SUCCESSES AND CONSTRAINTS FOR IMPROVING PUBLIC PRIVATE PARTNERSHIP IN HEALTH SERVICES DELIVERY IN TANZANIA

By Prof Josephat Itika, Dr Oswald Mashindano & Dr Flora Kessy

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LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
APHFTA	Association of Private Health Facilities in Tanzania
CSSC	Christian Social Services Council
DDH	Designated District Hospital
HIV	Human Immuno - Defiency Virus
HSR	Health Sector Reform
MCH	Mother and Child Health
(MDGs)	The Millennium Development Goals
MoH	Ministry of Health
MoH SW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya (*Swahili*)
NACP	National AIDS Control Programme
NGOs	Non Government Organisations
NSGRP	National Strategy for Growth and Reduction of Poverty
PMO-RALG	Prime Minister's Office- Regional Administration and Local Government
PO- RALG	Presidents' Office- Regional Administration and Local Government
PPP	Public Private Partnership
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
URT	United Republic of Tanzania
WHO	World Health Organisation

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However, much as we sincerely appreciate the contributions from all key stakeholders consulted, we remain accountable for errors, omissions and interpretations which may be found in this report.

EXECUTIVE SUMMARY

This is a study on Public-Private Partnership (PPP) in health services delivery. It includes a Joint Annual Review of the Ministry of Health and Social Welfare (MoHSW), the Presidents' Office-Regional Administration and Local Government working with the private sector. The objective of the study was to examine successes and constraints for strengthening PPP in the health sector. It provides details on the areas for strengthening PPPs in Tanzania in terms of how are they initiated and challenges overcome.

Key successes are noted in terms of the increasing number and demand for PPP interventions. However good intentions of key stakeholders to strengthen PPPs in the health sector, there are many constraints comprising of regulatory framework, coordination, financial support, stakeholders' trust, commitment and accountability, human resource capacity and utilisation, access to essential drugs, tax relief and adherence to professionalism. Some recommendations were made on strategic actions for implementation of PPPs by the MoHSW.

It is concluded that although there has been very strong dissatisfactions with the performance of PPPs in the country, given the long history of the marginalisation of the private sector which has contributed to poor capacity and mistrust between the government and the private sector, the areas of partnerships are increasing in number and demand, therefore interventions for improving PPPs should be not only a collaborative effort among the PPP key stakeholders, but should also observe the partnerships norms. Building on the attained successes and working on the existing constraints should be the motive of the partners to improve partnerships in health service delivery in Tanzania.

1.0 INTRODUCTION

> *"…My Government is determined to create such effective and efficient public service that will be relevant to the changing needs and times. To succeed, we call for the full cooperation and support of all stakeholders in a spirit of genuine PARTNERSHIP between Government and the Private sector to promote competitive growth, job creation and enhancement of national wealth…"(* President Benjamin W. Mkapa, 2000).

Public Private Partnership (PPP) as a catchy phenomenon has been used differently by different scholars and gained momentum in the 1990s. Scholars share a common understanding of PPP as *collaboration* between the public and private sector organisations where there is pooling together of resources (financial, human, technical, and information) from public and private sources to achieve a commonly agreed social goal. Here the term "private" is used loosely to mean stakeholders who are not part of the government organs. In this case, the formality or informality of partnerships is not considered as important as the end in itself. For the purposes of simplicity, the term is used to signify *collaboration, participation,* and *partnership* interchangeably.

It is now common knowledge that the private sector, the government and the community can all gain from PPP if there are genuine concerted efforts to work together (MoH/PORALG, 2005, Itika, 2007). Citizens as part of the key stakeholders under PPPs have a genuine stake in making health services accessible, affordable, reliable and of good quality. The government may gain through enhanced capacity to deliver health services to citizens while NGOs will also improve capacity to deliver and achieve value for money. The private sector will improve capacity if it assumes that there are skills and resources that will benefit from public sector services, such as commercial incentive increased efficiency, and focus on customer requirements. The demand for PPP calls for innovative approaches and provision of regulatory frameworks that have direct links with the private sector. The Millennium Development Goals (MDGs) and National Strategy for Growth and Reduction of Poverty (NSGRP), (URT, 2005) for example, have placed the community (citizen) at the centre of the agenda, with responsibility for improving health services on the government and private sector working as partners

1.1 Efforts to Strengthen PPPs in the Health Sector in Tanzania

The evolution and development of policies and strategies for improving health services in Tanzania demonstrate high government commitment to provide free health services to the marginalized population. It was only after serious deterioration of health care services in the 1980s caused by government failure to meet the costs that led to the re-thinking about the role of the private sector. The importance of the private sector in health service delivery moved towards market-based socio-economic reforms to the establishment of the Private Hospitals Regulation Amendment Act of 1991, which facilitated the re-establishment of private medical and dental services.

The demand for better services and the need for improved public health status, particularly in the rural poor, led to the development of Health Sector Reforms (HSR) in 1994 and in 1996. This pushed the government to approve a health sector reform strategy. Later the Health Sector Reform Action Plan for 1996-1999 was also endorsed (MoH, 1998). The action plan included six strategies:

decentralisation, improvement of central health systems, health management, financing, human resources, and *partnership*. Subsequently, developed HSR Programme and Action Plan of 1999-2002 (URT, 1998).

In order to devolve more power to the local level, the Local Government Reform Programme (URT, 1998) was formulated as a policy instrument to facilitate decision making and accountability in municipalities and district councils on public health-related matters amongst others. These policy documents made it clear the government's intention to work closely with the private sector (for profit) and non-governmental organizations (NGOs).

Therefore, the health sector reforms are closely linked with Local Government Reform Programme (LGRP), which aimed to decentralise personnel, planning, and financing decisions of service delivery to the districts. As of January 2000, 35 districts had been decentralised, forty-five more districts were to be decentralised by January 2001 and the remaining ones were to be completed by January 2002 (URT, 2001).

Today, the process of decentralisation is completed although some remnants of central government such as control from the centre is still strongly felt. Districts were to be responsible for staffing decisions and setting their service priorities, district health plans were to be funded through block grants, in addition to donor funding provided through the basket financing mechanism. However, less is seen on the ground to be implemented as expected. The Local Government Reform places significant emphasis on human resource development to ensure adequate planning and budgeting services. This was part of capacity building initiatives stirred by the then on-going reforms. Implementation of health plans is monitored and additional funds are withheld if standards of achievement are not accomplished. The Ministry of Health and Social Welfare retains control of policy, regulatory, and strategic functions and also continues to provide certain essential services, including immunisations, family planning, and the treatment of chronic illnesses, tuberculosis, and leprosy.

In 2000, the then Ministry of Health (MoH) developed key performance indicators and outputs for assessing public private partnership in health service delivery in the country. The indicators are the degree of collaboration among partners in terms of numbers, the contribution of the private and public sector in partnerships and client satisfaction rate. The performance of PPPs was expected to be in the form of implementation strategies and timeframes. Policy and legal review was to be completed by 2001; mechanisms for promoting PPP discipline were to be in place by 2002. Guidelines to private providers to enable them qualify for government support, and mechanisms for joint inspection of health facilities and employees was to be in place by 2002 (MoH, 2000).

1.2 The Need for Better Understanding of PPPs in the Health Sector in Tanzania

The position that PPP is the best policy, strategy and a collaborative mechanism for the improvement of health service delivery in Tanzania is no longer an area of controversy. The current debate is how to make PPPs work for maximum benefits of all stakeholders. The most comprehensive study on PPP in health service delivery, commissioned by the Ministry of Health and Presidents' Office Regional Administration and Local Government (MoH/PORALG, 2005), and Tanzania Joint Annual Review, MoH (2005), observed that despite the good intention of key stakeholders to strengthen PPPs in the

health sector, there were still strong dissatisfactions in many areas. These include regulatory framework, coordination, financial support, stakeholders' commitment, human resource capacity and utilisation, access to essential drugs, tax relief and adherence to professionalism.

The technical review meeting organized by the Health Sector Reform Secretariat of the MoHSW in September 2007 noted knowledge gaps in regulatory framework and the profile of PPPs in the country. Nevertheless, it is also important to note successes stories. Thorough study of successes and constraints is a starting point in developing interventions. Therefore, the focus of this research is to answer the question: What are the key successes and constraints of PPPs in the health sector?, and what should be done as part of the processes of nurturing, developing and improving PPPs in health services delivery in Tanzania?

1.3 Research Objectives

The general research objective was to investigate the successes and constraints in the process of implementing PPP programmes in health sector with a focus on regulatory framework, coordination, financial support, stakeholders' commitment, human resource capacity and utilisation, access to essential drugs, tax relief and adherence to professionalism. More importantly was to identify appropriate policy interventions and specific actions that need to be taken by the key stakeholders in improving PPP programmes.

In developing specific objectives, the key assumption was that successes or constraints in PPPs lie in the areas chosen for collaboration, how collaboration started and the extent to which key stakeholders were prepared for partnerships. By using the same line of thought, the specific study objectives were to:

(i) identify key areas of partnerships and the process used to initiate and engage into collaborations;
(ii) examine the extent of partners' preparedness before working as partners;
(iii) document successes and constraints in the process of working together as partners; and
(iv) suggest interventions necessary for the improvement of PPPs.

1.4 Research Questions

In order to achieve the above objectives, the following questions were to be answered:

(i) What are the areas of partnerships and how they started?
(ii) To what extent were the partners prepared for PPP?
(iii) What are the successes and constraints?
(iv) What key interventions are required for strengthening PPP?

2.0 METHODOLOGY

2.1 Data Collection Methods

The research was conducted in six regions namely Dar es Salaam, Morogoro, Songea, Dodoma, Mwanza and Arusha. The rationale for the selection of these regions was the presence of PPPs (large, medium and small) and the need to have geographical representation of other regions in the country. Data were collected from regional and district, faith based, private for profit hospitals, health centres and dispensaries. Pharmaceutical industries, pharmacies and the Medical Stores Department were also involved in the study. The Ministry of Health and Social Welfare was also included to get the picture of the public representation in the PPPs in the country.

An interview guide was prepared to lead researchers in the process of collecting data. Different sets of questions were designed depending on the role of a particular stakeholder in specific areas of partnerships. Three experienced research assistants were recruited to support the research team. These were given exposure on the overview of PPPs and the developments in the health sector. They were also coached on how to use the interview guide.

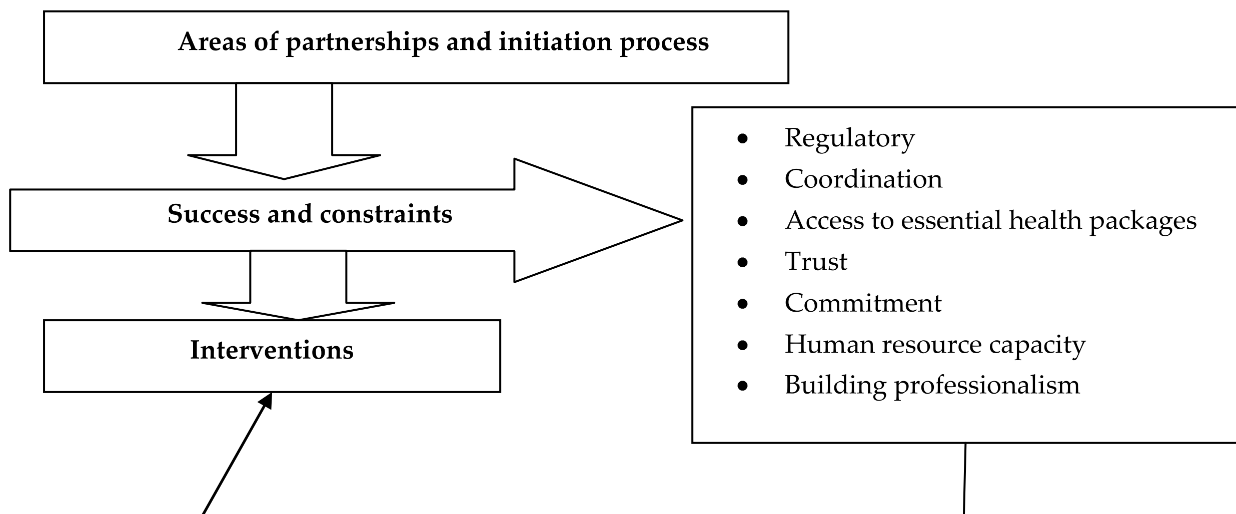
In-depth interview of key informants was the major method of data collection. This method was found useful because deep understanding of PPPs requires exploration through probing and dialogue. Key informants were Directors of relevant departments in the Ministry of Health; Doctors in charge of hospitals, health centres and dispensaries; Owners and/or Managers of faith based and private for profit hospitals, health centres and dispensaries; Owners and/or Managers of pharmaceutical industries and pharmacies; and Heads of relevant departments from Medical Stores Department.

Apart from in-depth interviews, several documents were reviewed for secondary data. These were Local Government Act, 1982; Private Hospitals Act 2002; the Procurement Act, 2004; Municipal and District Strategic Plans; Applications for health service provisions licenses; and "MTUHA (*Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya* Na 2.1)" which is the guiding document for standard recording of medical care provision for patients. Others were Health Sector Reform Strategies and Guidelines; PPP Technical Reviews from the Ministry of Health, Joint Technical Preparatory Meeting report; "*Mwongozo wa uanzishaji na uendelezaji wa bodi za huduma za afya za halmashauri na kamati za afya za vituo vya huduma (Hati Rasmi, 2001*)"; and other independent studies and policy documents.

2.2 Data Presentation and Analysis

Data in the form of notes check list and rich texts were cleaned, summarised and organised into themes in order to identify emerging patterns across the regions and stakeholders in PPPs. Matrices were used to display data while contents are analysed descriptively. The analytical framework was guided by a process model whereby the areas of partnerships and the process of their establishment determined the extent to which such partnerships were well prepared and hence used to measure successes or constraints. The areas of success or constraints were identified in the categories of regulatory, coordination, access to essential health packages trust, commitment, human resource capacity building, and professionalism (Fig 1)

Figure 1: Analytical Framework



3.0 FINDINGS

3.1 Areas of Partnership

Public-Private Partnerships (PPPs) in the health services delivery are part of the implementation of health care programmes under the MoHSW and NGOs which covers reproductive and child health, HIV AIDS, Malaria, basket funding support systems and management information system. The study found that Local authorities and regional hospitals were the implementers of PPP programmes as directed by programme designers and financiers at the national level.

For district and regional hospitals, the language of a PPP was not familiar, it was narrowly understood as the collaboration with private service providers mainly faith based organizations (FBOs) in health care programmes including family planning, immunisation, HIV AIDS counselling and testing. The broader PPP definition include "design and build, design, build, and operate, design, build, operate and maintain, build, operate and transfer, build, lease, and transfer, design, build, finance and operate, design, build, finance and maintain, build, own and operate, and buy, build and operate" (URT, 2009). There was only one specific PPP project in Mwanza that fited the definition of a PPP in the area of construction. This operated under the collaboration of the government of Tanzania and Bugando Medical Centre on construction and management of a Blood Bank for the Lake zone.

It was often noted that major stakeholders in each of the partnership programme determine or influence the choice of other partners, how collaboration starts and how should such collaboration work. Therefore, as it was noted earlier, although partnerships differed in terms of areas and the processes of initiation, there were no substantial differences in terms of the nature of successes, constraints, lessons learned and the interventions required across regions in the country. The major reasons for such uniformity is because; all PPPs operate within the same limited national regulatory framework; all PPPs aim at supporting health care programmes initiated, supported and coordinated by the MoHSW or NGOs; all operated within an environment of lack of trust and commitment between the public and private stakeholders; and all operated in an environment of resource constraints.

In most cases, partnerships were essentially directed at capacity building for improved health services delivery in a wide spectrum. The study has documented 23 three types of partnerships, some of which are as simple as informal sharing of experiences between the private and public service providers. The more significant types of partnerships are described more in details hereunder.

(i) Training

Joint training is one of the fundamental area of partnerships between the public and private sector. Indeed all doctors and nurses working in private hospitals have benefited from training programmes organised by the MoHSW. This is highly commended achievement. However, not all staff benefited from training as one doctor and nurse complained during separate interviews:

"…these days I am told that the municipality conducts courses for nurses but these ones are always left out. I think there is a misunderstanding somewhere. …"

One nurse who was attached to a private hospital complained that she had stayed for 5 years without training despite many requests for training, while her colleagues in government clinics attended several courses every year.

In some cases, staff from local authorities who were providing mother and child services in private hospitals under collaborative arrangements were trained and coached by private doctors as part of the supervisory process. Coaching was done particularly when doctors felt that some nurses were not competent enough as one doctor commented;

"They brought nurses here who were not competent enough… it was like dumping the unwanted ones. I trained them… when they learned that they were now good they shift them to other clinics… I warned them…"

It was difficult to find out the extent to which these complaints were founded because each stakeholder seemed to point an accusing finger to another. However, this was a reflection of the existence of mistrust and commitment to the noble cause of partnerships by some individuals in some areas of decision making or implementation of partnerships.

(ii) Resource sharing

The interesting feature in partnerships is the way deficiencies were complemented through joint resource sharing among the partners. For example, in some cases when there was shortage of malaria drugs from the municipality, mothers were given the drugs by a faith based dispensary at the rate of Tshs. 100 per dose as compared to Tshs. 500 in other private service providers. They were also given Ferrous Sulphate for fifty shillings per dose.

In some local authorities, outreach services were offered in a village located about 8 kilometres from public hospital three times per month through combine efforts. As a complimentary, the municipality provided vaccines, co-nurses and out of pocket allowance of Tshs. 5000 per trip per staff.

Sharing resources so largely involved situations where the private service providers agreed to allocate a room for local government staff to provide mother and child services. However, physical infrastructures were not always enough showing the challenging area. Technical support through the use of tools and equipments from the private service providers though not formalized was often made available. It was often alleged that private service providers lack essential tools and equipments, at times they were better than the government in some local authorities, but mutual support played a very important role in facilitating health care service provision where collaborations were available as one doctor in charge commented:

"…cases of defective BP and weighing scales used by the municipality staff are common… this makes nurses from the municipality who provide services here under agreement with our hospital unable to provide services to pregnant mothers… we lend them in order to rescue the situation. … even when the working tools require repair or replacement… no body cares… I do not know why government officials in charge behave like this"

This scenario depicts typical service delivery under bureaucratic government structure and the embedded dysfunctions which require not only how to widen areas of collaboration but also the

danger of shifting the government culture of inefficiency in service delivery to the private sector. Eventually, patients opt for private sector services and hence denounce government legitimacy in service delivery to its citizens particularly the poor.

(iii) Joint Treatment

There was also joint diagnose and treatment of diseases. The government provided reagents while the private hospital conducted laboratory tests under subsidised rates. The patient paid an average of Tshs. 300 instead of Tshs. 500 market rate. However, the faith based service providers were offering cheaper services ranging from Tshs. 200 to 300 for malaria test. It was the opinion that the government should make more contributions to the partnership in services like electricity bills and office space and maintenance. Sometimes, private hospitals provide emergency services including accidents and treatment of cholera in the anticipation that patients would pay or the private doctor would be compensated. This area of collaboration was vital for the improvement of emergence services. Although emergency services were accompanied by high risks and government hand was necessary, efforts to get support from the government seemed frustrated as one Doctor- Owner manager complained:

"…Cholera outbreak is a public issue and, therefore, it is the government's responsibility to control it and treat patients when affected. We find it our duty too to treat cholera patients as quickly as possible before even the government comes in… It is very expensive and risky for our staff. It should be covered through partnership agreement but I have to bear it myself… also if anything goes wrong with patients who receive reproductive and child health services here under collaboration I do not know where to go or who to ask because it does not seem that government officials are interested. …I do not think that the public officials know the meaning of risk because they do not even come to ask how we are coping"

Nevertheless, emergency services are not common in the public-private partnership framework. In the absence of comprehensive insurance schemes for everybody, this service becomes very unbearable. It is important that health insurance schemes cover the costs and where PPPs exist, it should also cover extend the services for common goal of quality health for all.

(iv) Participation in Planning

All the national and sectoral policies and laws make it mandatory for the public and private sector entities to work together through planning to ensure that there are no duplication of efforts and misuse of resources. However, in most cases, private service providers are not invited, and when invitations are made, it is done in a hurry in such a way that the private sector fails to honour as one participant lamented:

"… One day we received a letter asking us to prepare our budget and present it to the municipality on the same day… this was impossible.…we had to forget about it"

When the responsible officer from the local authority was asked about involvement of the private sector in planning process he was by large pessimistic. According to him, the private sector personnel are too ignorant of the planning issues. This pessimism again signals the recurrent argument for lack of trust among the private and public service providers.

(v) Basket Funding

It is government policy that all private hospitals providing health services in areas where there are no district hospitals; such hospitals should be categorized as "Designated District Hospital (DDH)" and receives support through basket funding arrangement. In one incidence, it was found that a hospital categorised as DDH was allocated Tshs 15,262,816 for the 2004/2005 financial year. However, there were complaints that this figure was not revealed to the hospital officials. The sum was paid to a company that supplied a number of goods most of which were neither asked for nor required by the hospital. Complaining on the matter, the hospital in charge lamented saying:

"…we do not understand why they brought all these goods for… we have never told them we need such items and of that quantity… we need money to repair water tanks and buy a new water pump"…"I am not interested in accounting for goods that I did not request" (Referring to accountability for the goods received).

The effects of ineffective participation of the private service providers in health planning at the council level noted earlier has also led to negative consequences including lack of commitment and accountability. This state of affairs if go unchecked can lead to wastage of resources at the expense of the poor people who are the tax payers and supposedly the main targeted beneficiaries.

(vi) Supply of Drugs and Other Essentials

Public – private partnerships could be noted with pharmacies in the form of supplies of drugs whenever there were shortages and the MSD could not meet the needs on time. However, this could happen as a "last resort" because of the belief that drugs and other essentials were more expensive in private pharmacies than in MSD. Another concern was noted on the quality of drugs from pharmacies. However, this concern was true in some few cases, but in indeed, drug supplies from private pharmacies were more efficient, better quality and of lower price. Experiences from Bugando Medical Centre and Sekou Toure Regional Hospital in Mwanza show that in most cases the private pharmacies supplied better quality drugs, more efficiently and at lower costs when compared with MSD

4.0 WHO INITIATES PUBLIC-PRIVATE PARTNERSHIPS (PPPs)?

This section provides the rule of the game and conducts by showing who initiates the public-private partnerships. In countries where PPPs are directed by specific regulatory frameworks, there are clear formulas on how to initiate PPPs depending on the type of a project needed. The regulatory framework will also provide optional models suitable for particular PPP projects and guide government officials and private people on the merits and demerits of each option. It also guides on which option is suitable for a particular project than another. The framework will also determine the extent to which a particular PPP project may become successful or not depending on the extent to which it addresses areas of resource sharing, risks and accountability.

Although there are various pieces of legislations and guidelines in Tanzania that could be used to initiate and design PPP models and projects, there is no specific regulation for PPPs and the level of awareness of general laws is very low. The initiation of PPPs has taken various forms depending on the situation at hand. This is most true in PPPs in primary health care service delivery, where PPPs have largely depended on how particular public officials have understood and interpreted government intention and strategy to work with the private sector through of the health sector reform- strategy (7). It has also depended on the readiness, willingness and ability of the private sector individuals to sense the opportunity for collaboration and benefits. The responses from key informants from the public and private sector participants at the regional and district levels show who initiates PPPs:

"…Before opening the dispensary, it was the municipality which requested a room to run MCH services in order to reduce distance and queuing at the Municipal Health Centre (Quoted from the Private Dispensary In Charge- translated from Swahili) *…Having some sort of collaboration is not a choice but a must…you cannot get a license to operate a dispensary without MCH unit"… marriage of compromise … we MCH nurses work with other staff in this hospital like neighbours"* (Quoted from a dispensary manager and one nurse on different occasions- translated from Swahili).

Another perspective on a similar question gets a different response from the official from the municipality saying;

*"…Their doctor came to complain that the dispensary will be closed if we cannot help to find a clinical officer. Although we have severe shortages, we had to send one clinical officer to work there until they are able to recruit" (*Quoted from the Municipal Doctor in Charge- translated from Swahili). Another officer, had an experience of the starting point of the process of collaboration as when a private dispensary was registered and opened;

"… Collaboration starts when they apply for a permit to open a dispensary. We give them a registration form… we visit their premises and when we are satisfied… we allow them to operate… we send our nurses there to provide MCH services or if they can do it themselves we supply them with a refrigerator and vaccines" (Quoted from the Head of Health Services Department- translated from Swahili version).

It can be noted that Public-private partnerships (PPPs) start as a part of the process of the implementation of national programmes or "working with a neighbour"

Some national programmes require training of all staff regardless of their employer. This makes collaboration as mandatory from programme design stage by key stakeholders. In some other cases, partnerships start as a matter of trying to respond to the requests of a neighbour in need as observed that:

> **"…** *When there is training we invite all targeted employees regardless of whether they are employees of government or not at the full cost of the government… sometimes when they have patients they refer them here for laboratory tests. We conduct the tests for a normal fee like any patient. The private service provider describes the diagnosis and prescribes treatment. We also give the ALU for giving patients free of charge..."*

Public-private partnerships (PPPs) can also be initiated by the private sector. Sometimes PPPs can start out of individual initiative to venture into the unknown. With some luck, collaboration starts as one of the participants described the beginning of the journey to partnerships saying;
"… I wrote a letter asking for MCH services in my hospital because I could see mothers passing here going to the General Hospital or Health Centre and I thought I should do something about it. Instead of replying to my letter, they brought a refrigerator, vaccines and nurses. I gave them one furnished room where they provide their services to date"

The practical example was drawn from some officials from the NHIF identifying potential partners who can provide health care services to NHIF customers. Negotiations are made, and if all partners are satisfied, a contract is signed. This is typical of PPP initiated collaborations where patients receive health services through National Health Insurance Schemes.

However, it becomes extremely difficult to describe how partnerships start. This is usually the case particularly with faith based NGOs which started working with the government even before independence and no documentation was made or could be traced. *"…Our collaboration started a long time ago before the reforms. It was personal and depended on individual initiatives and interests. We are trying to make it formal but the process is very bureaucratic and frustrating"* (Quoted from the head of faith based hospital- translated from Swahili).

It was not possible to establish how collaborations started in all big church based hospitals. Officials claimed that there were memoranda of understanding but remained under lock.

In very formal way, some areas of partnerships follow strict guidelines under the Public Procurement Act 2004. This mostly applies in the procurement of drugs, tools and equipments.

"…partnership is in the form of supply of drugs and other essentials. It starts by visiting some pharmacies we think can supply us, negotiate and request Performa invoice. ...invoices are compared and the winner is awarded tender to supply" (Quoted from Municipal Medical Officer). The above discussion convey a message that there are problems as well as diverse ways of establishing strong PPP foundations but also in setting-up a clear PPP model suitable in a particular environment.

Although we have opted to use a rather conventional term "model", we use it interchangeably with terms like "Type" "Form" "Framework" or "Category" depending on whether it is used in the academia, policy or practice. While we do agree with the similarity of the terms, we consider PPP models as menu available for shopping when a government or a private sector entity wishes to

collaborate. As noted earlier, a model for health service delivery, unlike in the infrastructure sector could be simple collaboration, joint venture, direct contract, lease or concession. Each of these models has benefits depending on the needs and expectations of partners in demand for collaboration.

Based on the above criteria and the observed evidence, it is concluded that majority of PPP cases make it extremely difficulty to judge on the particular models of partnerships used because of the fluidity of the relationships. At best we noted that most collaboration can be described as "general semi-formal agreements" to share available resources and expertise for perceived well-being of health services seekers. This makes PPP models to fall in some somewhere between simple collaboration to joint ventures. Therefore, most PPPs were started through informal or semi formal arrangements for the purpose of sharing available resources (including expertise) between the government and private sector organisations for direct or implied benefits to the key stakeholders.

5.0 SUCCESSES AND CONSTRAINTS OF PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

Successes for PPPs depend on strong policies, laws, norms and procedures (regulatory framework). A survey of the experiences of PPPs in Tanzania shows both successes and constraints of the existing regulatory framework. Table 1 summarizes the main observations.

Table 1: Successes and Constraints of the Regulatory Framework for PPPs

S/N	Indicator	Successes and Constraints	
		Successes	**Constraints**
1	Hospital Regulations Act 1991	-Allows the private sector to operate -States the regulatory role of the government	Not for PPPs
	Local Government Act 1982	Calls for government collaboration with the private sector	-Limited provision for PPP framework - Limited awareness
2	Health Sector Reforms	Encourages PPPs	-No specific guidelines on how to go forPPPs - Lack of awareness - No specific law on PPPs
3	Local Government Reform Programmes	Encourages PPPs	
4	Hati Rasmi 2001	- Creates health boards and committees - Puts in place the role of the private sector	-Addresses simple collaborative issues than robust PPPs - Limited awareness - Limited commitment
5	Strategic and comprehensive health plans	Express intensions to work with the private sector	-No clear guidelines - Limited awareness -Limited commitment
6	National Strategy for growth and poverty reduction	-Makes PPPs mandatory	- Lack support instruments for managing PPPs
9	Public Procurement Act 2004	- Provides strong basis on PPPs	-It is for public procurement and not on PPPs as such -More on supplies and infrastructure - Limited concern on health service provision which is more sensitive
10	Tanzania Food and Drug Authority	- Puts legal basis for quality control	- Limited awareness - Limited commitment
11	Medical Stores Department Act	-Establishes Medical Stores Department -Facilitates supplies of essential drugs	- Bureaucratic- delays - At times poor quality drugs, tools, equipments - Frequent shortages
12	National Health Insurance Fund	- Better access to services through public- private arrangements	- Conflicting interests - Dishonesty - Distrust - Bureaucracy
13	Service Agreement	- Formulated	- Only few officials are aware

Source: Interview data

5.1 Coordination of Public-Private Partnerships (PPPs)

There are various bodies which coordinate PPP activities. The Ministry of Health and Social Welfare has a department and a team of experts who are supposed among other things to coordinate PPPs. In 2001 the Ministry formulated (HATI RASMI) which establishes boards and committees in hospitals, health centres and dispensaries. This organ is also required to facilitate the coordination of PPP activities. Similarly, the private sector has APHFTA which also help to coordinate efforts of the private sector in the process of engaging with the government in working together. Table 2 displays some of the organs.

Table 2: PPP Coordination Supporting Organs

S/N	Indicator	Successess and Constraints	
		Successes	Constraints
1	Health Boards and Committees	-Public and private sector stakeholders meet -Share experiences	- Effectiveness depends on personalities -In some regions the participation of the private sector for profit is very limited - Limited awareness - Mistrust Lack of feedback
2	APHFTA	- Coordinates activities of members including training - It is a speaking voice of private practitioners	Some practitioners are not aware of the role of APHFTA
3	CSSC	- Coordinates and regulates the functions of church based health service providers -Networks with the government and other service providers	Ability to influence depends on wishes of church leaders The choice of the types of PPPs is influenced by Christian based ethics and codes of conduct
4	Others	The ministry of health and social welfare has a management and coordinating unit for PPPs	-Not very proactive - Roles and responsibilities are not clearly known to the key stakeholders

5.2 Trust, Commitment and Accountability

Strong PPP requires that each partner has certain strengths to fulfil agreed obligations, commitment and be ready to account for whatever happens. This requires the availability and reliability of sufficient resources to share and account for. In most cases both the government and the private sector do not have enough resources to finance PPPs. Even if some private health providers could take the bigger share of the costs of partnerships, it would be difficult for the government to institute a flexible regulatory framework of accountability. Table 3 summarises conditions for successes and feasible constraints in PPP commitment and accountability.

Table 3: PPPs Conditions for Successes Commitment and Accountability

S/N	Indicator	Successes and Constraints	
		Successess	Constraints
1 2	Financial commitment	Basket funds	-Not enough - The private is not involved in decision making - dependency on treasury
		Bed grants	- Only for faith based service providers - Not adequate
		Staff grants	- Do not cover all staff
3	Facilitation of PPPs	Some officials cooperate and facilitate PPPs	-Low responsiveness - Unnecessary bureaucracy - Lack of transparency and facilitation of participation
4	Trust	There are perceptions that trust will improve	- Generally both the private and government officials mistrust each other

Source: Interview data

Critical shortages of qualified staff in the health sector are common constraint in both public and private hospitals, health centres and dispensaries. When physical shortages are coupled with low working morale, the problem becomes even more serious. The Ministry of Health and some international NGOs support human resource capacity building through training. The APHFTA also supports and coordinates training for staff working in the private sector. However, the demand and supply for qualified staff is still a big challenge (Table 4).

Table 4: Human Resource Capacity Building and Utilisation

S/N	Indicator	Successes and Constraints	
		Successes	Constraints
1	Staff secondment	• Some doctors work in church based service providers through secondment	• No effective monitoring of the quality of staff • No harmonisation of reward systems • - Increasing staff turnover
2	Staff pay	• The government pay salaries for seconded doctors	• Staff outside secondment receive lower pay • Relatively poor reward for staff employed by faith based service providers • Inability to attract and retain qualified staff
3	Capacity	• Some qualified doctors working in government hospitals get part time jobs in private hospitals. This improves capacity of the private sector	• These doctors have more than one master. This reduces efficiency, commitment and accountability • Patients have to bear the costs
4	Training	• Joint training • There are training programmes offered by the government as well as by the private sector	• Not systematically planned • Some times depends on personal relationships and networking
5	Quality	• Big hospitals have high qualified staff	• At the level of dispensaries, on average, the private sector has less qualified staff

Source: Interview data

Other constraints of PPP in the health sector involves access to essential Health Packages. Although it is assumed that access to the essential health packages will significantly increase access and reduce costs of health services, this does not seem to be the case. Patients and health service providers are

still complaining that there serious shortage of drugs, tools and equipments, and where available quality has been declining over years. Even faith based service providers who have advantage of getting subsidised essential health packages do not seem to offer cheaper services (Table 5).

Table 5: Access to Essential Health packages through PPPs

S/N	Indicator	Successes and Constraints	
		Successes	Constraints
1	Drugs and equipments	Faith based get subsidised through MSD Supplies essential drugs to designated district hospitals	• No access of private for profit service providers • Does not cover private for profit providers • Shortage of supplies • Delays • Less quality
2	**Free drugs**	• ERVs, • Vaccines • Anti - malaria	• Short supply and erratic • Some private providers do not get

5.3 Weak Professionalism

Weak professional practice and code of conduct leads to poor health and loss of human life. The Ministry of Health and Social Welfare works with different international and local partners to build highly professional and ethical cadre in the health sector regardless of whether such cadre work in private or public hospitals. Indeed, one single area where partnership between public and private sector has worked well is through training of clinicians and nurses. Different of member associations including APHFTA and CSSC use various fora to emphasise on the code of ethics and conduct and also mobilise resources for training and development of staff. However, despite these achievements, constraints are also visible (Table 6).

Table 6: Building Professionalism in Medical Services through PPPs

S/N	Indicator	Successes and Constraints	
		Successes	Constraints
1	Training	Joint training	• Resources are not enough
2	Code of ethics and conduct	Awareness creation	• Often abused • No significant efforts to sanction abusers
3	Use of membership associations	Associations of practitioners are used to build professionalism through training	• Shortage of resources • Poor communication

Source: Interview data

Looking at the areas which signal the regulatory framework and the types of collaboration between the government and the private sector, and also by referring to the successes and constraints, we have a long way to go before we are able to significantly get the best out of PPPs.

6.0 CONCLUSION AND RECOMMENDATIONS FOR INTERVENTIONS

This study examined the successes and constraints of creating and strengthening public-private partnerships in the health service delivery. It looked at how partnerships start and how best can they be maintained. There are many areas of interventions that require concerted efforts. Some are to do with high-level government organs; others can be best handled at the local level, while still others require partnerships. Since the study involved different stakeholders, it may be useful to categorise the recommendations to specific stakeholders as follows:

Since data support that PPP is the right policy option for improving health service delivery, it is important for the local authorities to work closely with the responsible ministries (Prime Minister's Office, Regional Administration and Local Government and the Ministry of Health and Social Welfare) in establishing specific policies, laws and regulations to guide the initiation and management of various forms of PPP in the health sector. This will reduce many problems which arise due to lack of clarity, responsibility and accountability in PPP arrangements. Local authorities should establish PPP units that will be responsible for identifying suitable areas for partnerships, conducting feasibility studies, facilitating monitoring and evaluating their establishment. Such units will coordinate PPP initiatives with support from the national level unit.

Having an appropriate PPP policy and regulatory framework is one thing, but making it effective is another. Strong PPP requires that each partner has plan for sustained strengths, including financial, technical and human resources, to fulfil the agreed obligations and be ready to account for whatever happens. The research findings show that local authorities run health service partnerships by depending on resources from the central government and donors through top- down health programmes. It is important that local authorities develop strategies for reducing donor dependency by setting budget allocation from their own revenues special for supporting public- private sector partnerships.

While the current centralised PPP programmes go on, it is high time for the local authorities to negotiate with the cental government so that contractual relationships with development partners support directly to the local authorities instead of through the top-down programmes of the MoHSW. This could facilitate robust of PPP where the contribution of each stakeholder would be determined in a systematic manner.

Although PPP is well accepted in health service provision, the major problem is lack of trust and commitment among some responsible officials. Both the community and local authorities do not trust the private sector operators because of their tendency to maximise profits on the expense of quality of services. Lack of trust is partly attributed by lack of transparency in transaction costs. It is recommended that private sector partners should make their books of accounts more open on public money spending during negotiation for partnerships.

The study noticed that most PPPs are between the local authority and faith- based organizations (FBOs) health service providers. They have been doing commendable job by putting service to the community. However, like in government dispensaries, health centres and hospitals, the critical

shortages of skilled staff tackled through continuous training and improved pay packages in order to attract and retain qualified and motivated staff.

It is concluded that, Public-private partnerships is the best policy option for improving health service delivery in the country. Despite of the strong dissatisfactions with the performance of PPPs in the health service , given the long history of the private sector as well as the increasing number of PPPs in the service delivery, poor capacity and mistrust between the government and the private sector need to be worked upon. Therefore, policy directed interventions for improving PPPs should be not only a collaborative effort among the PPP key stakeholders but also each stakeholder should make efforts to abide to accountability and transparency principles. While building on the existing successes and working on the constraints, the focus of the Public-private partnerships motive should be to improve partnerships in health service delivery in Tanzania.

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