price prestigious and conspicuous developments to attract those who have money. Perhaps basic primary care may tend to be excluded from private sector involvement. This will have the implication of putting increasing responsibilities on the government in that it may find itself burdened with the responsibilities of rendering the bulk of primary health care, while the VAs and private-for-profit providers invest more into tertiary high-tech and conspicuous services that are inaccessible to the general population. During the SAP implementation processes the government needs frequent policy reviews to ensure incentives and/or regulations that tie the private sector (VAs and the for-profit investors) to invest in essential primary and preventive services that can be accessible at affordable prices. In short, the process of privatization has to be planned, if not mapped and monitored to ensure balanced provision, efficiency, and effectiveness in both government and private sector.

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