## Major Applied Research Paper No. 14

# PRIVATE SECTOR DELIVERY OF HEALTH CARE IN TANZANIA

**Phases 2 and 3: Field Work, Research Results, and Policy Recommendations**

**Submitted to**
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# ABSTRACT

This study provides baseline information and analysis that the Ministry of Health in Tanzania can use to further elaborate policies to enhance public-private partnerships in the health sector in order to expand coverage, strengthen quality and efficiency of health services, and improve the health status of the population. Tanzania has at times deliberately restricted private sector activity in health, and at other times has encouraged and supported growth of certain types of private sector providers. Since the early 1990s the government has made private sector development a cornerstone of its health sector reforms.

Prepared for the Health and Human Resources Analysis for Africa (HHRAA) project of the U.S. Agency for International Development, the study has three main components:

- a description of the size and scope of the private sector in health care delivery in Tanzania and an assessment of the actual and potential role of the private sector in promoting the public health agenda;
- a description of the current linkages between the public and private sectors in health care and an examination of areas where collaboration could potentially improve health services delivery; and
- an examination of the factors that affect development of the private sector in Tanzania, especially legal, regulatory, tax, and financial matters.

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# ACRONYMS

| | |
|---|---|
| DDH | Designated District Hospital |
| DHS | Demographic and Health Survey |
| GDP | Gross domestic product |
| GNP | Gross national product |
| HFS | Health Financing and Sustainability Project |
| HHRAA | Health and Human Resources Analysis for Africa, USAID |
| IMF | International Monetary Fund |
| NGO | Nongovernmental organization |
| MCH | Maternal and child health |
| MOH | Ministry of Health |
| ORS | Oral rehydration salts |
| ORT | Oral rehydration therapy |
| RMA | Rural medical aid |
| SAP | Structural adjustment program |
| TB | Tuberculosis |
| TBA | Traditional birth attendant |
| USAID | U.S. Agency for International Development |
| VA | Voluntary agency |

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This report is part of the research and analysis activities of the Health Care Financing and Private Health Sector Development portfolio of the HHRAA project, under the technical direction of Abraham Bekele.

# FOREWORD

This paper is one in a series of reports on findings and policy recommendations from Phase 3 of the Major Applied Research conducted by the Health Financing and Sustainability Project (HFS).

The Health Financing and Sustainability Project (HFS) is a five-year initiative funded by the U.S. Agency for International Development (USAID). The project's mandate is to provide technical assistance, conduct applied research, implement training, and disseminate information on health care financing throughout the developing world. The project seeks to influence policy change by advancing knowledge; testing and improving delivery, financing, and administrative methods; strengthening institutional capacity; and enhancing technical capabilities. To date, HFS has been involved in health care financing activities in over 30 developing countries around the world. Applied research activities account for one-quarter of HFS project activities.

HFS has conducted its major applied research in three phases. Phase 1 included a review of the literature and of past experience and the development of a conceptual framework. The papers generated under Phase 1 are essentially conceptual and methodological and are therefore oriented to field researchers and teachers. Nevertheless, because these papers also underscore current gaps in knowledge, they are of use to international donors, health ministry decision-makers, and others who are concerned with health care policy.

Phases 2 and 3 were designed to reduce the gap in current knowledge identified in Phase 1. Phase 2 comprised the field research and data collection, and Phase 3 has involved data analysis, report writing, and dissemination. Phase 3 papers have as their main audience developing country decision-makers and policymakers, inside and outside the countries where the research was conducted. Methods, findings, and recommendations are written in nontechnical language, with technical information provided in appendices.

Phase 3 products also will be of interest to international donors because they validate or reject important hypotheses and evaluate existing policies. These papers also test new or improved research methods, identify directions for further research, and contribute empirical information to the general body of knowledge. Therefore they should be useful to researchers and academicians.

## THE ROLE OF APPLIED RESEARCH IN HEALTH POLICY REFORM

Health financing reform is a prominent political issue and a priority for the health sector around the world. In industrialized nations, containing health care costs has been one main impetus behind efforts to reform health financing policies. In developing countries, a key motivating factor for reform efforts has been the growing demand on increasingly strained public resources represented by the traditional commitment of governments to provide free health services to all.

At the center of the policy debate are discussions about ways to improve equity and efficiency. Ideally, health care financing practices and policies should promote both equity — financial and physical access to care — and efficiency — maximization of health gains through reductions in the costs of production and increases in appropriate consumption. These discussions also include debate about the impact of health financing reforms on quality of care, access by the poor, and the respective roles of the public and private sectors.

Formulating effective policies to address these issues requires sound empirical information about a broad range of questions on the demand and supply sides of the market for health services. In many developing countries, sound empirical data are seldom available and the public debate about health financing often is dominated by conventional wisdom that may not be well grounded in reality. Some examples of conventional wisdom that require empirical testing include:

- "The poor will not pay for health care services."
- "The private sector is more efficient than the public sector in producing health services."
- "The private sector has no role in meeting the public health agenda."
- "Where the largest share of total health resources is spent on curative care, the allocation of resources is inefficient."
- "Social financing and risk-sharing schemes will not be effective in poor, rural areas."

A new body of research has begun to emerge that tests the validity of some of these common beliefs about health financing. For example, empirical studies of health care demand in developing countries have demonstrated that when given the choice, even the poorest often prefer to pay for better-quality health care rather than obtain free but low quality health services.

Public policy concerning health finance can greatly benefit from improved knowledge about such issues as the willingness of people to pay for health services, the relative efficiency of public and private providers, private sector roles, and the cost-effectiveness of investment in curative and preventive care. Yet despite the greater attention recently given to applied research in health finance, large gaps in our knowledge remain.

## AN AGENDA FOR APPLIED RESEARCH

HFS applied research seeks to advance knowledge in key policy areas and to develop analytical capabilities among developing country researchers. The research is designed to address key policy questions, explore neglected areas of research, improve analytical methods, and test new methodological techniques. With the review and advice of an external Technical Advisory Group, the project identified four broad areas of inquiry where major applied research was warranted: cost recovery, productive efficiency, social financing, and the private sector. To meet USAID contractual requirements, the project also identified nine specific topics within these categories (see box).

| HFS MAJOR APPLIED RESEARCH: AREAS, TOPICS, AND QUESTIONS | | |
|---|---|---|
| **Research Area** | **Phase 1 Research Topic** | **Main Research Question** |
| COST RECOVERY | Quality of Care | Willingness to pay for improvements in quality |
| | Protecting the Poor | Design of equitable cost recovery systems |
| | Efficiency in Consumption | Design of monetary and other mechanisms that promote efficient patterns of demand for care |
| PRODUCTIVE EFFICIENCY | Pubic Sector Reform | Feasibility of improving efficiency in production through personnel incentives |
| | Reallocating Public Sector Spending | Definition of optimal allocation pattern and appropriateness of current allocation patterns |
| SOCIAL FINANCING | Expanding Its Role | Feasibility of risk-sharing for the poor |
| PRIVATE SECTOR | Development of Private Health Care Markets | Determinants and implications of private sector development |
| | Public-Private Differences in Efficiency | Existence of differences in productive efficiency between government and private providers |
| | Public-Private Interactions | Feasibility of socially beneficial collaboration between government and private sector |

HFS conducted literature reviews (Phase 1) for all but one of these nine topics (the exception was reallocating public sector spending). At USAID's request, an additional field research topic — an assessment of the economic impact of malaria — was also studied. Field research has been conducted (Phase 2) and analytical papers have been written (Phase 3) in all four of the major research areas. These cover the six specific topics as follows:

- Willingness to pay for improvements in health service quality in the context of cost recovery
- Impact of health service quality improvements on costs, efficiency, and demand
- Efficiency of public sector health services
- Comparison of public and private sector efficiency in health service delivery
- Impact of social financing of health services on demand, equity, and sustainability
- Development of private sector health services
- Economic impact of malaria

In addition to these applied research papers, HFS has produced a wide array of research instruments and data bases. (A list of these is provided in an HFS Theme Paper on "Data Collection as a Policy Tool.")

## POLICY-ORIENTED APPROACH TO APPLIED RESEARCH

HFS has conducted all the field research activities with active collaboration and involvement of local researchers and decision-makers. In addition, when considering alternative field sites for major applied research, HFS sought to identify opportunities where research results would feed directly into the policy reform process.

In Niger, for example, HFS provided technical assistance to the government to test two cost-recovery systems for curative care in ambulatory public facilities: a fee per episode of illness and a household tax with a copayment. Major applied research was conducted to assess and compare key indicators under the two financing systems, including the improvements in quality of care, the costs of quality improvements, people's willingness to pay for quality improvements, and equity implications of the financing methods. Research activities were intertwined with technical assistance to design and implement improved management systems for health facilities, new management procedures for clerical personnel, and improved diagnostic and treatment practices for medical staffs.

In Senegal, HFS conducted applied research to assess various dimensions of the current health system, including the legal and regulatory framework of health financing; the effectiveness of village health committees; the costs, financing, and efficiency of public and private providers; the size, role, and evolution of the private sector; and the demand for health care. The government of Senegal is planning major regional demonstration projects to implement some of the recommendations that emerged from this research.

All HFS major applied research products undergo a formal review process that involves project staff, external experts from academic and international institutions, and members of the project's Technical Advisory Group. HFS seeks excellence in its products and welcomes comments or suggestions about its research work.

If you have questions or comments about our applied research work, please contact the Technical or Applied Research Directors. For information about or to order written HFS products on research, technical assistance, and training, please contact the project's Information Center.

*Ricardo A. Bitran*
*Director of Applied Research*

# EXECUTIVE SUMMARY

The Health and Human Resources Analysis for Africa (HHRAA) project of the U.S. Agency for International Development (USAID) provided funding to USAID's Health Financing and Sustainability (HFS) Project to study development of private sector health services in Tanzania. This study is part of HHRAA's larger effort to study private sector development in health in four African countries: Kenya, Senegal, Tanzania, and Zambia. The larger effort reflects USAID Africa Bureau's interest in identifying opportunities for public-private partnerships in health as one way to use existing resources more effectively to increase and improve the availability of health services for African populations and thereby to improve health status. This study also constitutes one of the HFS project's major applied research activities.

These issues are particularly relevant to Tanzania, where the public sector has at times deliberately restricted private sector activity in health and at others has encouraged and supported growth of certain types of private sector providers. In addition, constraints on public sector resources in Tanzania have made it increasingly important to look for nongovernmental sources of health funding — such as user fees — and for nongovernmental sources of health care to augment available health services to better meet the health needs of the population. Since the early 1990s, the government has made private sector development a cornerstone of its health sector reforms.

## PURPOSE AND SCOPE

The purpose of this study is to provide baseline information and analysis that the Ministry of Health (MOH) can use to further elaborate policies to enhance public-private partnerships in order to expand coverage, strengthen quality and efficiency of health services, and improve health status in Tanzania. Specifically, the study aims to:

- Describe the size and scope of the private sector in health care delivery in Tanzania and assess the actual and potential role of the private sector in promoting the public health agenda;
- Describe the current linkages between the public and private sectors in health care and identify areas where collaboration has the potential to improve health services delivery; and
- Identify factors that affect development of the private sector in Tanzania, especially legal, regulatory, tax, and financial matters.

## METHODOLOGY

This study relied extensively on secondary sources of information, available from existing reports, analyses, government statistics, and surveys. The HFS field research team, composed of Tanzanian and HFS staff researchers, also conducted a large number of field interviews, a random sample survey of 61 private providers, and interviews with patients in Dar es Salaam and Kilimanjaro. The interview survey did not cover the informal health sector, including traditional health providers and birth attendants, because of the inability to establish a sampling frame for that category.

## FINDINGS AND RECOMMENDATIONS

### Using the Private Sector to Expand Access to Health Services

This study identified three major types of private sector providers currently operating in Tanzania, as classified by ownership and financial orientation: nonprofit voluntary agency facilities, employer-based facilities, and for-profit health care providers. Leaving the traditional sector aside for practical reasons, the study also identified five subcategories of private sector providers: 1) nonprofit providers run by voluntary agencies and designated as "approved organizations;" 2) employer-based private and parastatal providers; 3) for-profit providers affiliated with "approved organizations;" 4) for-profit providers approved prior to 1991; and 5) all other independently owned for-profit health providers approved since 1991.

Nonprofit private sector providers, primarily church-based and voluntary agency health facilities have historically played a large role in Tanzania. Voluntary agencies owned 44 percent of the nation's hospitals registered in 1993 and nearly half of all hospital beds. Included in these totals are the "Designated District Hospitals"—17 hospitals owned by nonprofit voluntary agencies that the MOH incorporated into its health network shortly after independence in 1961. Although the DDHs are still owned by the voluntary agencies, they are now fully funded and directed by the MOH and are now generally considered to be public facilities.

Liberalization of the laws concerning private providers has caused an explosion of independently owned for-profit facilities, which now account for 42 percent of all private facilities in Dar es Salaam, including 83 percent of all private hospitals and 57 percent of all privately owned hospital beds.

### Recommendations

- Given the long history of collaboration between the public sector and nonprofit private health providers in Tanzania and given the wide distribution of nonprofit providers throughout the country, the MOH should continue its strong collaboration with nonprofit voluntary agency health providers to sustain their contribution to the general availability of primary care and hospital-based health services in the country.
- Given the diversity of private sector health providers in Tanzania, the MOH will need to continue to develop different incentives, regulatory approaches, and collaborative mechanisms to take account of the different practice patterns and financial orientation of for-profit and nonprofit providers.
- Given the current distribution of for-profit health providers, the MOH probably can concentrate its collaborative efforts with for-profit providers in Dar es Salaam, using that experience as a pilot for extension to other urban areas. The MOH should immediately focus on developing a systematic vision and set of policies to channel the growth among for-profit providers—the main area of private sector growth since the 1991 liberalization—in directions that will make better use of public sector resources.
- Employer-based health providers appear to be relatively neglected in the current reform efforts and represent a hidden capacity that could be exploited for increasing the capacity of the health system. The MOH should assess the potential role of employer-based health services in the private provision and/or financing of health services.

## Using the Private Sector to Expand Access to Priority Public Health Services

In assessing the potential contribution of the private sector to specific health services, this study focused on key public health services, including childhood communicable diseases, tuberculosis, malaria, and reproductive health services such as family planning and maternal and perinatal services (including delivery).

Findings from this study indicate that a more substantial portion of private health providers, especially the hospitals and clinics, provide priority public health services than may have been realized. While a precedent and the relevant experience for providing these services thus exists, the data also show that this capacity varies by type of private provider as well as by individual provider. In general, the private hospitals and health centers are much more likely to provide priority public health services than the many dispensaries.

### Recommendations

- The public sector in Tanzania has a well-developed capacity for providing preventive services such as childhood immunizations and has a good record of coverage. Given the public sector's strong comparative advantage in this regard, it makes no practical sense to shift responsibilities for these services to the private sector. The MOH should not, however, discourage those private providers who now deliver preventive services from continuing to do so, and it might selectively provide incentives to private providers to deliver preventive services where no public provider exists.
- The MOH should consider focusing on the private sector's capacity in curative health services at the hospital level as well as at the primary care level. Since most private hospitals and health centers normally provide maternal and child health and tuberculosis services with no incentives from the MOH, there is potential for the private sector to help the government absorb the increasing demand for these services.

## Improving Public-Private Collaboration

This study focused on three sets of public policies that affect private sector development: legal and regulatory measures governing private practice, financial incentives and disincentives, and health service pricing structures that affect both provider income from fee revenues and the population's use of and demand for health services. The main issue in public-private sector relations in Tanzania is no longer whether to collaborate but how and what forms of collaboration and incentives are most appropriate and cost-effective.

### Laws and Regulations

Tanzania has taken major steps to legalize private medical practice, especially since 1991, and the major legal and regulatory issues now facing the MOH include implementation, monitoring, and enforcement of regulations. This study reported at least two potential problems that require attention.

First, this study reported evidence that a large group of health facilities and individual providers use permits obtained by an "approved organization" to establish and run for-profit health care units with little or no supervision from the parent voluntary organization. The existence of hidden affiliates of "approved organizations" presents serious issues for licensing, registering, and identifying private sector providers, as well as for quality assurance.

A second problem involves the uneven quality of clinical practices in both the public and private sectors. This study reported evidence that less than half of the church-based, voluntary agency, and government health facilities in Dar es Salaam followed acceptable clinical practice and that a substantial percentage had potentially serious clinical errors. In addition, many experienced stockouts of essential drugs.

### Recommendations

- The MOH needs to strengthen the registration process and involve professional provider associations in the registration and monitoring effort.
- The MOH, in collaboration with the provider associations, should develop quality assurance mechanisms and training programs and should develop means to exchange information on clinical practice and drug management in which public and providers each excel.

## Financial Incentives

This study reviewed several aspects of the financial environment facing private sector health providers: the ease of obtaining credit, level and types of taxation, the prospects for earning adequate income from fee revenues; and the availability of direct government subsidies. In general, data available for this study show that four trends are emerging under the current financial environment.

First, direct government subsidies have been targeted toward the nonprofit, voluntary agency private health providers. Second, the most rapid growth in private sector health facilities has been among small dispensaries, which do not require much start-up capital. Third, incentives for different forms of private practice are likely to be quite different in urban and rural areas. Fourth, the capacity of employer-based providers, especially parastatals, equals or exceeds the nonprofit sector in terms of health facilities, beds, and medical personnel. Additional arrangements exist among private employers to reimburse medical services for employees.

### Recommendations

- At this stage in the growth of the private sector, it is important that the MOH base any financial incentives offered to encourage private sector development on a solid assessment of 1) the impact of current financing arrangements on the pace and direction of growth, and 2) whether current trends are proceeding in a direction deemed most useful to the overall development of the health sector.
- In developing policies for providing financial incentives, the MOH should be clear about 1) what level of private health facility (hospital, health center, dispensary) and what type of ownership or financial orientation (profit or nonprofit) the MOH most wants to encourage, and 2) what mechanisms (taxes, credit, subsidies)—or combination of mechanisms—are most cost-effective for encouraging growth of that level of health facility. If private providers are already delivering services that the MOH wants to encourage without any particular government financial incentives, the MOH need not introduce any.
- The MOH should continue its efforts to assess the feasibility and potential benefits of different forms of health insurance and the likely impact of such insurance on private sector development as well as on people's use of health services. Experience elsewhere in the world has shown that the availability of health insurance has a significant effect on the growth and financial viability of private sector health providers.

- The MOH should separately analyze the financial incentives that may be needed for employer-based health providers, as opposed to those appropriate for other private sector providers. Employer-based reimbursement for health services needs to be considered separately from health insurance issues more generally.

## The Impact of Private Sector Development on Public Sector Reform

An expanded private sector offers alternatives to the public sector that can have both positive and negative—and intended and unintended—effects on the government's goals for health sector reform. Data from this study illustrates at least two such situations.

### Public and Private Sector Competition for Patients

The availability of private providers which people perceive to provide higher quality care can draw patients away from the public sector. The beginning of a shift toward the private sector is evident among patients interviewed for this study. They perceive that the private sector provides higher quality services (better drug availability; "better treatment") than public health facilities and that such perceptions were often the basis on which they chose a private over a public provider.

This trend can benefit the public sector to the extent that it frees public resources to serve a smaller number of patients more effectively. But it also can have negative effects to the extent that it draws away precisely those people who are most able to pay for health services. This latter effect is particularly important in the context of the cost-recovery effort that the MOH has initiated. If a large majority of paying patients leave the public sector for the private sector, it would have a significant impact on cost-recovery revenues, which the MOH needs to improve public sector services.

### Recommendations

- These trends mean that it is especially important to the success of cost recovery and of efforts to strengthen the public health sector that the MOH continue its efforts to improve and maintain the quality of care in government health facilities. Quality improvements should be pursued across the board in the public sector, which now competes with the private sector in providing a full range of curative services at all levels of care in hospitals, health centers, and dispensaries and also in providing preventive and other high-priority public health services.
- In making quality improvements in the public sector, it is important to give priority to those factors the population uses to judge quality—particularly in the context of cost recovery. Experience with the introduction of user fees in government health facilities in many African countries demonstrates that people's willingness to pay for health services, and hence the success of cost recovery, depends on making needed quality improvements.
- It is important that the MOH coordinate its pricing strategy with that used by private sector providers and that fees for services in the public sector be adequate to produce revenues that, along with MOH budget funding, are sufficient to make the desirable quality improvements.

## Public and Private Sector Competition for Health Personnel

An expanded private sector also can attract health manpower away from the public sector because of the potential for higher incomes. Provider interviews conducted for this study found evidence that this dynamic is already operating in Tanzania.

One solution Tanzania has tried in this regard is to require public sector medical personnel to seek permission to "moonlight." While this arrangement permits government employees to supplement their incomes, this study found evidence that in practice this arrangement draws more provider time away from public sector work than intended. Experience in Tanzania and elsewhere in Africa suggests that "moonlighting" and permitting private wings to exist within public hospitals can have mixed benefits for the public sector. While they may represent reasonable short-run solutions, other alternatives are probably needed in the long run.

While the issue of personnel incentives is relatively widely recognized in Sub-Saharan Africa, as yet there are no widely accepted solutions. Tanzania has included managerial and organizational elements in its health sector reform plans that can help to address the problem.

### Recommendation

- The MOH will need to address the issue of incentives, monetary and other, for work in the public sector. Findings from this study indicate that a sharp focus on personnel incentives is important not only for managerial issues already recognized in the MOH reform plan, but also because of the competition for health personnel exerted by an expanded private sector.

# 1.0 INTRODUCTION

The Health and Human Resources Analysis for Africa (HHRAA) project of the U.S. Agency for International Development (USAID) provided funding to USAID's Health Financing and Sustainability (HFS) Project to study development of private sector health services in Tanzania. This study is part of HHRAA's larger effort to study private sector development in health in four African countries: Kenya, Senegal, Tanzania, and Zambia. The larger effort reflects USAID Africa Bureau's interest in identifying increased possibilities of public-private partnerships in health as one way to use existing resources more effectively to increase and improve the availability of health services for African populations and thereby to improve health status.

With growing recognition of the size, scope, and diversity of private health services in Africa, African governments and international donors have taken an interest in better assessing the potential of the private sector help achieve public sector health goals. This recognition, in turn, has focused attention on the importance of regulatory, legal, and other action by the public sector in creating an environment in which the private sector can effectively provide quality services.

These issues have particular relevance to Tanzania, where the public sector has at times deliberately restricted private sector activity in health and at others has encouraged and supported growth of certain types of private sector providers. In addition, constraints on public sector resources in Tanzania have made it increasingly important to seek nongovernmental sources of funding for health services — such as user fees — and nongovernmental sources of health care to augment available health services to better meet the health needs of the population. Since the early 1990s, the government has made private sector development a cornerstone of its health sector reforms.

## 1.1 PURPOSE AND SCOPE

The purpose of this study is to provide baseline information and analysis that the Ministry of Health (MOH) can use to further elaborate policies to enhance public-private partnerships in order to expand coverage, strengthen quality and efficiency of health services, and improve health status in Tanzania. Specifically, the purposes of this study, as requested by HHRAA, are to:

- Gather existing information on the size and scope of the private sector in health care delivery in Tanzania and generate additional data through field surveys and interviews;
- Assess the actual and potential role of the private sector in promoting the public health agenda;
- Describe the current linkages between the public and private sectors in health care and identify potential areas of collaboration that could improve health services delivery; and
- Identify factors that affect development of the private sector in Tanzania, especially legal, regulatory, tax, and financial matters.

Although the MOH in Tanzania has given increasing attention to and maintains various statistics on the private sector, available information on the size, composition, and scope of the private sector is not always reliable. Information is not readily available on the health services delivered by private sector providers, the populations served, or the factors that affect patterns of service delivery. Evidence suggests that the recent

liberalization of government policies toward the private sector has had intended and unintended effects on the private health providers. The recent rapid growth in the numbers and types of private providers has added to the uncertainty about the size, scope, and role of the private sector.

Gathering what information is available and supplementing it with new information from providers therefore can help lay the base for 1) a more comprehensive assessment of the size, scope, and distribution of private sector health services; 2) a better understanding of the momentum of growth in the sector; and 3) an initial identification of important linkages and areas for collaboration between the public and private health sectors. It also can help identify major issues concerning how the private sector can help advance the public health agenda in Tanzania for further analysis.

This study is not intended to be a comprehensive or definitive review of all types of private sector health activity. This study focuses on the role of private health service delivery providers. It does not include Tanzania's equally important initiatives to increase the role of private financing of government services through user fees, and it covers only secondarily other major actors in the private sector in health, e.g., pharmacies and health insurance companies. In addition, the study focuses on filling selected gaps in information about private sector health providers — especially gaps related to the impact of various factors on the growth of this sector — as well as some gaps in information on patients' perceptions and utilization of public and private sector providers. Further, at HHRAA's request, the study focuses on the potential contribution of private sector providers in expanding coverage and access to preventive and primary health services; it does not examine in depth their current and potential role in hospital services.

The intended users of the study results are government policymakers and program managers (primarily in the ministries of health, finance, and planning) and USAID/Dar es Salaam staff. It is also hoped that the study will be useful to USAID/Washington offices, contributing to a better understanding of key aspects of private health sector development and the impact of public policy on the growth of the sector in Sub-Saharan Africa. The approach to assessing the private sector used here should be useful as well to other countries that might wish to replicate the study. Finally, the HHRAA project's attempt to collect similar kinds of information on the private health sector in four countries will help build a comparative and cumulative database from which generalizations may emerge.

## 1.2 HOW THE STUDY WAS CONDUCTED

The HFS research team collaborated closely with university-based Tanzanian researchers and the Tanzanian MOH in collecting and interpreting the data and in writing the final report. Because USAID/ Washington initiated the overall effort and sought comparability across countries, most elements of the research agenda and design were predetermined before field work began. Nevertheless, Tanzanian counterparts and the USAID/Dar es Salaam provided comments and advice that were incorporated into the final study to adapt it to the unique situation in Tanzania. The Tanzanian research team also selected the field sites and the provider interview sample, and Tanzanian interviewers conducted the field surveys. The Tanzanian and HFS research team also sought additional relevant information and documentation from the MOH, professional organizations, international and donor agencies, and research centers.[1]

Field work for the study took place in three parts. First, an HFS research team traveled to Tanzania in December 1993 to conduct initial planning and information-gathering with Tanzanian counterparts. Next,

[1] For a complete list of contacts, see Appendix 1.

the Tanzanian research team conducted provider interviews during January–April 1994, joined for part of that period by HFS personnel. Finally, HFS staff traveled to Tanzania in October 1994 to discuss findings and to obtain comments and input on the draft report from MOH counterparts and the Tanzanian research team.

## 1.3 ORGANIZATION OF THE REPORT

*Section 2* describes the methodology and database for the study. *Section 3* provides the context for the analysis by describing the health status of the Tanzanian population, the goals and priorities of the health sector, and the current stage of the government's health sector reform efforts. *Section 3* also describes the economic and health financing context in which private health sector development policies are taking place. *Section 4* presents findings from this study's field work and data collection on: 1) the size and scope of the private sector; 2) contributions private sector providers are making to the public health agenda; 3) existing collaboration and linkages between the public and private sectors; and 4) factors affecting the development of the private sector, including the regulatory and financial environment. The last section highlights the main findings of the study and offers conclusions and recommendations.

# 2.0 METHODOLOGY

## 2.1 DEFINITIONS AND TYPOLOGIES FOR PRIVATE SECTOR HEALTH PROVIDERS

This study followed the methodological approach that USAID's Data for Decision-Making project developed for HHRAA for use in the four-country comparative study of private sector development in Africa (Berman and Hanson, 1993). That methodology identified a simple typology using the criteria "ownership" and "financing" as starting points for distinguishing between the public and private sectors and for identifying combinations that frequently occur in practice (see *Exhibit 2-1).* They made this distinction because privately owned health services can receive public financing (for example, from government taxes or social insurance funds) and publicly owned government health facilities can receive private financing (for example, from user fees paid by patients or from health insurance purchased by private individuals or funded by private sector employers).

These combinations of public and private ownership and financing help identify some of the key areas of potential public-private collaboration. For example, Tanzania's recent privatization policy represents a move toward permitting an increase in private capital participation in the ownership and provision of health care services. One of the main interests of the MOH in a review of private sector development is to assess whether lifting former restrictions has actually encouraged private capital investment in health services and/or stimulated growth in the number of privately owned health service providers (represented by the bottom right quadrant of the matrix in *Exhibit 2-1).*

Tanzania's recent health financing reforms also have established a measure of private financing for government health services by permitting collection of user fees in government health facilities. These changes in policy about charging user fees in the public sector are key to Tanzania's efforts to improve health services and are represented by the upper right quadrant of the matrix. The focus of this study, however, is on the bottom two quadrants — that is, on public-private partnerships (lower left) and on purely privately owned and financed efforts (lower right).

A variety of criteria can be used to distinguish further among private sector providers. One common criterion often used to further distinguish among private sector providers is financial orientation — whether the entity operates on a for-profit or nonprofit basis. For-profit providers include a wide array of traditional and Western-medicine health practitioners operating individually or in groups. Nonprofit health providers usually include those owned by church missions or other voluntary agencies. Nevertheless, the dividing line between for-profit and nonprofit is often difficult to identify and often is a legal category related to tax status rather than a practical distinction.

Other common criteria include medical orientation (whether traditional or Western) and the complexity of the health facility and services offered (hospital, health center, or dispensary). These criteria serve primarily to emphasize the wide diversity of types of private sector providers, all of which influence not only the potential for private providers' contribution to the public health agenda, but also the appropriate mechanisms for public-private partnerships.

**EXHIBIT 2-1**
**TYPOLOGY OF HEALTH PROVIDERS BY TYPE OF OWNERSHIP AND FINANCING**

| Ownership | Financing | |
|---|---|---|
| | Public | Private |
| Public | Services provided in government health facilities free of charge | Services provided in government health facilities for a fee |
| Private | Services provided in church mission or other NGOs, with government subsidies for salaries or other operating expenses | 1) Services provided by private practitioners and financed through fees-for-service or insurance or employer-based arrangements; or<br>2) Services provided by private practitioners and financed directly by patients and/or relatives; or<br>3) Services provided by private practitioners and financed through employer-provided arrangements |

Source: Berman and Hanson, 1993.

## 2.2 PRIVATE PROVIDER TYPOLOGY

For purposes of this study, private sector health providers in the formal sector Tanzania are grouped into three broad categories and five subcategories. The three categories reflect broad ownership groups, as well as the financial orientation of private providers. The subcategories reflect the complex history of the private health sector in Tanzania and represent different types of relationships with the public sector.

### 2.2.1 Nonprofit (Voluntary Agency) Health Providers

- The first category is comprised of providers owned, financed, and managed by a legally "approved organization," generally religious and other nonprofit registered entities (e.g., hospitals, dispensaries and other health facilities owned by the Lutheran Church, Catholic Church, Assemblies of God, Moslem Council of Tanzania [Bakwata], Red Cross, Bahai, and Cooperative Unions). Voluntary agencies have enjoyed a strong relationship with the Government of Tanzania and receive government subsidies in the form of staff and/or bed grants.

A special subgroup of this category includes 17 Designated District Hospitals (DDHs), which are owned and managed by religious organizations but are fully financed (personnel and all other operating costs) by the government, which took responsibility for these facilities shortly after independence. Because these facilities function like, and serve as part of, the government's network of health facilities, they are generally considered public rather than private, even though private organizations retain ownership of the facilities. Two large referral hospitals designated by the government as zonal, national referral hospitals — Kilimanjaro Christian Medical Center (Lutheran Church) and Bugando Hospital (Catholic Church) — fall into this category.

### 2.2.2 Employer-Based Providers

- The second category includes health facilities owned by public-private parastatals and by private companies expressly to treat their own employees and their dependents. These units also sometimes treat nonemployees on a fee-for-service basis.

Many large companies in Tanzania, most of which are parastatal (quasi-private) organizations, provide health services for employees and their dependents. An informal employer survey conducted in 1991 found that most large employers in Dar es Salaam operate their own clinics and pay the hospital bills of employees and their families (Forgy, 1992). A more recent study surveyed 200 employers of 20 or more workers, encompassing a total of 60,000 employees. The survey found that only seven companies did not offer health care for their employees (Abel-Smith and Rawal, 1992). The most common arrangement involved private clinics contracting with companies to provide health services for their employees (46 percent of companies surveyed), followed by company-owned and -managed dispensaries and clinics on the premises (24 percent). Eleven percent of employers surveyed provided occupational health services. As a rule, the larger the employer, the more likely it is that there is a clinic on the premises. Health services through these companies usually cover all employees from the day they begin.

### 2.2.3 For-Profit Providers

- The third category is a group of health care facilities that uses permits obtained by the "approved organizations" to establish and run for-profit health care units with little or no supervision from the approved organizations. These affiliated providers negotiate with the approved organizations to be allowed to use their MOH-obtained permits to start, own, and manage a for-profit unit. These facilities often are not officially recognized by the government, but since the liberalization of laws in 1991, a number of them have broken their ties with the "approved organizations," have changed their names, and have changed their official status to for-profit providers (see below).
- The fourth category includes organizations such as the Aga Khan Foundation and Hindu Mandal, as well as some individuals who have been allowed to operate health care services on a for-profit basis by special application to the Minister of Health's discretion when other options proved to be too cumbersome or unfavorable.
- The fifth and largest category includes all other independently owned for-profit dispensaries, clinics, maternities, and hospitals that are fully financed by private individuals and/or organizations and permitted following the 1991 Private Practice Act.

This group of providers has grown rapidly since the enactment of the 1991 Private Practice Act, which was intended to reduce the constraints on the growth of private capital in the provision of health services. Some of this growth is accounted for by providers who once operated under the umbrella of "approved organizations" (as discussed above) but have re-established themselves as wholly independent facilities. Most for-profit facilities are located in large urban areas. The greatest number of them are small dispensaries in cities such as Dar es Salaam which provide outpatient services only. They typically are owned by a physician who works in the public sector and are run by a medical assistant or nurse, with the physician keeping evening and part-time hours. Private dentists also fall under this category.

- A sixth category of private providers includes those in the informal sector. These providers include traditional herbal healers, birth attendants, spiritual healers, and some qualified and unqualified individuals who practice Western medicine without licenses and who move from house to house to treat patients. Traditional healers continue to be popular in Tanzania, even in the urban areas where modern health care facilities are most accessible. Recognition by the MOH of this category is nominal and minimal except for the traditional birth attendants (TBAs). TBAs are an important source of health care in several parts of the country, assisting in up to 30 percent or more of all births in some regions. The government has provided training for TBAs in safe birthing practices, and community groups such as the Dar es Salaam City Council have worked with TBAs on community-based primary care programs.

In addition to the direct service delivery providers who are the focus of this study, the private health sector in Tanzania includes a large group of pharmaceutical retailers. This group consists of privately owned pharmacies, examination clinics, and retail shops. Only registered pharmacies can legally sell medicines in Tanzania. According to government statistics, private sector pharmacies and retailers distributed one-third of all drugs (by value) supplied to mainland Tanzania in 1990-91 (MOH, 1991). The DHS survey found that around 5 percent of family planning users obtained their contraceptives from these outlets. *Exhibit 2-2* summarizes these categories of private providers in Tanzania.

## 2.3 DATA BASE

The design for this study called for extensive reliance on secondary sources of information, available from existing reports, analyses, government statistics, and surveys. The MOH and several international donor organizations already conducted a variety of information-gathering activities and analyses about the private sector's present and potential role in health care in Tanzania (e.g., MOH, 1994b; World Bank, 1989 and 1993a; USAID, 1990; Vethouse Associates, Inc., 1994; Abel-Smith and Rawal, 1992 and 1993b). The HFS team met with a large number of organizations and individuals to obtain this information, including several MOH divisions. (See *Appendix 1* for a list of contacts.) Two special surveys also were available at the time of the study, one from an urban health initiative in the capital Dar es Salaam (Kanji, Kilima, and Munishi, 1992; and Dar es Salaam City Council, 1993), and another from the Demographic and Health Survey project (DHS, 1991-92). The HFS research team also further analyzed the Demographic and Health Survey data set to obtain information on the private sector's contribution to selected public health services in Tanzania.

This study brings together information from these data sources as well as one additional primary data-gathering activity: an interview survey of 61 private providers and interviews with patients at selected health facilities *(Appendix 2* includes samples of the interview questionnaires). The provider survey was designed primarily to fill information gaps about the impact of government policies and other factors on the practice

patterns of private health providers. The informal patient survey was designed to provide insights into qualitative factors that affect people's use of public or private health providers.

**EXHIBIT 2-2**
**TYPOLOGY OF PRIVATE HEALTH CARE PROVIDERS IN TANZANIA**

| Employer-Based | Voluntary Agency* | Private For-Profit |
|---|---|---|
| Parastatal organizations and private companies | Church-based (Catholic, Protestant) and Islamic groups (e.g., BAKWATA)<br><br>NGOs (Red Cross, etc.)<br><br>Private nonprofit facilities affiliated with Voluntary Agencies | Independently owned hospitals, clinics, dispensaries, maternities, dentists<br><br>For-Profits affiliated with voluntary agencies<br><br>Informal sector traditional providers:<br>- TBAs<br>- Herbalists<br>- Spiritualists<br><br>Pharmaceutical retailers:<br>- Pharmacies<br>- Retail shops |

* Includes Designated District Hospitals (DDHs)

## 2.4 FIELD SURVEY SAMPLE

The Tanzanian research team selected two regions, Dar es Salaam and Kilimanjaro, in which to interview private health providers because an initial inquiry in 1993 had indicated a higher volume of private sector activity in these regions than was documented in the official records at the MOH headquarters. In both regions, various categories of private sector entities exist, from private for-profit to private nonprofit. A proportionate sample was randomly picked from the five categories of private providers identified above, comprising a total of 61 units in the two regions.

The interviews followed a flexible questionnaire that was developed and pretested *(see Appendix 2)*. Interviews were conducted among owners, managers, and responsible people found at the 61 units of the sample. The research team also interviewed officers responsible for the registration, management, and monitoring of the private health sector at the MOH headquarters in Dar es Salaam, as well as the regional and the district/municipal headquarters. Regional-level heads of some approved organizations such as Bahai, Red Cross, and Holy Leaf also were interviewed.

The team also conducted a mini-survey of facility users at some inpatient private hospital wards which are well known for attracting patients from the government hospital wards and distant places. These interviews

were informal and sought to elicit information on what attracts people to the private sector when they could have received services at no cost at the government-owned units in their own neighborhood.

The interview survey did not cover the informal health sector, which includes traditional health providers and birth attendants, because of the inability to establish a sampling frame for that category. A detailed study of this sector would be valuable, however, because of the significant demand for the services of the traditional healers and allied professionals.

# 3.0 HEALTH AND ECONOMIC CONTEXT

## 3.1 DEMOGRAPHY AND HEALTH STATUS

This section summarizes the main features of the demographic and health situation in Tanzania in which public and private health sector service delivery providers must function. Tanzania has made a great deal of progress in improving health status since independence, having achieved a high rate of child immunization and having increased health facilities and manpower to make services available to a majority of the population. But major problems remain, particularly to address "traditional" public health concerns such as malaria and respiratory diseases, as well as low contraceptive prevalence rates in the face of high population growth rates. The spread of HIV/AIDS and related increases in tuberculosis pose major problems for the public health system's capacity. These health problems are unevenly distributed between urban and rural populations, between children and adults, and between well-educated and less well-educated citizens.

### 3.1.1 Population and Demography

*Exhibit 3-1* presents demographic indicators for Tanzania between 1967 and 1988. Tanzania's population as of mid-1994 is estimated at 29.8 million (PRB, 1994) and has tripled since 1948. According to the 1988 census, the population is growing at an annual rate of 2.8 percent, down from an annual growth rate of 3.2 percent between 1978 and 1988, as shown in *Exhibit 3-2*. However, other estimates show a growth rate of 3.4 percent per year, one of the highest in Africa and higher than the average of 3.1 for Eastern Africa (PRB, 1994). Tanzania's population will double within the next 21 to 25 years, depending on the estimated growth rate. This high growth rate coupled with reductions in infant mortality in recent decades has left the country with a very young population: an estimated 47 percent of the population is under the age of 15.

Although still considered sparsely populated, the country's overall population density has increased from 14 persons per square kilometer in 1967 to 26 persons in 1988. In 1978, only five of the country's 20 administrative regions (excluding Zanzibar) had more than a million people; by 1988 this number had climbed to 12. As in many parts of Africa, the urban population has nearly tripled since 1967 and is currently estimated at more than 18 percent of the entire population. The urban areas are currently growing at an annual rate of 5.68 percent, with much of the increase due to migration from rural areas (Government of Tanzania, 1994).

Tanzania's total fertility rate, although quite high, has been declining gradually over the last 15 years, from 6.9 children per woman in 1978 to 6.3 in 1992 (DHS, 1991-92). There are substantial differences in fertility rates between urban and rural areas and between regions, as shown in *Exhibit 3-3*. While women in Dar es Salaam have an average of 4.0 children, total fertility rates in several rural areas of the country are as high as 6.9 to 7.1.

**EXHIBIT 3-1**
**DEMOGRAPHIC INDICATORS, TANZANIA, 1967, 1978, AND 1988**

| | Census | | |
|---|---|---|---|
| | 1967 | 1978 | 1988 |
| Population (millions) | 12.3 | 17.5 | 23.1 |
| Population density (pop./sq. km) | 14 | 20 | 26 |
| Urban population (percent of total) | 6.39 | 13.78 | 18.33 |
| Crude birth rate | 47 | 49 | 46 |
| Crude death rate | 24.4 | 19.0 | 15.0 |
| Total fertility rate | 6.6 | 6.9 | 6.5 |
| Infant mortality rate (per 1,000 live births) | 155 | 137 | 115 |
| Life expectancy at birth | 41 | 44 | 48 |

Source: DHS, 1991-92.

**EXHIBIT 3-2**
**TOTAL POPULATION AND RATES OF POPULATION GROWTH, TANZANIA, 1948-1988**

| Year | Population | Rate of Growth (%) |
|---|---|---|
| 1948 | 7,744,600 | — |
| 1957 | 9,084,100 | 1.77 |
| 1967 | 12,313,469 | 3.04 |
| 1978 | 17,512,611 | 3.20 |
| 1988 | 23,126,310 | 2.80 |

Source: Government of Tanzania, 1994.

**EXHIBIT 3-3**
**ESTIMATED TOTAL FERTILITY RATES**
**BY RESIDENCE AND ZONE, 1991-1992**

| | Total Fertility Rate (Women aged 15 to 49) |
|---|---|
| **Residence** | |
| Dar es Salaam | 4.0 |
| Other urban | 5.6 |
| Rural | 6.6 |
| **Zone** | |
| Coastal (Tanga, Morogoro, Coast, Dar es Salaam, and Zanzibar) | 5.7 |
| Northern Highlands (Arusha and Kilimanjaro) | 6.0 |
| Lake (Tabora, Kigoma, Shinyanga, Kagera, Mwanza, and Mara) | 6.9 |
| Central (Dodma and Singida) | 7.1 |
| Southern Highlands (Iringa, Mbeya, and Rukwa) | 6.3 |
| South (Lindi, Mtwara, and Ruvuma) | 5.1 |
| Total | 6.3 |

Source: DHS, 1991-92.

Due largely to improvements in public health, life expectancy in Tanzania has risen from 41 years at birth in 1967 to 51 in 1994 (PRB, 1994). A great part of this increase is a result of declining infant mortality rates, which have decreased from 225 per 1,000 live births in 1961 to 92 in 1987. Under-five mortality has declined from 163 in 1977 to 153.6 by 1991 (DHS, 1991-92; MOH, 1994b). As shown in *Exhibit 3-4*, mortality rate estimates from the 1991-92 DHS are consistently higher for neonates, infants, and children under age 5 in the urban areas than the rural areas, although Dar es Salaam is not included in these estimates.

There are also substantial differences in mortality rates between regions. The infant mortality rate of 128 per 1,000 live births estimated for the Dodoma and Singida regions in the center of the country is two and a half times the estimated rate of 55 for the wealthier Arusha and Kilimanjaro regions (see *Exhibit 3-4)*.

**EXHIBIT 3-4**
**ESTIMATED INFANT AND CHILD MORTALITY RATES BY RESIDENCE AND ZONE, TANZANIA, FOR THE TEN-YEAR PERIOD 1981-1991**

| | Mortality Rates[1] | | |
|---|---|---|---|
| | Neonatal | Infant | Under-five |
| **Residence** | | | |
| Urban[2] | 52.1 | 108.3 | 159.2 |
| Rural | 36.9 | 97.2 | 152.2 |
| **Zone**[3] | | | |
| Coastal (Tanga, Morogoro, Coast, Dar es Salaam, and Zanzibar) | 44.7 | 107.0 | 160.3 |
| Northern Highlands (Arusha and Kilimanjaro) | 34.4 | 55.5 | 78.6 |
| Lake (Tabora, Kigoma, Shinyanga, Kagera, Mwanza, and Mara) | 38.1 | 107.1 | 168.9 |
| Central (Dodoma and Singida) | 51.2 | 127.9 | 190.6 |
| Southern Highlands ( Iringa, Mbeya, and Rukwa) | 31.8 | 79.9 | 130.2 |
| South (Lindi, Mtwara, and Ruvuma) | 41.5 | 99.1 | 163.1 |
| Total | 40.0 | 99.4 | 153.6 |

[1] per 1,000 live births

[2] Not including Dar es Salaam and Zanzibar

Source: DHS, 1991-92.

Contraceptive prevalence remains low in Tanzania. About 7 percent of married women overall use modern methods of contraception, which compares with rates of 36 percent and 28 percent in neighboring Zimbabwe and Kenya (DHS, 1991-92; PRB, 1994). As would be expected, the highest rates of contraceptive use are among women in urban areas, including Kilimanjaro (25 percent), Arusha (12 percent), and Dar es Salaam (11 percent), while as few as 1 percent to 3 percent of married women use modern contraception in several of the country's rural regions.

### 3.1.2 Health Status and Major Health Problems

Infectious diseases remain the overwhelming cause of mortality and morbidity in Tanzania. Malaria, upper respiratory tract infection, and diarrheal diseases are the leading causes of illness and major causes of death in children under age 5 (MOH, 1993). Chronic malnutrition, an underlying cause of much child mortality, is also prevalent in the country. The 1991-92 DHS found that almost half (47 percent) of the children surveyed were found to be stunted, an indication of past malnutrition, with 20 percent were severely stunted. Almost 6 percent of children were found to be acutely undernourished (wasted) during the survey and 29 percent were underweight (DHS, 1991-92). Regional differences were large; the proportion of underweight children in the Mtwara region and Zanzibar was at least twice (48 percent and 40 percent, respectively) of the proportion in Dar es Salaam (20 percent), and the proportion of severely underweight children was three times as high. In addition, the incidence of low birth weight, a major risk factor for infant mortality and an indication of poor maternal nutrition, was found to be 17 percent of all births (DHS, 1991-92).

Neonatal and perinatal mortality are also significant. Although the vast majority of women (97 percent) receive at least some prenatal care, a little more than half (53 percent) give birth in health facilities and are assisted by trained medical or paramedical staff. Forty-six percent of women give birth at home and are attended by relatives, traditional midwives (TBAs), or no one (DHS, 1991-92). Overall, TBAs assisted in 13 percent of all births reported during the DHS. The use of TBAs varies greatly by region, from 30 percent or more of total births in Rukwa and Iringa regions to as little as 3 percent in Ruvuma, Mwanza, and Tabora.

Immunization rates for children are quite high in Tanzania, according to both the DHS and national EPI surveys. Seventy-one percent of children between 12 and 23 months were fully vaccinated, 56 percent during their first year of life, and only 4 percent of 12- to 23-month-olds had never received any vaccinations. Overall coverage was 95 percent for BCG, 81 percent for measles, 77 percent for the third dose of polio, and 80 percent for the third dose of DPT. Although immunization rates vary somewhat by region, only in three of the country's 20 regions (Shinyanga, Mara, and Arusha) are the full immunization coverage rates below 60 percent (DHS, 1991-92).

The gains made in infant and child mortality over the last several years are being largely offset by the impact of the AIDS epidemic in the country. According to World Bank estimates, in the early 1990s AIDS killed 20,000 to 30,000 Tanzanians per year, representing 5-7 percent of all deaths. AIDS has surpassed malaria as the number one killer disease among adults and was a significant cause of death in children. According to one estimate, the infant mortality rate by the year 2010 will be 30 percent greater than it would have been in the absence of AIDS, and life expectancy will be reduced 35 percent from what it would otherwise have been (International Family Planning Perspectives, 1993).

The impact of the epidemic on health care resources has been dramatic. The World Bank estimates that almost *half* ($25-$27 million) of the government's total health budget of $58 million in 1991 was spent for AIDS treatment alone (International Family Planning Perspectives, 1993). Current HIV prevalence rates are estimated at between 1.4 percent and 5.3 percent, averaging 2.5 percent among the urban population and reaching as high as 17 percent in certain regions (e.g., Kagera) (International Family Planning Perspectives, 1993). As HIV-positive individuals become ill with AIDS and as the HIV prevalence rate increases in the coming years, the impact of the disease on the health care budget, as well as on the overall economy, will be even greater. One of the greatest challenges of Tanzania's health sector — both public and private — will be to prevent and control the spread of AIDS and increases in related diseases such as tuberculosis.

### 3.1.3 Public Health Sector Objectives and Approach

The overall objective of the health sector in Tanzania has been to improve the health and well-being of the population, with a particular focus on equity and access to primary health care services. The Ministry of Health emphasizes "equitable universal availability of effective essential health care at a cost the country and the community can afford" (MOH, 1994b). Indeed, Tanzania was an early leader among African countries in its attempts to make health, education, and social services available to the whole population. Until recently, these efforts have been largely government-sponsored, -managed, and -financed. Community-based "self-reliance" efforts have contributed labor to construct clinics and schools that the government subsequently staffed and operated.

The specific, current objectives of the government's health policy (MOH, 1994b) are to:

- reduce infant mortality and morbidity;
- increase life expectancy;
- reduce maternal mortality and morbidity;
- control communicable diseases;
- ensure treatment of common ailments;
- ensure availability and access to all in urban and rural areas;
- move toward self-sufficiency in health manpower;
- educate communities about common preventable health problems and on personal responsibility for individual health;
- promote multi-sectoral communications (education, agriculture, water and sanitation, community development, women's organizations, political parties, and nongovernmental organizations.

The government's efforts since independence to achieve broad health services coverage for the population have resulted in significant expansion of health facilities and manpower, as shown in *Exhibit 3-5*.

## 3.2 ECONOMIC BACKGROUND

The following section reviews the economic context in which the Government of Tanzania must conduct its health policy and fund public sector health services. A review of recent economic history shows that Tanzania, like most other African countries, experienced serious deterioration during the late 1970s and the 1980s, resulting in severe government budget constraints and several agreements with the International Monetary Fund. By 1990, the government's dependence on foreign assistance was five times higher than at independence in 1961. Although the government's health budget increased during this period, by the late 1980s it was not keeping up with inflation or population growth, and health services deteriorated with unavailability of needed medicines and disrepair of health facilities. Although Tanzania spends a greater share of its GDP on health than other countries with similar income levels, life expectancy in 1990 was lower than would be expected given its national income and educational level.

**EXHIBIT 3-5**
**GROWTH OF PUBLIC SECTOR HEALTH CARE SERVICES IN TANZANIA**

| | | 1961 | 1994 | Increase |
|---|---|---|---|---|
| 1. | **Facilities** | | | |
| | Hospitals | 98 | 174 | 78 |
| | Rural Health Centers | 22 | 276 | 1,154 |
| | Dispensaries | 875 | 3,924 | 266 |
| 2. | **Manpower** | | | |
| | Medical Doctors (M.D.s) | NA | 1,134 | — |
| | Medical Officers | 415 | 1,349 | 273 |
| | Medical Assistants | 200 | 2,233 | 1,016 |
| | Nurses Grade A | 388 | 7,972 | 410 |
| | Nurses Grade B | 984 | 12,721 | 1,193 |
| | Rural Medical Aids | 380 | 4,203 | 1,006 |
| | Allied Health Professionals | NA | 12,592 | — |
| | Maternal and Child Health Aids | 400 | 3,707 | 826 |

NA = data not available
Source: MOH, 1994a.

These conditions have indicated to the government that its capability to develop, improve, and sustain free public health services has become limited. It is in this context that the Ministry of Health has considered and adopted several steps toward major reforms in health financing, calling on patients to pay user fees, and in the provision of care, calling on the private sector to supplement or work in partnership with the government in health service delivery.

### 3.2.1 Macroeconomic Trends

When Tanzania achieved independence in 1961, the economy was based on private enterprise and was mainly agricultural. Following independence until 1967, there was no basic change in the structure of the free-enterprise economy. Annual GDP grew at more than 6 percent, exports grew at 8 percent annually, and manufacturing grew by 13.2 percent annually.

Drastic change in social and economic policies took place between 1967 and 1973. The Arusha Declaration in February 1967 put into motion policies that were meant to achieve the goals of a socialist state and self-reliance. The objective was to achieve economic justice and equity and to eliminate illiteracy, poverty, and disease. The state became responsible for health, education, and nutrition. All major firms involved in production, marketing, distribution, and finance were nationalized. In this transitional period, economic performance slowed.

GDP grew by 3 percent annually, manufacturing grew by 7.6 annually, exports grew by 1.1 percent annually, and imports increased at 7.1 annually, creating a sizable trade deficit.

The Tanzanian economy experienced a number of external and internal shocks after 1972. The economy was hit with the first oil shock of 1973, which sharply increased both prices and import expenditures. Next came the 1973-74 drought, drastically lowering domestic food supplies. Another shock to the economy was the 1978-79 war with Uganda, which was followed by the second oil shock in 1979.

By the early 1980s, the country was in deep economic crisis (see *Graph 3-1)*. The government attempted to stabilize the economy by employing its own stabilization program, which met with limited success. In 1986 the government and the International Monetary Fund (IMF) agreed to a three-year package of measures and policy reforms. Another IMF stabilization program followed in 1989, which attempted to deal with Tanzania's large balance-of-payments deficit (see *Appendix 3, Exhibit A3-1)*.

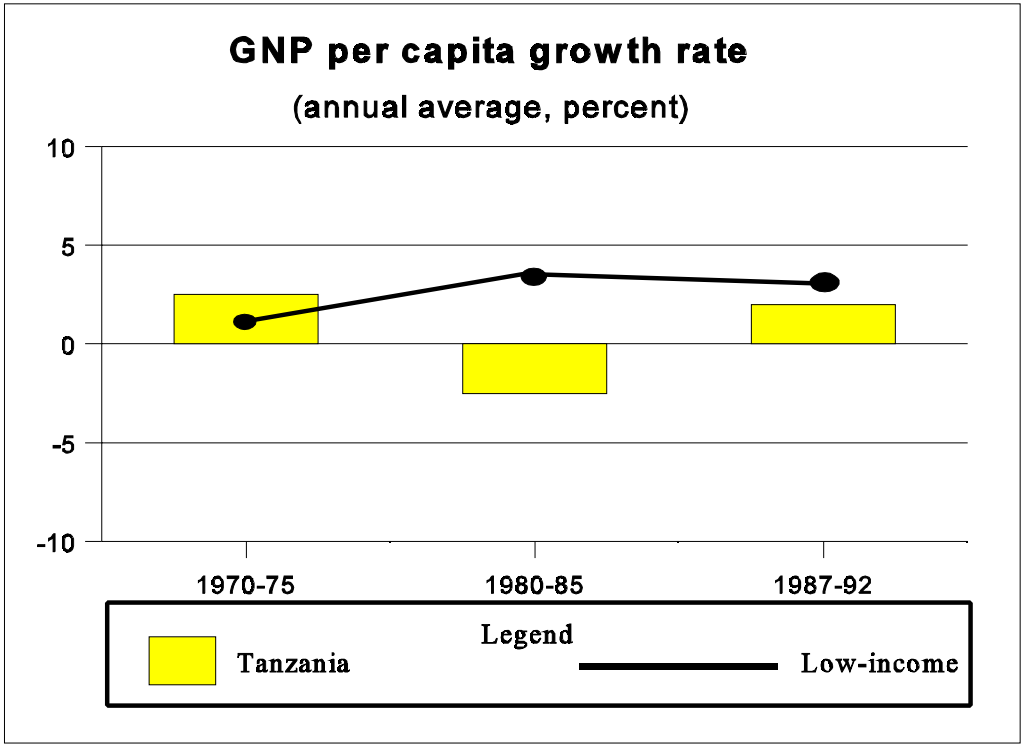
An estimated 90 percent of the economically active population of Tanzania still relies on the agriculture for its livelihood, and agriculture accounted for 84 percent of export earnings in the early 1990s. Low population density and varied agricultural resources account for a robust agricultural sector. It is estimated that only 8 percent of the country's land is cultivated, with only 3 percent of that under irrigation. The government is interested in increasing the area under cultivation.

The industrial sector suffered during the 1980s. The World Bank estimates that from 1965 to 1980 the annual growth rate was 4.2 percent but that it dropped to zero for 1980-90. Problems facing the industrial sector include the lack of foreign exchange, high oil prices, and a weak infrastructure. The industrial sector is based on import substitution, although some goods — such as textiles and clothing — are exported to neighboring countries. Tanzania's mineral resources include coal, iron ore deposits, phosphates, copper, lead, tin, nickel, and sulphur. Gold and diamonds are mined as well. A breakdown of GDP by economic activity is shown in *Appendix 3, Exhibit A3-2*.

### 3.2.2 Government Funding for Health Services

The government budget allocation to health declined from 9.4 percent in the early 1970s to about 6 percent in the early 1980s and increased again during the 1980s to a level of 8 percent by 1991 (MOH, 1993). As shown in *Exhibit 3-6*, the rate of increase in government allocations to health during the early 1980s was not sufficient to keep pace with inflation, which averaged 25.7 percent throughout the decade (World Bank, 1993b), but rates of increase in the last half of the decade generally exceeded the inflation rate.

When both inflation and the population growth rate are taken into account, the MOH budget was unable to maintain real per capita spending. As *Exhibit 3-7* shows, average real per capita spending in the public health sector was about 10 percent less in the 1989-93 period than in 1980, and only about 60 percent of the level of the mid- to late 1970s.




Graph 3-1 GNP PER CAPITA GROWTH RATE

**EXHIBIT 3-6**
**GOVERNMENT BUDGET ALLOCATIONS TO HEALTH, 1979-1992**

| | Total Government Budget | Health Spending | % Change in Nominal Spending* | % of Total Government Budget on Health |
|---|---|---|---|---|
| 1979-80 | 13,969.9 | 818.7 | — | 5.9 |
| 1980-81 | 15,320.0 | 926.0 | 13 | 6.0 |
| 1981-82 | 18,399.1 | 1,072.3 | 16 | 5.9 |
| 1982-83 | 20,017.0 | 1,063.1 | -0.1 | 5.3 |
| 1983-84 | 21,460.9 | 1,206.5 | 13 | 5.6 |
| 1984-85 | 26,728.0 | 1,816.2 | 50 | 6.8 |
| 1985-86 | 33,219.3 | 1,943.7 | 7 | 5.9 |
| 1986-87 | 51,142.1 | 3,256.2 | 67 | 6.4 |
| 1987-88 | 76,355.9 | 4,726.3 | 45 | 6.2 |
| 1988-89 | NA | NA | — | NA |
| 1989-90 | 113,964.0 | 9,101 | — | 7.9 |
| 1990-91 | 161,224.0 | 13,154.0 | 44 | 8.2 |
| 1991-92 | 199,670.0 | 16,409.0 | 25 | 8.2 |

NA = data not available
* The average annual inflation rate for the period 1980-91 was 25.7 percent.
Sources: MOH, 1993, and World Bank, 1993b.

In spite of the government's emphasis on self-reliance, poor economic conditions in Tanzania also resulted in the government becoming systematically more dependent on foreign aid. As *Exhibit 3-8* shows, while the share of external financing in the total development and recurrent government budget accounted for only 5 percent in 1961, it accounted for almost 30 percent in 1990. The share of external financing in the development budget alone increased from 28 percent in 1961 to almost 200 percent in 1990.

The declining capabilities of the government, as the economy declined, went hand in hand with an increase in demand for health care services from a rapidly increasing population. Government-owned units experienced deterioration in the quality of health care services, including chronic shortages of essential drugs and facilities left in a state of disrepair for most of the time. These conditions have been pointed out by many researchers (see, for example, Munishi, 1991; and Kanji, Munishi, and Kilima, 1992).

**EXHIBIT 3-7**
**PER CAPITA REAL PUBLIC EXPENDITURES ON HEALTH**
(period averages in 1980 Tshs.)

| Period | Average |
|---|---|
| 1971-73 | 31 |
| 1974-79 | 45.5 |
| 1980-82 | 32.3 |
| 1983-88 | 25 |
| 1989-93 | 28 |

Source: Vethouse Associates, Inc., 1994.

**EXHIBIT 3-8**
**SHARE OF EXTERNAL FINANCING IN GOVERNMENT BUDGET IN TANZANIA IN SELECTED YEARS 1961-1990** (in Tshs. '000,000)

| | Development Budget | Recurrent Budget | Total | External Financing | External Share of Develop-ment Budget (%) | External Share of Total Budget (%) |
|---|---|---|---|---|---|---|
| 1961 | 133 | 598 | 731 | 37 | 28 | 5 |
| 1971 | 884 | 1,781 | 2,665 | 385 | 44 | 14 |
| 1981 | 5,185 | 13,214 | 18,399 | 2,954 | 57 | 16 |
| 1990 | 25,354 | 145,643 | 170,997 | 50,616 | 200 | 30 |

Source: Vethouse Associates, Inc., 1994.

### 3.2.3 Impact of Government Health Spending

*Graph 3-2* shows Tanzania's position relative to 130 countries in terms of life expectancy and public expenditures on health in 1990. The graph shows that, even though Tanzania spends a larger share of its GDP on health than other countries with similar income levels, life expectancy is lower than would be expected given the size of the national economy and the population's education level. While the impact of HIV/AIDS had already contributed to lower life expectancy by 1990, these results also suggest that even the substantial share of government budget allocated to health is insufficient for Tanzania's current needs and might be spent more effectively. They also suggest that additional private resources need to be mobilized to help pay for and provide health services that the government is no longer able to fund.

For example, recent estimates indicate that additional funds of Tsh. 130 billion — almost triple the size of Tanzania's 1993-94 health budget — would be needed to provide the full package of basic health care that the World Bank now recommends (World Bank, 1993b). The recommended package is estimated to cost $12 per capita for low-income countries, compared with about $3 per capita available in Tanzania's 1993-94 health budget (Vethouse Associates, Inc., 1994).

## 3.3 HEALTH SECTOR REFORM

The Ministry of Health has been considering major reforms in the organization, financing, and management of the health sector and has already taken some steps to implement major changes. Budget constraints and deterioration of government health services helped prompt this reconsideration of Tanzania's traditional reliance on government-funded health services provided to all citizens free of charge.

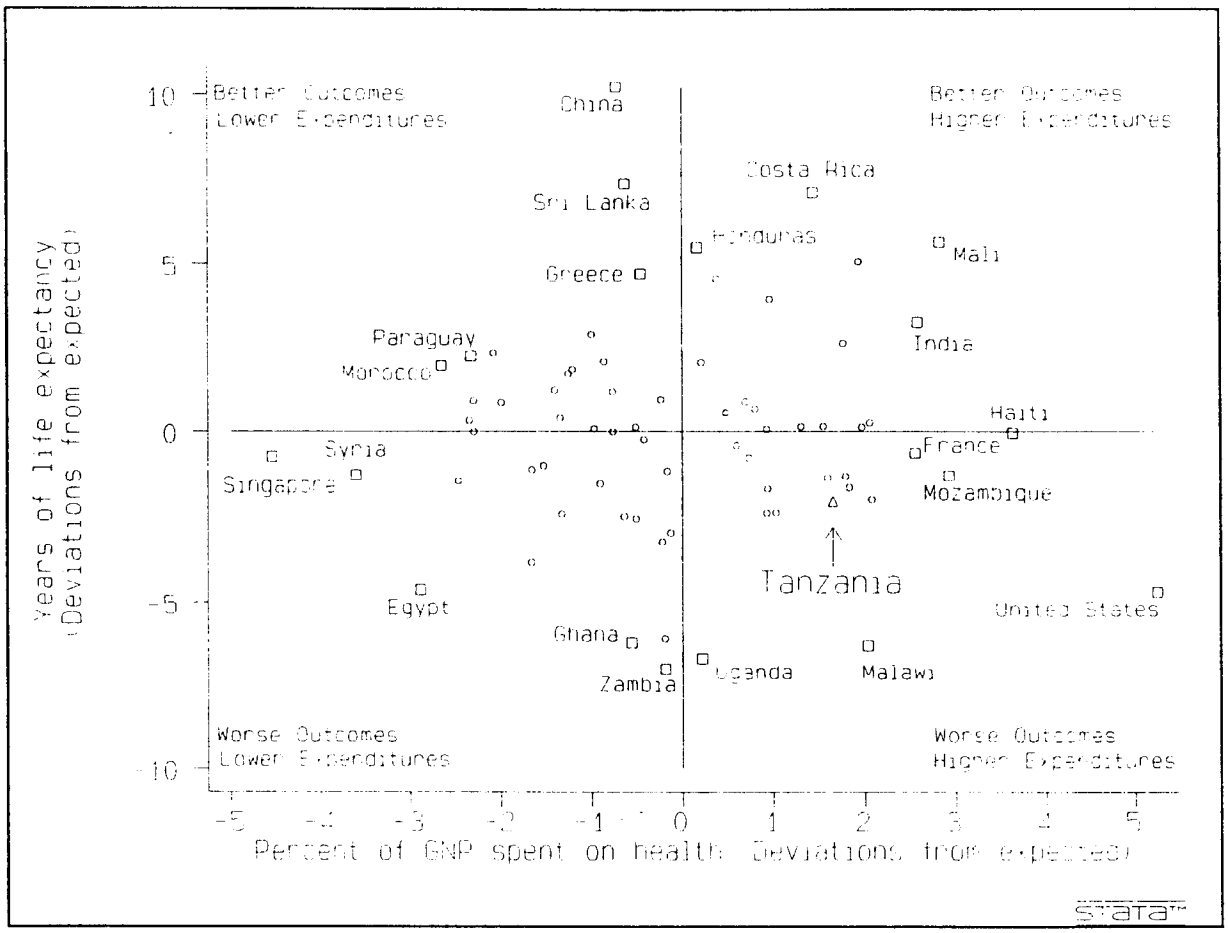
A major element of reform includes the introduction in July 1993 of cost sharing in the form of user fees for government health services as way to mobilize private sources of funds to help close the funding gap. Another cornerstone of the reform effort includes building on the 1991 Private Practice Act to "assist and encourage the private sector to grow and provide quality health care to complement the government's efforts towards the provision of equitable and affordable health care" (MOH, 1994b).

### 3.3.1 Overview of Reform Efforts

The process for reform started in 1993 with a health strategy note that focused on the need to reexamine the health services delivery system. A meeting was held at Mikumi November 2-23, 1993, to further develop ideas and directions for the reform effort. A national workshop was held at Kunduchi April 5-8, 1994, to discuss the issues in a wider cross-sectional context (MOH, 1994b). Workshop participants identified three categories of problem in the health sector: organizational issues, managerial issues, and financial issues.

Among the organizational problems were inappropriate use of health care manpower, a weak referral system, the changing role of the government from health care provider to regulator, and an underdeveloped private sector. The managerial problems included the lack of a comprehensive plan for the health sector, a lack of performance standards, and weak management support systems.

**GRAPH 3-2**
**RELATION BETWEEN HEALTH SPENDING AND LIFE EXPECTANCY**




*Source: World Development Report (1993).*

Most relevant for this study are the financial problems identified:

- Underfunding at all levels, especially shortages in drugs and supplies;
- Deteriorating physical structures and low staff morale;
- Donor dependence;
- Resource allocation biased toward curative care;
- Dependence on government as the single source for financing and provision of health care;
- Manpower shift to the private sector; and
- Costly treatment abroad.

To address the organizational, managerial, and financial problems, the MOH recommended that a number of activities be undertaken or strengthened. The measures the MOH identified to address the organizational problems focus on augmenting and complementing the work of the national government through development of the private sector, better targeting of public investment, devolving responsibility to local governments for delivery systems, improving the referral system, and developing a comprehensive primary health care program. The measures suggested to address the managerial problems include developing appropriate standards of care and building capacity for planning, management, and service delivery, particularly at the local level. The activities most relevant to this study are those to address the financial problems:

- Increase funding for health to no less than 14 percent of the government's budget;
- Better target resources to cost-effective services;
- Increase private financing through cost-sharing, insurance, and private payment;
- Develop better budgeting skills and accounting guidelines;
- Increase staff retention through better remuneration schemes;
- Regularly revise user charges to better reflect changing costs;
- Consider earmarking taxes such as tobacco and alcohol;
- Strengthen primary health care facilities;
- Provide better training in health planning, management, and financing;
- Increase local production of drugs, equipment, and supplies; and
- Decrease medical treatment abroad.

### 3.3.2 Sector Reform and Private Sector Development

As the health sector reform goals indicate, one of the cornerstones of the government's current health sector reform efforts is to take greater advantage of the potential of the private sector and to encourage private sector development in ways that can complement the government's provision of health services. This policy coincides with efforts to change the role of government from providing health care to regulating its delivery. The change in posture toward the private sector has its roots in a recognition of current public sector financial constraints which make it necessary to look to nongovernmental sources of health care, as well as in a changing political environment.

Specific elements of the current efforts to encourage private sector development derive from the complex history of the government's relations with private health providers. It is important to understand this historical context in order to understand the dynamics of the current reform efforts. These relations have evolved through at least three different political environments in Tanzania over the past 50 years: 1) before and immediately after independence in 1961; 2) from the Arusha Declaration in 1967 until introduction of the Structural Adjustment Program in 1988; and 3) since 1988 and especially after the 1991 Private Practice Act.

#### 3.3.2.1 Pre-Independence until the Arusha Declaration in 1967

Before and immediately after independence in 1961, the government encouraged private sector growth in general and in the health sector in particular. Pre-independence legislation, such as the Medical Practitioners and Dentists Ordinance of 1959 (chapter 409), allowed medical and dental practitioners to practice and collect fees for their services. Those in private practice were not required by the law to apply to the MOH, and there is no evidence that they were required to pay taxes. Senior government-employed doctors who treated patients in grades I and II (high grades) also could have private, paying patients in the hospital (intramural patients) and could maintain a private practice outside the hospital (extramural patients) after official working hours. These practitioners received 30 percent of the fees charged in intramural practice.

The 1959 law allowed only medical and dental practitioners to practice privately, however, and other categories of medical personnel were excluded (e.g., nurses). Assistant Dental and Medical Officers (licensed practitioners) were allowed to undertake practice in government institutions only under physicians' consultative guidance.

#### 3.3.2.2 Arusha Declaration until the Structural Adjustment Program

The Arusha Declaration in 1967 established a socialist government, discouraged private ownership of property and business, and committed the government to a policy of "equal access" under which it would provide health and other social services to the population free of charge. To implement this policy in the health sector, the government encouraged communities to construct health facilities as part of the self-reliance movement. Once these facilities were constructed, the government provided staff, equipment, and medicines. In this way, the government found itself taking responsibility for many rural health centers and dispensaries. This policy orientation partially explains the rapid increase in the number of government-owned health care units during this period.

In addition, the government also provided significant support, in terms of bed and personnel grants, to the health care units owned by some religious organizations. The government took total responsibility for the financing of supplies and personnel for 17 church-owned hospitals which were then named "Designated District Hospitals," or DDHs. Services in the DDHs were rendered free of charge to the population. Two large consultant hospitals — Kilimanjaro Christian Medical Center (Lutheran) and Bugando Hospital (Catholic) — also were taken over by the government to become zonal national consultant hospitals.

This expansion and the government's commitment to render free medical services went in tandem with a stance that frowned upon private medical practice. Private for-profit medical and dental practice was eventually proscribed in 1977 by the Private Hospital (Regulation) Act. Under that law, only *approved organizations* (mostly nonprofit and religious entities) were allowed to establish and manage private health care units. This was

essentially to allow religious organizations to continue to supplement public health care services at minimal and affordable prices.

To achieve "approved" status, an organization had to enlist under the Registrar of Societies and then to apply to the Registrar of Private Hospitals, who was appointed by the minister responsible for health. The procedure of getting MOH approval or a permit was quite lengthy and frustrating (Kanji, Munishi, and Kilima, 1992).

Other forms of private medical practice were allowed by the 1977 legislation under narrow conditions. The first condition, as mentioned, was that private practice could be undertaken only by "approved organizations." The second condition empowered the minister of health to give permits to some individuals and organizations to own and manage health care services. Many units were established under the umbrella of "approved organizations" under the first condition, but very few units were approved under the second.

A third condition was the government's undeclared tolerance of indigenous traditional healers. This allowed herbalists, spiritual healers, and traditional birth attendants (TBAs) to practice with little or no interference from the government. There are presently some moves to recognize and encourage the traditional methods of treatment for some diseases, and a number of clinics exist in Dar es Salaam, Kilimanjaro, and elsewhere at which people obtain and pay for treatment by traditional healers.

Two of the provisions of the 1977 law created an unintended effect. First, even though the 1977 law permitted "approved organizations" to collect fees from patients, it controlled the fees charged by the private for-profit hospitals and dispensaries. Second, medical personnel could practice outside government service only if they were employees of the "approved organizations." With the disincentives of regulated fees and a cumbersome permit process, as well as outright proscriptions on some kinds of private practice, numerous medical practitioners exploited the loophole related to affiliation with "approved organizations" and started up for-profit private hospitals and dispensaries under the umbrella of such organizations. In addition, a substantial number of unqualified junior health assistants were able to start up private health care units under this umbrella.

#### 3.3.2.3 1988 until the Present

The 1977 proscription (implemented in 1981) marginalized and reduced the rate of growth of the private health sector. It did not, however, destroy it. The current pattern of growth in the private health sector derives from this historical base. The first step under the Structural Adjustment Program (SAP) is to rationalize, liberate, and stimulate the health care services provided by the nonprofit "approved organizations." These organizations also shelter some private individuals who would not otherwise have received permits to practice under the 1977 law, as mentioned. These "sheltered" private entrepreneurs now can move away from the umbrella of "approved organizations" in order to acquire permits of their own to operate as for-profit entities.

The second step under the SAP in the wake of the 1991 Private Practice Act is to widen the scope of permit acquisition from approved *organizations* to approved *individuals*, to allow any qualified individual — including those who acquired permits by ministerial discretion in earlier periods — to establish for-profit or nonprofit health care services without the bureaucratic constraints of the past. The third step is to develop policies that will rationalize, standardize, and assist the growth of traditional health care services that are safe and that meet the population's needs.

These actions to liberalize the environment for private sector health providers are still relatively new, and there are still many questions to be addressed by the MOH and the government in general about the character, number, and potential of private sector health providers, as well as about their ability to contribute to public sector goals. In particular, the MOH sees a need for more detailed study to identify steps the government could take to encourage appropriate growth of traditional health practitioners.

*(Section 4.4* discusses the impact of the 1988 reforms and the 1991 Private Practice Act on the development of the private health sector in greater detail.)

# 4.0 FINDINGS

## 4.1 SIZE, SCOPE, DISTRIBUTION, AND QUALITY OF PRIVATE SECTOR HEALTH PROVIDERS

### 4.1.1 Number and Distribution of Private Health Providers in Tanzania

*Section 2* of this report describes the types of private sector health providers in Tanzania and groups them in a typology according to ownership and financial orientation. As indicated, the principal categories in the formal sector are represented by 1) nonprofit health providers owned by voluntary agencies, 2) employer-based providers, and 3) a large group of for-profit health providers. This section provides statistics on the number and distribution of these providers. As *Section 2* also mentioned, the scope of this study did not include collection of data on the informal sector, traditional health practitioners, or pharmaceutical retailers.

The distribution of health care facilities by ownership, according to Ministry of Health data, are shown in *Exhibit 4-1* and in *Appendix 4 (Exhibits A4-1 and A4-2)*, where they are broken down by region. The categories of ownership shown in these exhibits are government, voluntary agency, parastatals (employer-based), and private for-profit facilities. Facilities are categorized as hospitals, health centers (which provide mainly outpatient care but which typically have several beds), and dispensaries (which provide outpatient care only). The distribution of hospital and health center beds by ownership are presented in *Appendix 4 (Exhibit A4-3)*.

According to these official statistics, the government owns and operates approximately 76 percent of all health care facilities in the country, including 44 percent of hospitals, 96 percent of health centers, and 76 percent of dispensaries (MOH, 1993). The private sector plays its largest role, according to these data, through voluntary agency hospitals. Voluntary agencies owned almost 49 percent of the nation's hospitals registered in 1993 and nearly half of all hospital beds. These include the Designated District Hospitals, as noted above, are fully financed by and largely controlled by the government.

Dispensaries constitute the vast majority of health care facilities in Tanzania (87-90 percent). As shown in *Exhibit 4-1* and *Appendix 4 (Exhibit A4-2)*, three-quarters of the dispensaries counted by the MOH are government-owned, 17 percent are run by voluntary agencies, 6 percent are parastatal facilities, and only 1.2 percent (36) were categorized as private for-profit facilities.

There is reason to believe, however, that the government's figures vastly underestimate the size of the private health care sector in Tanzania, particularly the number of for-profit providers. During this study, the research team conducted a thorough search of all health care facilities and providers in Kilimanjaro and found a significantly higher number of both public and private providers than the government's statistics indicate (see *Exhibit 4-2)*.

**EXHIBIT 4-1**
**DISTRIBUTION OF PRIVATE HEALTH FACILITIES BY OWNERSHIP, TANZANIA, 1993, ACCORDING TO OFFICIAL GOVERNMENT STATISTICS**

| | Government | | Voluntary Agency* | | Parastatal | | Other Private** | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| Type of Facility | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Hospitals | 77 | 44.0 | 85 | 48.6 | 9 | 5.1 | 4 | 2.3 | 175 | 100.0 |
| Health Centers | 265 | 96.0 | 8 | 2.9 | 2 | 0.7 | 1 | 0.3 | 276 | 100.0 |
| Dispensaries | 2,218 | 76.1 | 485 | 16.6 | 175 | 6.0 | 36 | 1.2 | 2,914 | 100.0 |
| Total | 2,560 | 76.1 | 578 | 17.2 | 186 | 5.5 | 41 | 1.2 | 3,365 | 100.0 |

* Includes Designated District Hospitals (DDHs) ** Includes for-profit providers
Source: MOH, 1994b.

**EXHIBIT 4-2**
**NUMBER OF PRIVATE HEALTH FACILITIES IN KILIMANJARO, COMPARISON OF MOH DATA AND HFS FINDINGS**

| | MOH Statistics | | | | HFS Findings in Kilimanjaro | | | |
|---|---|---|---|---|---|---|---|---|
| Type of Facility | Government | Voluntary Agency | Other Private | Total | Government | Voluntary Agency | Other Private | Total |
| Dispensaries | 93 | 37 | 5 | 135 | 126 | 82 | 22 | 230 |
| Health Centers | 14 | 1 | - | 15 | 14 | 1 | - | 15 |
| Hospitals | 5 | 7 | 1 | 13 | 5 | 7 | 2 | 14 |
| Totals | 112 | 45 | 6 | 163 | 145 | 90 | 24 | 259 |

Sources: MOH, Health Information System Unit; HFS survey.

This survey found a total of 259 facilities in Kilimanjaro, compared to only 163 counted by the government. The number of facilities owned by voluntary agencies found in the survey was double the official number (90 versus 45). This study also found four times as many for-profit providers (in the "other" category) operating in Kilimanjaro than were counted by the government (24 versus 6). As expected, the greatest discrepancies were in the number of dispensaries, which are generally small operations. The survey team counted 104 private dispensaries, including those run by voluntary agencies and for-profit facilities, versus only 45 enumerated by the government. Private sector facilities are likely to be undercounted in all of the country's urban centers, where the majority of these facilities are located.

There are several apparent reasons for the government's underestimation of the private health care sector. First, as shown below, there has been a rapid increase in the number of for-profit facilities (mainly dispensaries) since the government liberalized its policies in 1991, which makes it difficult to keep an accurate, up-to-date count. In addition, there has been a "multiplier effect," with multiple dispensaries (and, in some cases, health centers or even hospitals) opening up that use the permit of a single voluntary "approved organization" — using the same name, same labels, and same permit. These additional facilities — which are by and large for-profit — often are not counted by the government.

There are three main reasons why many of these for-profit facilities do not readily change their status and register as for-profit entities. One is tax avoidance: nonprofit organizations are tax-exempt, and therefore nonprofit status confers a tax break on such facilities. Second, many of these facilities are owned by persons who are unqualified under MOH regulations. Third, the process for approval and licensing of health facilities is lengthy and cumbersome. However, between January 1988, when the Structural Adjustment Program began, and January 1993, 498 facilities were approved and registered as private for-profit facilities, including dispensaries, maternity homes, consulting clinics, and hospitals.[2]

### 4.1.2 Private Health Providers in Urban Areas

Results from the survey of all private health facilities in Dar es Salaam, conducted in 1993 by the Urban Health Project,[3] confirm this study's findings in Kilimanjaro that the size and scope of the private sector in health care delivery has been underestimated. The study painstakingly sought out all private facilities practicing modern medicine in the city and provides the most accurate picture to date of the private health care sector in Dar es Salaam. The study also can be used as an indicator of the picture in other major urban areas, where the bulk of private facilities are located. This survey focuses on modern medical facilities only (e.g., hospitals, health centers, and dispensaries) and does not cover traditional providers or pharmaceutical retailers.

One of the most striking findings from the survey is the rapid growth of private providers in recent years, particularly 1990-93 (see *Graph 4-1)*. The increase in the number of dispensaries, which make up 89 percent of all private facilities in Dar es Salaam, accounts for much of this growth. As shown in *Graph 4-2*, the growth in new practices has been greatest among for-profit providers. Since 1991 when the laws concerning private medical practice were liberalized, 70 new for-profit facilities have been established. There also has been considerable growth in the nonprofit sector, with the creation of 41 new establishments since 1991, although as mentioned,

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Interview with the Registrar of Private Hospitals, February 1994.

The Urban Health Project is a five-year project managed by the Dar es Salaam City Council and financed by the Swiss Tropical Institute and the government of Switzerland. The survey took place in September and October 1993.

it is not clear if all of these are truly nonprofit. Note that the growth of parastatal facilities during the early 1990s has remained relatively flat. In all, nearly half (46 percent) of the 253 private sector facilities counted during the survey have been established since 1991.

*Exhibit 4-3* shows a breakdown of the city's private health facilities by both ownership and type (e.g., dispensaries, health centers, and hospitals). Forty-two percent of all private facilities are designated as for-profit, 30 percent are nonprofit, and 28 percent are employee-based (parastatal). Of note is the fact that 15 of the city's 18 private hospitals — 83 percent — are for-profit enterprises, many of which have opened only in the last few years. This contrasts with the government's 1993 figure of four for-profit hospitals in the entire country (*Exhibit 4-1)*. Eighty-nine percent of all private facilities in Dar es Salaam are dispensaries, 7 percent are hospitals, and 4 percent are classified as health centers.

**EXHIBIT 4-3**
**DISTRIBUTION OF PRIVATE HEALTH FACILITIES IN DAR ES SALAAM BY OWNERSHIP AND TYPE, 1993**

| | Parastatal | | Voluntary | | Private For-Profit | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Hospitals | 2 | 11.1 | 1 | 5.5 | 15 | 83.3 | 18 | 7.1 |
| Health Centers | 2 | 20.0 | 3 | 30.0 | 5 | 50.0 | 10 | 4.0 |
| Dispensaries | 67 | 29.8 | 72 | 32.0 | 86 | 38.2 | 225 | 88.9 |
| Total | 71 | 28.1 | 76 | 30.0 | 106 | 41.9 | 253 | 100.0 |

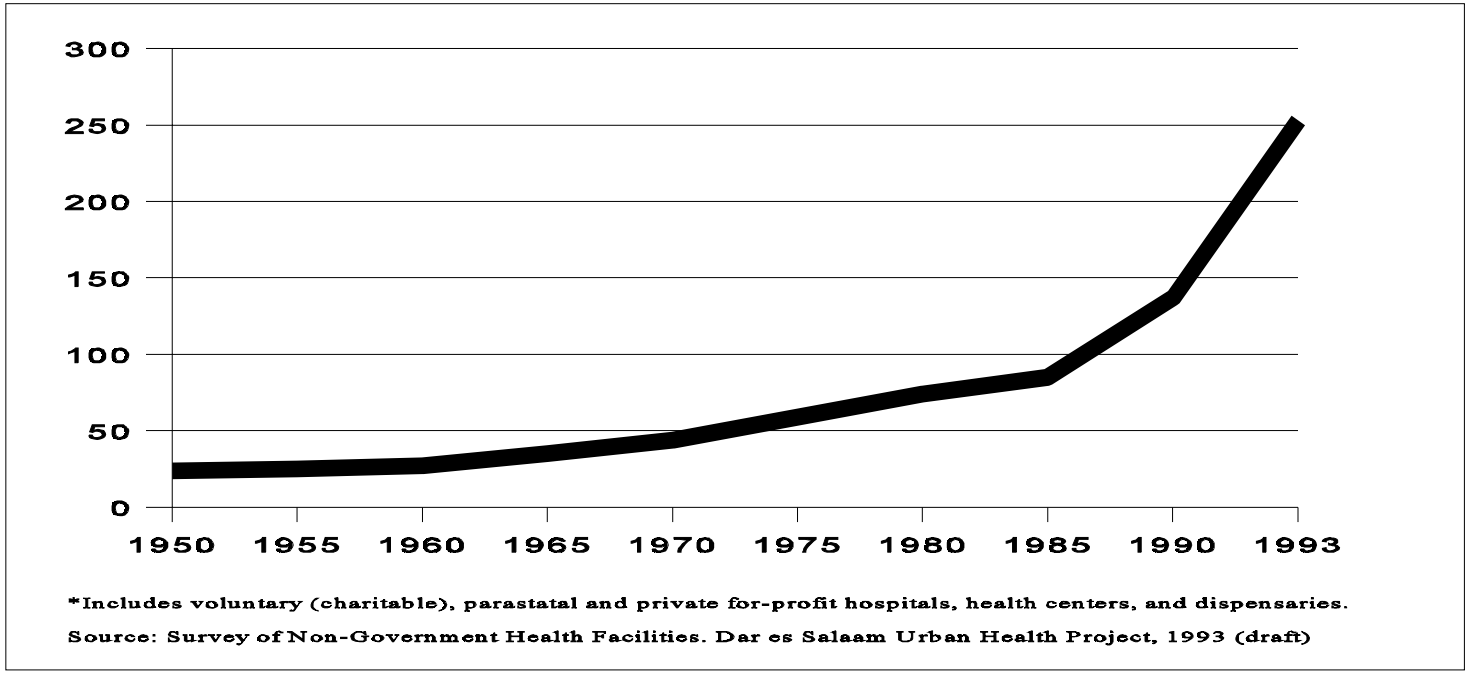
Source: Dar es Salaam City Council, 1993.

The distribution of hospital and maternity beds by ownership *(Exhibit 4-4)* demonstrates the important and growing role of for-profit facilities in the delivery of inpatient care in the city. For-profit hospitals and health centers account for more than half (57 percent) of all privately owned beds and 69 percent of all maternity beds counted in the survey. Parastatal facilities own 24 percent of private sector beds (and very few maternity beds), and voluntary agencies own another 19 percent.

**EXHIBIT 4-4**
**NUMBER OF HOSPITAL AND MATERNITY BEDS IN PRIVATE FACILITIES BY OWNERSHIP, DAR ES SALAAM, 1993**

| | Total Beds | Percent | Maternity Beds | Percent |
|---|---|---|---|---|
| Parastatal | 317 | 24.0 | 9 | 5.2 |
| Voluntary Agency | 246 | 18.6 | 44 | 25.4 |
| For-Profit Facilities | 757 | 57.4 | 120 | 69.4 |
| Total | 1,320 | 100.0 | 173 | 100.0 |

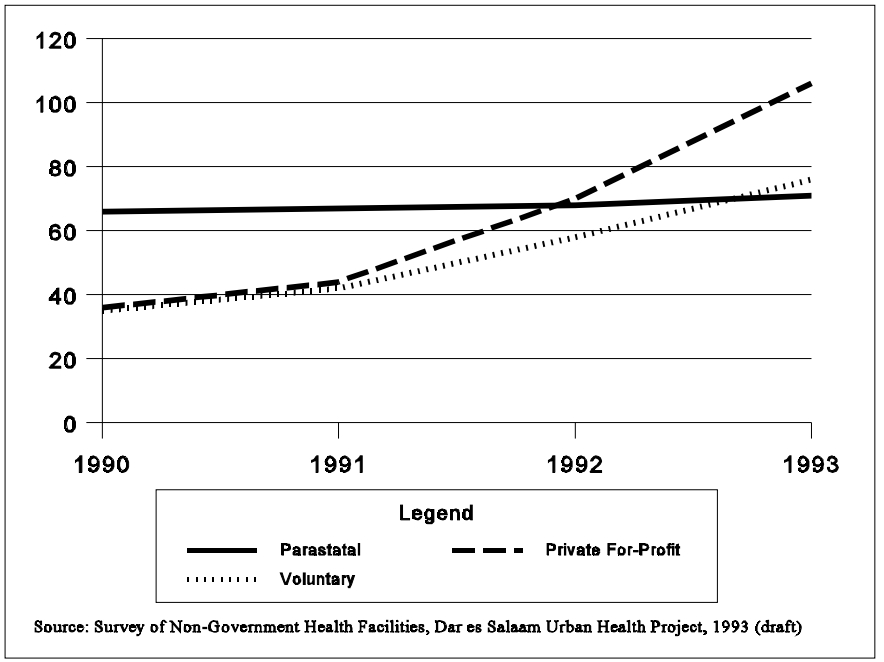
Source: Dar es Salaam City Council, 1993.




*Includes voluntary (charitable), parastatal and private for-profit hospitals, health centers, and dispensaries.

Source: Survey of Non-Government Health Facilities. Dar es Salaam Urban Health Project, 1993 (draft)

Graph 4-1: Growth of Private Health Care Facilities Dar es Salaam, 1950-1993 (no. of facilities*)




Graph 4-2: Growth of Private Health Care Facilities, Dar es Salaam by Ownership, 1990-1993

The number of doctors and other medical personnel employed in private sector facilities in Dar es Salaam indicates the size of these facilities and the scope of their services. *Exhibit 4-5* shows that for-profit providers employ 61.5 percent of all of the city's private sector physicians (260 of 423). About half of these for-profit doctors work in hospitals and health centers and the other half are employed in dispensaries. For-profit facilities also account for 49 percent of other medical staff, including nurses, nurse aids, medical assistants, and rural medical aides. Overall, for-profit facilities account for 50 percent of all medical personnel employed in the private sector.

**EXHIBIT 4-5**
**DISTRIBUTION OF DOCTORS AND OTHER MEDICAL STAFF IN PRIVATE HEALTH FACILITIES IN DAR ES SALAAM BY OWNERSHIP, 1993**

| | Doctors | | Other Medical Staff | | Total Medical Personnel | |
|---|---|---|---|---|---|---|
| Facility (n) | Number | Percent | Number | Percent | Number | Percent |
| PARASTATALS | | | | | | |
| Hospitals (2) | 8 | 1.9 | 113 | 3.5 | 121 | 3.3 |
| Health Centers (2) | 4 | 0.9 | 92 | 2.8 | 96 | 2.6 |
| Dispensaries (67) | 47 | 11.1 | 493 | 15.2 | 540 | 14.7 |
| Total (71) | 59 | 13.9 | 698 | 21.6 | 757 | 20.7 |
| VOLUNTARY AGENCIES | | | | | | |
| Hospitals (1) | 18 | 4.2 | 151 | 4.7 | 169 | 4.6 |
| Health Centers (3) | 5 | 1.2 | 72 | 2.2 | 77 | 2.1 |
| Dispensaries (72) | 81 | 19.1 | 742 | 22.9 | 823 | 22.5 |
| Total (76) | 104 | 24.6 | 965 | 29.8 | 1,069 | 29.2 |
| FOR-PROFITS | | | | | | |
| Hospitals (15) | 125 | 29.6 | 666 | 20.6 | 791 | 21.6 |
| Health Centers(5) | 7 | 1.6 | 78 | 2.4 | 85 | 2.3 |
| Dispensaries (86) | 128 | 30.3 | 831 | 25.7 | 959 | 26.2 |
| Total (106) | 260 | 61.5 | 1,575 | 48.6 | 1,835 | 50.1 |
| TOTAL (253) | 423 | 100.0 | 3,238 | 100.0 | 2,661 | 100.0 |

* Includes nurses, nurse aides, medical assistants, rural medical aides, and other paramedical staff.
Source: Dar es Salaam City Council, 1993.

It should be pointed out that *Exhibit 4-5* is based on information from the Dar es Salaam City Council facility survey (1993) and provides a good example of the difficulties of collecting information about the private sector given the fluidity of the situation. For example, while it may be true that there are 67 dispensaries in the parastatals, it is unlikely that there are 47 qualified M.D.s in those dispensaries. Doctors usually are assigned to hospitals, although they may also supervise one or more dispensary. For example, one doctor could supervise more than five dispensaries in one diocese from a base at the mission hospital.

The 15 for-profit hospitals in Dar es Salaam employ a total of 125 doctors, an average of 8.3 per facility. Making comparisons of hospital averages by ownership is somewhat misleading, however, because only one hospital is owned by a voluntary agency (and it has 169 medical personnel, including 18 doctors), and only two hospitals are owned by parastatal organizations.

The data in *Exhibit 4-6* show average numbers of staff for each type of private health facility in Dar es Salaam. For-profit dispensaries in Dar es Salaam had the most doctors per facility (1.5), compared to an average of 0.7 doctors per dispensary for parastatals, and 1.1 doctors for those run by voluntary agencies. For-profit dispensaries also employed an average of 11.2 total medical personnel per facility, slightly less than that of voluntary agencies (11.4), and considerably more than the average of 8.1 per parastatal dispensary.

Likewise the ratio of doctors to nurses and other medical staff are higher in for-profit dispensaries than in dispensaries owned by parastatals and voluntary agencies. On average, for-profit facilities employ one doctor for every 6.5 nurses and other medical staff, compared to one doctor for every 9.2 in voluntary agency facilities, and one doctor for every 10.5 for parastatals.

The same caution should be taken in using these data as in using the data from *Exhibit 4-5*. This study clearly demonstrates that even the least well trained personnel are usually referred to as "doctor" in both remote and urban areas. Also, dispensaries and health centers are opened up in the name of doctors, but these doctors were consistently absent from most of the units that were surveyed for this study.

In summary, data from this study and from the survey of private health facilities in Dar es Salaam indicate that the private sector plays an important role in the delivery of health care in Tanzania, especially in urban areas. The liberalization of the laws concerning private providers has caused an explosion of for-profit facilities, which in Dar es Salaam now account for 42 percent of all private facilities, including 83 percent of all private hospitals and 57 percent of all privately-owned hospital beds. The private sector also is becoming an increasingly important employer of medical personnel in urban areas, employing a total of 3,661 people in Dar es Salaam.

**EXHIBIT 4-6**
**DISTRIBUTION OF DOCTORS AND OTHER MEDICAL STAFF**
**IN PRIVATE HEALTH FACILITIES IN DAR ES SALAAM BY TYPE OF FACILITY, 1993**

| Facility(n) | Doctors | | Other Medical Staff | | Total Medical Personnel | |
|---|---|---|---|---|---|---|
| | Number | Average per Facility | Number | Average per Facility | Number | Average per Facility |
| HOSPITALS | | | | | | |
| Parastatals (2) | 8 | 4.0 | 113 | 56.5 | 121 | 60.5 |
| Voluntary Agencies (1) | 18 | 18.0 | 115 | 151.0 | 169 | 169.0 |
| For-Profit (15) | 125 | 8.3 | 666 | 44.4 | 791 | 52.7 |
| Total (18) | 151 | 8.4 | 930 | 51.7 | 1,081 | 60.1 |
| Percent of Total | 35.7 | | 28.7 | | 29.5 | |
| HEALTH CENTERS | | | | | | |
| Parastatals (2) | 4 | 4.0 | 92 | 46.0 | 96 | 4.6 |
| Voluntary Agencies (3) | 5 | 18.0 | 72 | 2.2 | 77 | 48.0 |
| For-Profit (5) | 7 | 8.3 | 78 | 15.6 | 85 | 17.0 |
| Total (10) | 16 | 8.4 | 242 | 24.2 | 258 | 25.8 |
| Percent of Total | 3.8 | | 7.5 | | 7.0 | |
| DISPENSARIES | | | | | | |
| Parastatals (67) | 47 | 0.7 | 493 | 7.4 | 540 | 8.1 |
| Voluntary Agencies (72) | 81 | 1.1 | 742 | 10.3 | 823 | 11.4 |
| For-Profit (86) | 128 | 1.5 | 831 | 9.7 | 959 | 11.2 |
| Total (225) | 256 | 1.1 | 2,066 | 9.2 | 2,322 | 10.3 |
| Percent of Total | 60.5 | | 63.8 | | 63.4 | |
| TOTAL (253) | 423 | 1.7 | 3,238 | 12.8 | 3,661 | 14.5 |
| Percent of Total | 100.0 | | 100.0 | | 100.0 | |

* Includes nurses, nurse aides, medical assistants, rural medical aides, and other paramedical staff.
Source: Dar es Salaam City Council, 1993.

## 4.1.3 Quality in the Private Sector

### 4.1.3.1 Quality of Primary Curative Care Services

In 1992, the Urban Health Project conducted a comparative study of the quality of primary curative outpatient services in public and private health dispensaries and health centers in Dar es Salaam (Kanji, Munishi, and Kilima, 1992). The study sample comprised 30 government health facilities and 15 voluntary agency (VA) facilities. Several of the facilities designated as VA facilities turned out, in fact, to be owned by individuals although they operated on a nonprofit basis. Despite the small number of private facilities included in the study, and the fact that only so-called voluntary agency facilities were included, the survey does give some indication of the comparative quality of private and public health services in Tanzania. The major aspects of quality covered include:

- structural quality, which covers the condition and cleanliness of facilities, as well as the availability and quality of drugs, medical equipment, and medical supplies;
- the technical quality of clinical practice;
- the quality of interpersonal interactions; and
- users' perceptions of the quality of care.

The survey found substantial differences in structural quality between government and private facilities. For example, 73 percent of VA facilities but only 43 percent of those owned by the government received a rating of "good" or "acceptable" levels of structural quality (as defined above). Twelve of the 30 government facilities (40 percent) received the lowest rating of "unacceptable," while none of the VA facilities were rated "unacceptable." Many more of the government facilities were in a general condition of disrepair than the nongovernmental facilities, with crowded conditions, no running water, leaking roofs, cracked walls, and so on.

The availability of drugs is a key factor in attracting clients and in keeping morale high among health workers. About half the government and VA facilities (53 percent and 54 percent, respectively) were found to be well stocked in five essential drugs (aspirin, chloroquine, procaine penicillin, oral rehydration salts, and benzyl benzoate). The VA facilities were found to be much better stocked with penicillin than the government facilities: 93 percent of the VAs surveyed had penicillin procaine and 40 percent had oral penicillin, versus only 46 percent and 25 percent of the government facilities. On the other hand, government facilities were much better supplied in oral rehydration salts (ORS) than the VA facilities: none of the four Protestant facilities and only one of the four Muslim facilities had any stocks of ORS. The nongovernmental facilities were more likely to have essential medical equipment than the public facilities.

Technical quality was assessed by judging the adequacy of history-taking, examinations performed, and diagnosis and treatment prescribed. Although the technical quality of clinical procedures was significantly higher in Protestant facilities than in government facilities, the VAs on the whole did not demonstrate significantly higher quality than government-run facilities.

Fifty-one percent of consultations in Protestant facilities followed acceptable clinical practice versus 46 percent in Muslim facilities, 44 percent in Catholic facilities, and only 25 percent in government facilities. However, roughly equal proportions of consultations at VA and government facilities (38 percent and 36 percent, respectively) were judged to follow potentially serious and/or dangerous clinical practice (e.g., missed diagnoses),

and there were no significant differences among the various denominational groups of VAs. The study found that standards and regulations defined by the MOH and implemented in the government sector often are not followed by VA facilities. For example, whereas government facilities treat childhood diarrhea with oral rehydration therapy, the VA facilities treat such cases with up to seven different medical products.

Overall, the private facilities demonstrated higher quality in their interpersonal interactions with clients than did the government facilities. Seventy-three percent of consultations that took place in VA facilities were judged acceptable, compared with 52 percent of government consultations. Medical personnel in the VA facilities, especially those run by Protestant churches, were more likely than the personnel in government facilities to explain the diagnosis and treatment to patients, to give detailed instructions to them for followup, and to spend sufficient time with patients.

Not surprisingly, users had a much more positive view of the VA facilities than of the government facilities, even when their perceptions did not match objective measures. Eighty percent of users interviewed at VA facilities said they received good treatment, compared to 56 percent of users of government facilities. Only 1 percent of VA facility users felt they received bad treatment, compared to 19 percent of users of government facilities. This is despite the fact that no overall differences were found in waiting times between government and VA facilities. Furthermore, although drug availability did not differ significantly between VA and government-run facilities in the survey, 86 percent of users at VA clinics viewed the availability of medicines as good or very good, compared to only 6 percent at government facilities.

In sum, the Dar es Salaam survey found that the physical facilities and interpersonal skills of staff at the private clinics were considerably better than those at the government facilities. The VA facilities also were found to enjoy a much more positive perception among members of the public than government clinics. Nonetheless, the study demonstrated a critical need for significant improvements in the availability of drugs and medical equipment and in the quality of clinical practice at both government and private facilities.

#### 4.1.3.2 Patient Perceptions of Quality

This study included a survey of 61 providers and a small survey of 20 patients in three church-owned hospitals. The findings tend to confirm the findings from the Urban Health Project quality study described above (e.g., Dar es Salaam City Council, 1993).

Providers were asked to indicate the extent to which the poor quality of government health services motivated them to start private practices. All of the providers surveyed said that they realized that many patients were increasingly dissatisfied with government services. Furthermore, they felt that the dissatisfaction was an important factor in creating demand for private health services — tempered by the extent to which private providers could offer a higher quality of services than currently available in the public sector.

In an effort to provide higher quality services, the private facilities in the survey (both nonprofit and for-profit) offer a full package of curative services, including a simple examination (even when it was not necessary), diagnosis, and prescriptions for and dispensing of medicines. The owners of these facilities also try to ensure that they have drugs available at all times. In addition, several providers offer extended service hours as an added convenience to patients. At the Pasua Bakwata dispensary in Moshi municipality, for example, medical services are provided any time; the owner and a nurse, who reside in the building housing the dispensary, are always on call.

The patient survey was administered to 20 inpatients at three church-owned hospitals in Kilimanjaro (Machame, Kilema, and Marangu). An earlier pilot study in this region reported that patients from as far away as several hundred kilometers bypassed the free government services in their districts to use these hospitals. The patients in the survey were randomly selected and included patients from distant areas and from the neighborhood.

The patients were asked which factors motivated them or their relatives to seek services at these hospitals rather than at government facilities which are less expensive. More than 60 percent of respondents said that their main reason for using the mission hospitals was that they received "better treatment" than at government facilities. Other common reasons were that the private hospitals were closer to their homes, that medicines were available, and that they were in the habit of using these facilities. Ninety-four percent of respondents claimed that drugs were always available in the church-owned facilities, whereas stockouts of essential drugs were common at the government facilities. Nearly all patients expressed satisfaction with their treatment in the nongovernmental facilities (including nursing care) and with the cleanliness of these facilities.

## 4.2 PRIVATE SECTOR CONTRIBUTIONS TO THE PUBLIC HEALTH AGENDA

Given the problems outlined above in estimating the size and scope of the private sector — especially given the rapid growth of this sector in the last few years — it is difficult to determine with any precision its role in providing public health services to the population. Nevertheless, some data are available to indicate the potential role the private sector could play.

This study focuses on key public health services that the HHRAA methodology called for in the four-country comparative study of the private sector (Berman and Hanson, 1993). These public health services include preventive and treatment services for the major public health problems in many African countries, including Tanzania, such as childhood communicable diseases, tuberculosis, malaria, and AIDS, as well as reproductive health services such as family planning and maternal and perinatal services (including delivery).

In addition to the private provider survey conducted as part of this study, data on the provision of public health services have been drawn from two other sources: the Tanzania Demographic and Health Survey (DHS, 1991-92), and the Dar es Salaam Survey of Non-Governmental Health Facilities (Dar es Salaam City Council, 1993). Information from the DHS household survey on where respondents sought preventive and public health services was available only for items concerning family planning and childbirth services. However, the DHS also includes a facilities survey, which involved site visits to 422 hospitals, health centers, and dispensaries, and included questions on the availability of child survival services (immunizations, oral rehydration therapy, and growth monitoring), and reproductive health services by ownership of the facilities. Some of the results of the facilities survey are given below. Unfortunately, only a relatively small number of private sector facilities were included in the survey; out of the 422 facilities, 346 (82 percent) are government-owned, 66 (15 percent) are owned by voluntary agencies, and only 10 (2 percent) are private for-profit facilities. Of the 10 for-profit facilities, eight are dispensaries, one is a hospital, and one is a health center. The small number of for-profits included in the survey is probably explained by the fact that the private provision of health care became legal around the time of the survey with the passage of the 1991 Private Practice Act. The DHS data presented in this section should be interpreted with caution because of the small number of private sector facilities included — especially for-profits — and uncertainty over how representative the sample of facilities is.

### 4.2.1 Preventive Services and Communicable Diseases

In the provider interviews conducted for this study, 50 percent of the voluntary agency facilities said that they offer a list of preventive services, compared to only 21 percent of for-profit facilities. Preventive services included health education activities, prenatal care, and immunizations.

In the DHS facilities survey, nearly all hospitals and health centers claimed that they provided child immunization services, including all 31 voluntary agency and for-profit facilities. Most government dispensaries (95 percent) also claimed to provide immunizations, compared to 70 percent of the VA dispensaries and only half (four of eight) of the for-profit dispensaries. A somewhat smaller proportion of facilities said that immunizations were currently available, and fewer still had their vaccine supplies confirmed by the interviewer. As seen in *Exhibit 4-7*, just under 90 percent of government and voluntary hospitals and health centers, as well as one of the two for-profit hospital/health centers, were confirmed to have vaccines on hand. Vaccines were out-of-stock at a quarter of the government dispensaries that claimed to provide immunizations, but government-run dispensaries were still more likely to provide immunizations and to have vaccines available (69 percent) than either VA dispensaries (46 percent) or for-profit dispensaries (37 percent). Despite the small number of private sector dispensaries included in the survey, these figures tend to confirm the findings of the private provider survey that there is a relative lack of preventive care services at for-profit dispensaries.

**EXHIBIT 4-7**
**CURRENT AVAILABILITY OF IMMUNIZATION SERVICES AND VACCINES AT TANZANIAN HEALTH FACILITIES BY TYPE OF FACILITY AND OWNERSHIP, FROM DHS SURVEY, 1991-92**

| | Immunizations Currently Available | | | | Vaccine Supply Confirmed | | | |
|---|---|---|---|---|---|---|---|---|
| | Hospitals/ Health Centers | | Dispensaries | | Hospitals/ Health Centers | | Dispensaries | |
| Type of Facility | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Government | 132 | 89.2 | 153 | 77.3 | 129 | 87.2 | 137 | 69.2 |
| Voluntary Agency | 28 | 96.6 | 22 | 59.5 | 26 | 89.6 | 17 | 45.9 |
| Private For-Profit | 2 | 100.0 | 4 | 50.0 | 1 | 50.0 | 3 | 37.5 |
| Total | 162 | 90.5 | 179 | 73.7 | 156 | 87.1 | 157 | 64.6 |

Source: DHS, 1991-92.

Concerning the treatment of childhood diarrhea with oral rehydration therapy, *Exhibit 4-8* shows that government hospitals in the DHS facilities survey were more likely to have a rehydration unit than hospitals run by voluntary agencies (91 percent versus 74 percent). The one for-profit hospital included in the survey did not have a rehydration unit. The majority of health facilities surveyed had supplies of oral rehydration salts (ORS) on hand, including 75 percent of the for-profit dispensaries, although there is no indication of how often they are used by each facility. Nearly all the hospitals and health centers and a majority of dispensaries reported that they conduct regular child growth monitoring sessions — a standard child survival strategy to detect and prevent malnutrition — although for-profit dispensaries again were the least likely to perform this service (only four of the eight facilities in this category did so).

**EXHIBIT 4-8**
**CURRENT AVAILABILITY OF ORAL REHYDRATION SERVICES AND SUPPLIES AT TANZANIAN HEALTH FACILITIES BY TYPE OF FACILTY AND OWNERSHIP, FROM DHS SURVEY, 1991-92**

| | Existence of Rehydration Unit | | Current Availability of Oral Rehydration Salts (ORS) | | | |
|---|---|---|---|---|---|---|
| | Hospitals | | Hospitals/Health Centers | | Dispensaries | |
| Type of Facility | Number | Percent | Number | Percent | Number | Percent |
| Government | 51 | 91.1 | 119 | 80.4 | 178 | 89.9 |
| Voluntary Agency | 20 | 74.1 | 22 | 75.9 | 31 | 83.8 |
| Private For-Profit | 0 | 0.0 | 2 | 100.0 | 6 | 75.0 |
| Total | 71 | 82.6 | 143 | 79.9 | 215 | 88.5 |

Source: DHS, 1991-92.

Concerning the treatment of tuberculosis, a major cause of morbidity and mortality in the country, the Survey of Non-Governmental Health Facilities (Dar es Salaam City Council, 1993) showed that 46 percent of hospitals and health centers in Dar es Salaam provide these services, compared to only 14 percent of dispensaries (see *Exhibit 4-9)*. Parastatal dispensaries were much more likely to offer TB treatment (28 percent) than those owned by either voluntary agencies (7 percent) or for-profit enterprises (8 percent).

### 4.2.2 Maternal and Perinatal Health Services

The Survey of Non-Governmental Health Facilities in Dar es Salaam (Dar es Salaam City Council, 1993) provides information on the delivery of maternal and child health (MCH) services at private health facilities *(Exhibit 4-9)*. The proportion of private sector dispensaries that reported delivering MCH services ranges from 16 percent of for-profits to 28 percent of voluntary agency dispensaries and 31 percent of parastatal dispensaries.

Women in the DHS household survey were asked where they delivered their last child *(Exhibit 4-10)*. While nearly half delivered at home, the vast majority of those who used the formal health sector went to a government facility. Only 7.4 percent delivered their last child at private sector facilities and the majority of these went to VA facilities. Only 0.2 percent (9 of 5,522) delivered their last child at for-profit facilities. This undoubtedly reflects the small number of for-profit health facilities that existed at the time of the survey. The DHS facilities survey indicates that the private sector could play a significantly larger role in delivering childbirth services.

**EXHIBIT 4-9**
**NUMBER OF PRIVATE FACILITIES IN DAR ES SALAAM PROVIDING MATERNAL AND CHILD HEALTH, FAMILY PLANNING, AND TUBERCULOSIS TREATMENT SERVICES BY TYPE OF FACILITY AND OWNERSHIP, 1993, FROM SURVEY OF NON-GOVERNMENTAL HEALTH FACILITIES**

| | MCH Services | | Family Planning | | TB Treatment | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Hospitals/Health Centers | | | | | | |
| Parastatal | 2 | 50 | 2 | 50 | 4 | 100 |
| Voluntary Agencies | 2 | 50 | 2 | 50 | 2 | 50 |
| Private For-Profit Facilities | 15 | 75 | 10 | 50 | 7 | 35 |
| Total | 19 | 68 | 14 | 50 | 13 | 46 |
| Dispensaries | | | | | | |
| Parastatal | 21 | 31 | 24 | 36 | 19 | 28 |
| Voluntary Agencies | 20 | 28 | 23 | 32 | 5 | 7 |
| Private For-Profit | 14 | 16 | 15 | 17 | 7 | 8 |
| Total | 55 | 24 | 62 | 28 | 31 | 14 |

Source: Dar es Salaam City Council, 1993.

**EXHIBIT 4-10**
**DISTRIBUTION OF WOMEN BY SITE OF DELIVERY OF THEIR LAST CHILD, FROM DHS SURVEY, 1991-92**

| Delivery Site | Number | Percent |
|---|---|---|
| Home | 2,655 | 48.1 |
| Government Facility | 2,413 | 43.7 |
| Voluntary Agency Facility | 354 | 6.4 |
| Parastatal Facility | 44 | 0.8 |
| Private For-Profit Facility | 9 | 0.2 |
| En Route/Other | 47 | 0.8 |
| Total | 5,522 | 100.0 |

Source: DHS, 1991-92.

As shown in *Exhibit 4-11*, more than 90 percent of the nongovernmental hospitals and health centers surveyed said that they provide delivery services, as did 50 to 60 percent of the nongovernmental dispensaries. A majority of private sector facilities reported that they provide pre- and postnatal services as well *(Exhibit 4-11)*.

**EXHIBIT 4-11**
**AVAILABILITY OF MATERNAL AND PERINATAL HEALTH SERVICES AT TANZANIAN HEALTH FACILITIES BY TYPE OF FACILITY AND OWNERSHIP, 1993, FROM DHS SURVEY, 1991-92**

| | Delivery Services | | Pre-Natal Care | | Post-Natal Care | |
|---|---|---|---|---|---|---|
| Ownership of Facility (n) | Number | Percent | Number | Percent | Number | Percent |
| Hospitals/Health Centers | | | | | | |
| Government (148) | 136 | 91.9 | 137 | 76.5 | 124 | 83.8 |
| Voluntary Agencies (29) | 28 | 95.6 | 29 | 100.0 | 27 | 93.1 |
| Private For-Profit (2) | 2 | 100.0 | 2 | 100.0 | 2 | 100.0 |
| Total (179) | 166 | 92.7 | 168 | 93.9 | 153 | 85.5 |
| Dispensaries | | | | | | |
| Government (198) | 163 | 82.3 | 185 | 93.4 | 117 | 59.1 |
| Voluntary Agencies (37) | 22 | 59.5 | 23 | 62.2 | 21 | 56.8 |
| Private For-Profit (8) | 4 | 50.0 | 5 | 62.5 | 2 | 25.0 |
| Total (243) | 189 | 77.7 | 213 | 87.6 | 140 | 57.6 |

Source: DHS, 1991-92.

Data from the Dar es Salaam Survey of Non-Governmental Health Facilities seem to contradict the findings from the DHS facilities survey *(Exhibit 4-12)*. While most VA and for-profit hospitals and health centers in Dar es Salaam reported that they provide childbirth services, only 8 percent of VA and for-profit dispensaries did, in contrast with 50 percent or more of those that participated in the DHS survey. The Dar es Salaam Survey also shows that just over a quarter of parastatals provide childbirth services.

**EXHIBIT 4-12**
**PRIVATE HEALTH CARE FACILITIES PROVIDING CHILDBIRTH AND DELIVERY SERVICES, DAR ES SALAAM, 1993,**
**FROM SURVEY OF NON-GOVERNMENTAL HEALTH FACILITIES**

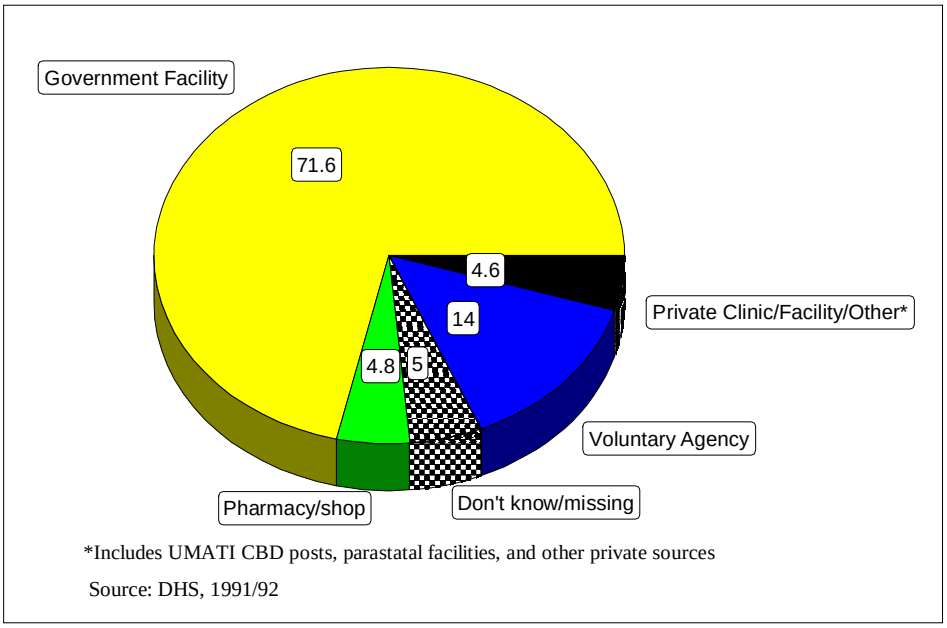
| Facilities | Dispensaries | | Health Centers/ Hospitals | | Total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Parastatals | 19 | 28.3 | 1 | 25.0 | 20 | 28.2 |
| Voluntary Agencies | 6 | 8.3 | 3 | 75.0 | 9 | 11.8 |
| For-Profits | 7 | 8.1 | 11 | 55.0 | 18 | 17.0 |
| TOTAL | 32 | 14.2 | 15 | 53.6 | 47 | 18.6 |

Source: Dar es Salaam City Council, 1993.

### 4.2.3 Family Planning Services

Data from the DHS household survey show that 23 percent of family planning users obtained their contraceptive supplies from private sources, including VA facilities (14 percent), private pharmacies and shops (4.8 percent), and private clinics and other private sources (4.6 percent) (see *Graph 4-3*). According to the DHS facilities survey, the majority of private sector hospitals and health centers provide family planning services, including 79 percent of those owned by voluntary agencies and the two privately owned hospitals/health centers included in the survey *(Exhibit 4-13).* A smaller proportion of private sector dispensaries, however, indicated that they provide family planning: 38 percent of the VA dispensaries and 50 percent of private for-profit dispensaries. The average number of new family planning clients was largest for government-owned hospitals and health centers (40 per month). It ranged from 25 to 30 for health centers, and was about 12 per month for dispensaries (regardless of ownership). Data from the Dar es Salaam private facilities survey support the DHS findings that only a minority of private sector dispensaries (between 17 and 36 percent) currently provide family planning services (see *Exhibit 4-9).*

These data indicate that a more substantial portion of private health providers, especially hospitals and clinics, provide public health services than may have been apparent. While a precedent and the relevant experience thus exists for private sector provision of these services, especially among voluntary agencies, data also show that the government has a large established capacity for key preventive and communicable services. While a substantial percentage of private providers offer childbirth services, the vast majority of women choose either home or government facilities to deliver their babies. A large majority of people also choose government facilities for family planning services and supplies, although these are relatively widely available at both public and private sector providers.




Graph 4-3: Distribution (%) of Current Family Planning Users by Source of Contraceptive Supply

**EXHIBIT 4-13**
**AVAILABILITY OF FAMILY PLANNING SERVICES AND AVERAGE NUMBER OF NEW FAMILY PLANNING CLIENTS PER MONTH AT TANZANIAN HEALTH FACILITIES BY TYPE OF FACILITY AND OWNERSHIP, 1993, FROM DHS SURVEY, 1991-92**

| Ownership of Facility (n) | Family Planning | | Mean New Family Planning Clients per Month | |
|---|---|---|---|---|
| | Number | Percent | | |
| Hospitals/Health Centers | | | Hospitals | Health Centers |
| Government (148) | 136 | 91.9 | 39.9 | 83.8 |
| Voluntary Agencies (29) | 23 | 79.3 | 21.2 | 93.1 |
| Private For-Profit (2) | 2 | 100.0 | 24.0 | 100.0 |
| Total (179) | 161 | 89.9 | 34.5 | 85.5 |
| Dispensaries | | | Dispensaries | |
| Government (198) | 182 | 91.9 | 12.2 | |
| Voluntary Agencies (37) | 14 | 37.8 | 10.6 | |
| Private For-Profit (8) | 4 | 50.0 | 13.8 | |
| Total (243) | 200 | 82.3 | 12.0 | |

Source: DHS, 1991-92.

## 4.3 COLLABORATION AND LINKAGES BETWEEN THE PUBLIC AND PRIVATE SECTORS

Given the changing role of the Ministry of Health, which is moving to become a regulator as well as a provider of health care, and given the MOH's apparent inability to satisfy the population's demand for health services, it is important to find ways to collaborate with all elements of the private sector. This section will briefly describe the current state of collaboration. (Recommendations for future directions in this area are presented in *Section 5.)*

Collaboration with all the elements of the private sector can help achieve a number of MOH objectives, especially with regard to better targeting limited resources to the most vulnerable groups. In principle, collaboration with the private sector can improve the government's ability to ensure delivery of the most cost-effective services to the most needy population groups in an efficient manner. The government must first identify the segments of the private sector most appropriate for such collaboration and must structure financial arrangements (with built-in incentives) for service delivery and target clientele.

Another area of potential collaboration is for the public sector to shift some responsibility for delivering expensive curative care to the private sector. At this stage in the development of the private sector in Tanzania, the prospects for achieving this objective are limited, but steps can be taken to prepare for such a transition in the future.

One of the most important linkages between the public and private sectors occurs through government laws and regulations. The following section focuses on direct forms of collaboration that have existed between the public and private health sectors, especially in the form of government subsidies for the nonprofit sector. It also reports findings regarding providers' views about several issues surrounding public-private collaboration that arose from the provider survey conducted for this study. *(Section 4.4* elaborates on the discussion in *Section 3* of MOH and government efforts to liberalize the environment for private sector health providers through the Structural Adjustment Program and the 1991 Private Practice Act.)

### 4.3.1 Collaboration with the Nonprofit Sector

Public-private collaboration in health care delivery is not a new concept in Tanzania. The government and the nonprofit voluntary agencies have long had a positive and productive relationship. The linkages between these two sectors have taken two forms.

The first form of collaboration is the government running the privately owned mission hospitals known as Designated District Hospitals (DDHs). Following the Arusha Declaration of 1967, the government assumed financial and technical control of 17 mission hospitals and incorporated them into the public sector provider network as DDHs. The extent of government financing and operational control over these facilities has led them to be considered essentially public sector providers, although the private voluntary agencies retain ownership of these facilities.

The second form of collaboration has consisted of partial financial subsidies for some nonprofit, voluntary agency health facilities, primarily church-run facilities. These subsidies take two forms: bed grants and staff grants. The World Bank estimates that the government provides about one-third of the operating funds for voluntary agency facilities, with the remaining two-thirds coming from user fees and external sources (World Bank, 1993a).

The long-standing, productive relationship between the government and the voluntary agencies provides a basis for even stronger collaboration which would allow the public sector to achieve some of the most important objectives of the health sector reform plan. For example, the government might retarget subsidies for service provision, rather than for bed or staff capacity.

### 4.3.2 Collaboration with the For-Profit Sector

In contrast to the relationship between the public sector and the nonprofit elements of the private sector, which can be characterized as collaborative and which offers strong prospects for further collaboration, the relationship between the public sector and the for-profit segment can best be described as tense and uneasy. The Dar es Salaam sample of the provider survey carried out for this study found that the public sector's historic mistrust of for-profit operations in the health field is met with equally strong private sector mistrust of the government's commitment to liberalization in the health sector.

Distrust between public and private sectors is not unique to the health sector or to Tanzania. The short history of coexistence since the 1991 Private Practice Act has not yet allowed the two groups to adapt to new realities. The provider survey found that some for-profit providers (especially hospital owners and managers) were frustrated by the fact that the government treated nonprofit providers as if they were part of the government. They spoke of being told to attend meetings without much notice and to make services available to the public sector (e.g., ambulance services) without prior arrangements and without payment. While such instances were rare, some private providers interpreted them either as part of a slow transition by the MOH from control over provision of health services to a more regulatory role or as evidence of the MOH's inability to give up complete control of health care provision.

The provider survey found that for-profit providers are not well organized and feel that they have no forum to present their concerns, even though several provider associations exist. Effective and active provider associations would help the public sector to develop working relationships with the for-profit private sector. They also would help the two-way communication needed to develop appropriate public-private partnerships.

## 4.4 FACTORS AFFECTING DEVELOPMENT OF THE PRIVATE SECTOR

As *Section 3* of this report indicated, the MOH is in the process of developing a reform agenda that would address the sizable problems facing the current health system. A major element of the reform program is an effort to assist and encourage development of the private sector to complement the public sector in health service delivery. Identifying appropriate ways to encourage greater private participation involves several steps. A first step is to assess private providers' potential to contribute to public sector goals by reviewing their current size, characteristics, and operational capacities. *Sections 4.1 and 4.2* provided baseline information for that kind of assessment. Another step is to assess factors that affect private sector development.

Following the methodology that HHRAA developed to assess the private sector's potential to contribute to public sector goals (Berman and Hanson, 1993), this study focuses on three areas that affect private sector development. The first is the legal and regulatory environment, with a focus on laws and regulations that govern private practice. The second is the financial environment facing private providers, with a focus on tax and credit conditions. The last area is the population's use of and demand for health services, with a focus on prices for services in the private sector and the ability of the population to pay them.

The three areas that affect private sector development and the list of factors enumerated below represent some of the core elements and are illustrative of those that need to be considered in pursuing collaborative efforts and in assessing the potential contribution of private providers to the public sector agenda. They are by no means

the only ones that the MOH needs to consider in determining whether and how it may be useful to collaborate with private sector providers.

## 4.4.1 Legal and Regulatory Environment

### 4.4.1.1 Current Legal and Regulatory Requirements

*Section 3* discussed the historical context of Tanzania's current efforts to reform the legal and regulatory environment to encourage development of private sector health providers in ways that might complement the public sector's efforts. Over the last 25 years government policy toward private sector health providers has passed through several phases, from relatively open to legally prohibitive to the current period of re-liberalization. It also showed a consistent pattern in which the nonprofit, voluntary agency health providers operated in a more permissive environment than for-profit health providers.

*Exhibit 4-14* summarizes the main requirements for establishing a private practice or hospital under the 1991 Private Practice Act. As this summary shows, the requirements and related fees are now essentially the same for nonprofit and for-profit health providers.

The licensing requirements under the new law and related regulations do not vary by the financial orientation or organizational affiliation of the private sector provider, and both public and private health providers must be registered under the Medical Council. However, while nonprofit and for-profit hospitals (with the exception of Designated District Hospitals), private doctors, and other paramedical practitioners are authorized to collect fees, nurses and public doctors are not. The law also provides a specific fee schedule for various services. *Exhibits 4-15 and 4-16* summarize the licensing and fee collection requirements.

### 4.4.1.2 The Impact of Legalization

Legalization has had a dramatic effect on the growth of the private sector in Tanzania, even with the attendant registration fees and taxes on profits. Under the liberalization provided by the 1991 Private Practice Act, there has been rapid growth in the number of for-profit hospitals, consulting clinics, dispensaries, maternity homes, and pharmacies all over the country, but especially in the major urban locations. For example, according to the MOH, Dar es Salaam now has more than 74 wholesale and retail pharmacies, most of which opened after 1991. Of the 498 private facilities listed as approved by the MOH by late 1993, 294 (59 percent) were enlisted and sanctioned by the MOH after the 1991 law, and there are many still in the pipeline awaiting permits from the MOH Private Hospitals Advisory Board.

**EXHIBIT 4-14**
**REQUIREMENTS FOR ESTABLISHING A PRIVATE PRACTICE OR HOSPITAL**

| | |
|---|---|
| Private Doctors | — Must be registered under the Medical Council (Cap. 409)<br>— Application for Private Practice subject to endorsement by the District Medical Officer and Regional Medical Officer<br>— Application under Private Hospital Registrar for license under the Private Hospitals (Regulation) Act, 1977 (Section 9) [for dispensary, application fee of Tsh. 10,000/=; for health center, Tsh. 15,000/=; for hospital, Tsh. 20,000/=; for consultation room, Tsh. 7,000/=]<br>— Application for Business License under the Municipal Council of Local Government |
| Nonprofit Hospitals | — Application for private hospital subject to endorsement by the District Medical Officer and Regional Medical Officer<br>— Application under Private Hospital Registrar for license under the Private Hospitals (Regulation) Act, 1977 [application fee of Tsh. 20,000/=]<br>— Application for Business License under the Municipal Council of Local Government |
| For-Profit Hospitals | — Application for private hospital subject to endorsement by the District Medical Officer and Regional Medical Officer<br>— Application under Private Hospital Registrar for license under the Private Hospitals (Regulation) Act, 1977 [application fee of Tsh. 20,000/=]<br>— Application for Business License under the Municipal Council of Local Government |
| Other Paramedical Practitioners | — Assistant Medical Officer and Assistant Dental Officer—subject to licensure under the Medical Practitioners and Dentists Ordinance (Section 7)<br>— Application for private practice subject to District Medical Officer and Regional Medical Officer endorsement<br>— Application to the Registrar under the Private Hospitals (Regulation) Act, 1977 (Section 6D)<br>— Application for Business License under the Municipal Council of Local Government |
| Other Practitioners | — Nurses—Not applicable<br>— Opticians<br>— Application for registration under the Optical Act, 1965 (Section 5)<br>— Application for Business License under the Municipal Council of Local Government |

Source: World Bank, 1993a.

| EXHIBIT 4-15<br>LICENSING REQUIREMENTS | |
|---|---|
| Private Doctors | — Required to register under the Medical Council of Tanganyika through the Medical Practitioner and Dentists Ordinance (Section 13) [Tsh. 500/=]<br><br>— Required to work in one or more government hospitals or institutions for not less than three years. Provided under the Medical Practitioners (Conditions Pre-requisite to Registration) Rules 1968 (Rule 2[b]) |
| Public Doctors | — Required to be registered under the Medical Council of Tanganyika through the Medical Practitioners and Dentists Ordinance (Section 3) [Tsh. 500/=] |
| Other Paramedical Practitioners | — Assistant Medical Officers (AMO) and Assistant Dental Officers (ADO) are required under the Medical Practitioners Ordinance (Section 7) to be licensed with the Medical Council of Tanganyika before practice [Tsh. 500/=] |
| Other Practitioners | — Nurses are required to be registered under the Nurses and Midwives Ordinance (Cap. 325)(Section 7) with the Nurses and Midwives Council [Tsh. 500/=]<br><br>— Opticians are required to be registered under the Optical Act, 1965 to be registered before practice (Section 5) [Tsh. 2,000 as an individual; Tsh. 10,000 as a body corporate] |
| Source: World Bank, 1993a. | |

| EXHIBIT 4-16<br>REQUIREMENTS FOR SETTING AND COLLECTING FEES | |
|---|---|
| Private Doctors | — Authorized to collect fees for consultations provided under the Private Hospital Regulation Act, 1977 (Section 6D) |
| Public Doctors | — Not authorized |
| Nonprofit Hospitals | — Voluntary Agencies—Fee collection authorized under the Medical Grant in Aid to Voluntary Agencies Regulations, 1980, Government Notice number 47, Rule 11<br><br>— District Designated Hospital—not [yet] authorized |
| For-Profit Hospitals | — Authorized to collect fees under the Private Hospitals (Regulation) Act 1977 (Section 6D) |
| Other Paramedical Practitioners | — Assistant Medical Officer and Assistant Dental Officer are authorized to demand fees under the Private Hospitals Regulation Act, 1977 (Section 6D) |
| Other Practitioners | — Nurses—Not authorized<br><br>— Opticians—Authorized under the Optical Act, 1965 (Section 23) |
| Source: World Bank, 1993a. | |

The World Bank conducted a study of the legal structures governing the private provision of health services in Tanzania in order to identify any remaining weaknesses or shortcomings in existing legal and regulatory framework (World Bank, 1993a). Although the study concluded that current laws place no serious constraints on the development of the private sector, it identified several remaining weaknesses:

- The current legal structure does not include a framework for resolving disputes relating to patient rights and provider responsibility.
- The amendment to the 1977 Private Hospital Act still imposes a fee structure that reflects the government's view of what is affordable more than the costs of providing services or general market conditions. Among the Dar es Salaam providers interviewed for this study, hospital owners and managers indicated that while hospital and other health facilities do not display or use the fee schedule, they do worry that the government may in the future choose to enforce some of these laws. This uncertainty about the behavior of the government discourages large investments in the private sector.
- There is no system of checks and balances, leaving the MOH with exclusive control.
- The licensing process is cumbersome, and separate taxes are collected in different places.
- The Private Hospital Act does not clearly define who is allowed to establish private practice.

#### 4.4.1.3 The Impact of Laws and Regulations on Quality of Personnel

The regulatory environment has not kept pace with the rapid changes that have followed the 1991 law. The inadequate regulatory environment is compounded by the general lack of qualified health personnel in Tanzania, which constrains the smooth growth of both the private and the public health sector.

Even under current licensing and registration requirements, lower-level professionals — nurses, rural medical aids (RMAs), and medical assistants — have been able to enter the private health care market by claiming to be employees of approved organizations, and unqualified people are now managing health facilities contrary to existing regulations. Professional ethics do not seem to be an effective means of controlling such activities. Government-owned facilities are very infrequently supervised and inspected (Munishi, 1991; Kanji, Munishi, and Kilima, 1992), and the government has meager resources for controlling and inspecting the mushrooming private health care sector. Additional monitoring responsibilities have overstretched governmental capacity.

One example of this situation involves hospital dispensaries and pharmacies. Under existing regulations, dispensaries must be managed and supervised by approved medical personnel, preferably at the M.D. level, who must satisfy MOH qualifications. Most of the dispensaries surveyed in Kilimanjaro (95 percent) were owned and managed by medical assistants and RMAs — third and fourth levels, respectively — who were unqualified to own/manage dispensaries or clinics. This means that if MOH regulations were applied strictly, most of the nonprofit and the for-profit dispensaries in Kilimanjaro — and in many other areas of the country — would have to close. If the regulations were strictly administered, then the volume of private services in health would shrink dramatically.

As mentioned, there is abuse of the provision that provides "approved organizations" with umbrella permits that allow them to open up several units under a single permit. Such additional facilities are claimed to belong to approved M.D.s and "approved organizations," but they were often found to be personal business

entities of unqualified juniors (nurses, RMAs, medical assistants, etc.). Worse still, there was little or no evidence that these facilities were actually being supervised by the M.D.s whose names appeared on the entrances.

Allowing for the collection of fees in the private sector also is having an impact on the availability of qualified personnel in the public sector. Government wages last employees only about 12 to 15 days a month, and so they seek supplemental income, often by taking part-time jobs at private hospitals, dispensaries, pharmacies, or clinics. This is a main source of the human resources supporting the growth of the private health care sector, because trained resources in the medical field are in high demand.

However, this trend may have a negative impact on the quality of health services at the government units. Such "moonlighting" — which is officially encouraged by the government — sometimes has resulted in a number of professionals joining together to start their own health facilities while still working for the government. These professionals follow a carefully planned timetable, with one partner at the health unit at all times. Sometimes a few junior assistants are employed in place of the partners.

The current system in Tanzania lacks the regulatory capacity to match the expanding private health care sector. The country's unhealthy economy and the declining budget allocation for the MOH may cause the regulatory infrastructure to suffer further, which may mean that the growing private health sector becomes substandard. Controls on the private health sector are much needed, especially standards for medical practice, given the current growth of the private sector and the relaxed regulatory environment. Relaxing the regulatory environment may have stimulated growth in the sector, but to ensure adequate quality there must be quality and safety standards that are spelled out clearly and administered effectively.

## 4.4.2 Financial Environment

### 4.4.2.1 Availability of Capital

Capital availability has been and remains a major constraint to the growth of the private health sector in Tanzania, although the magnitude of this constraint varies by level of service and type of provider. Getting start-up capital has been more difficult for facilities categorized as for-profit than for nonprofit facilities. This is because the nonprofit agencies often have diversified sources of funding, including donated building materials, equipment, and drugs. An example is the donor-sponsored Catholic dispensary at Uchira ward in the Kilimanjaro region. Nonprofit facilities that are parish- or church-owned often are established with in-kind contributions and financing from members.

*Exhibit 4-17* summarizes the findings of the provider survey concerning the availability of capital for starting a practice, as well as the ease of purchasing drugs and equipment. As the exhibit shows, there is little difference in the responses of nonprofit and for-profit providers interviewed. It should be noted that the nonprofit providers interviewed were for the most part individuals who were doing business under the permit of an "approved organization." The interviews made clear that actual church-owned units have few problems getting start-up capital, while investment capital remains a problem for the private health sector. This situation will require the attention of the government if it seeks to motivate private sector participation in the financing and provision of health care services.

**EXHIBIT 4-17**
**EASE OF ACCESS TO START-UP CAPITAL, DRUGS, AND EQUIPMENT**
(percent of respondents)

| | For-Profit Investors | | Nonprofit Investors | |
|---|---|---|---|---|
| | Easy | Difficult | Easy | Difficult |
| Availability of Capital | 7 | 93 | 17 | 83 |
| Procurement of Drugs | 88 | 12 | 80 | 20 |
| Purchase of Equipment | 83 | 17 | 73 | 27 |

*Exhibit 4-17* shows that providers find equipment and drugs easy to find on the local Tanzanian market. However, many providers elaborated that while some equipment and drugs were made readily available by the liberalization of the Tanzanian economy, they were too expensive for a small-scale investor. Providers would have to pass the cost of such expensive equipment on to consumers in the form of higher prices, which threatens to make the services inaccessible and possibly to price them out of the market.

Under normal conditions, especially in developed market economies, investment capital is available through financial institutions such as banks. Small-scale providers consistently complained that credit to finance buildings, equipment, and drugs is quite hard to come by. Therefore, individuals mostly limit themselves to establishment of small dispensaries and pharmaceutical outlets rather than hospitals and specialist clinics, which usually call for higher capital commitments.

Financial institutions do not tend to consider the health sector a viable area of investment. One problem is that the banks and creditors require collateral before they can advance credit, and a majority of those who are starting dispensaries, clinics, and pharmacies are either low-paid practitioners who have retired with an insignificant pension fund or individuals who have left or are still employed in the government system. They have little or no savings for substantial investment in an expensive undertaking such as health care delivery, and a majority of such individuals have no assets to serve as collateral.

The study found two aspects of the problem of access to capital. The first is that recently established one-person facilities are started with meager financing, usually from the owner's and/or initiator's family circle. The second, related to the first, is that the majority of such facilities are established in one or two rooms in a residential house and do not necessarily meet the premise-standards of the MOH. One has to question the quality of services sold under such arrangements, especially the level of medical practice standards.

### 4.4.2.2 Reliability of Income from Fee Revenue

The reliability of income from fees is closely related to the availability of start-up capital for private sector health providers. Many studies have shown, for instance, that the existence of health insurance is one of the major factors associated with the potential for growth in the private health sector. Insurance and other financial institutions were nationalized in 1967 with the advent of socialist policies under the Arusha Declaration. The National Insurance Corporation currently covers a relatively minute proportion of the population, and the absence of an elaborate insurance system denies private health investors a source of financing. The government is in the process of putting in place a form of insurance or some pre-paid schemes through which health services can be financed.

Employer-based health benefits provide another alternative for third-party payments for medical care. This study found some arrangements by which employees could be treated at some private facilities without having to make a cash payment. The treatment bills for such employees are paid by the employers on the basis of a negotiated contract with facility owners. For example, the Red Cross dispensary in Moshi municipality has contracts to treat employees of the Coffee Curing Company, Tanzania Electricity Supply Company, and the National Pharmaceutical Company. Some private facilities, such as the Tanzania Occupational Health Services of Dar es Salaam, cater almost exclusively to companies in need of preventive and curative health services for their employees. These contractual arrangements not only guarantee financing but also provide the owners of such facilities with a "captured" market at a time when competition for customers is stiff.

### 4.4.2.3 Taxation

Under the 1991 Private Practice Act, all private health providers except nonprofits are subject to business taxes and income taxes. Some practitioners such as opticians also are subject to a corporate tax. *Exhibit 4-18* summarizes these tax requirements.

**EXHIBIT 4-18**
**TAXATION OF HEALTH CARE PROVIDERS**

| | |
|---|---|
| Private Doctors | — Business tax to be paid annually to Municipal Councils<br>— Income tax to be payable annually to Income Tax Department of the Ministry of Finance |
| Nonprofit Hospitals | — Not applicable (no tax payment required) |
| For-Profit Hospitals | — Business tax to be paid annually to Municipal Councils<br>— Income tax to be payable annually to Income Tax Department of the Ministry of Finance |
| Other Paramedical Practitioners | — Business tax to be paid annually to Municipal Councils<br>— Income tax to be payable annually to Income Tax Department of the Ministry of Finance |
| Other Practitioners | — Opticians<br>— Business tax to be paid annually to Municipal Councils<br>— Income tax to be payable annually to Income Tax Department of the Ministry of Finance<br>— Corporate tax for those registered as a Body Corporate Under Section 8 of the Optical Act, 1965 |

Source: World Bank, 1993a.

As in virtually all countries, private providers in Tanzania perceive taxes to be excessive. Providers also reported that the tax system unfairly favors some providers over others. If an "approved organization," especially

a church organization, imports medical equipment and drugs that can be declared to be a bonafide gift from abroad, the goods are tax-exempt. On the other hand, if such imports are not categorized as church- or nonprofit-owned or as a gift, then normal sales and import duties are charged. The sale of tax-affected services tends to become expensive, making it more difficult to attract clients and private capital investment. Providers further complained that they must abide by too many cumbersome taxation procedures and regulations, including import duties, sales taxes, and income taxes.

Before 1993 the tax on drugs was about 5 percent. That tax category was recently increased to 40 percent, which created a furor in the private sector. In order to break even, some private operators had to increase their prices to such an extent that they risked losing their traditional customers. This tax was one of the major objects of complaint by the providers interviewed for this study.

These tax conditions encourage providers to circumvent the regulations under the new law. Since tax-exempt nonprofit "approved organizations" are not subject to the same taxes and regulations, it is more profitable for providers hidden under the umbrella of "approved organizations" to remain there. As long as they are not discovered by the tax authorities, these providers have little incentive to register with the MOH and to change their status.

### 4.4.3 Price and Ability to Pay

Many people question whether a private health sector can flourish in a country where the majority of the population is relatively poor and may not be able to pay fees sufficient to sustain private providers. Even though average per capita income in Tanzania is among the lowest in the world (less than US$200), about 87 percent of the for-profit providers interviewed in this study said that their clients were willing to pay for health services. The study had no opportunity to test the elasticity of demand (e.g., the effect of raising prices), but interviews showed that in both Kilimanjaro and Dar es Salaam the capacity of existing providers is higher than the current demand. In fact, some providers were forced by market conditions to lower their prices as low as marginal levels. The price attached to a routine examination at the University of Dar es Salaam health center, for example is Tsh. 400, and a full dose of malaria prophylactic ranges from Tsh. 1,500 to 3,000. The same items at Ubungo private for-profit dispensary sale for Tsh. 200 and 1,500, respectively.

Government guidelines for routine examinations set the price at Tsh. 400. However, all the for-profit units surveyed in Moshi municipality and some in Dar es Salaam charged prices ranging from Tsh. 100 to 300 per examination. And while government guidelines set the price for simple operations at Tsh. 4,000 to 5,000, the nonprofit church-owned facilities charge between Tsh. 1,500 and 3,000.

An interesting finding was that the for-profit and nonprofit providers informally assessed their customers' ability to pay and charged them according to this subjective judgment. Managers and owners interviewed in Dar es Salaam and Moshi pointed out that their employees usually are given some training (on the job) to enable them to become sensitive to customers' ability to pay. Customers are not usually turned away because they cannot pay for a high-priced service; instead they are offered a less expensive treatment or given an opportunity to defer payment (if the provider is comfortable that payment will be made eventually).

The danger is that some customers may be asked to pay more than the standard charges if they are judged able to do so. It is also likely that some will be given an alternative treatment that may be ineffective — albeit

lower in price. This issue cannot be addressed without a detailed assessment of the quality of treatment services sold on the market.

*Exhibit 4-19* summarizes the findings of a recent survey of 1,820 households, covering 11,961 people, on health-seeking behavior (Abel-Smith and Rawal, 1992). The survey provides an indication of the effects of income on choice of provider and willingness to pay for services. *Exhibit 4-19* shows that the use of private facilities increases with income level but that the use of the nonprofit mission facilities shows no clear relationship to income level. It also shows a gradual decline in the use of government health care services as income increases. It is plausible to assume that those with higher incomes seek alternative health care services, including private for-profit services, given the perception that public sector services are of lower quality.

**EXHIBIT 4-19**
**HEALTH-SEEKING BEHAVIOR BY INCOME QUINTILES**

| Action on Illness | Income Quintiles * | | | | |
|---|---|---|---|---|---|
| | I Lowest | II | III | IV | V Highest |
| No action | 7.5 | 1.5 | 3.2 | 1.8 | 4.7 |
| Self-care | 22.5 | 15.9 | 21.0 | 18.8 | 18.3 |
| Traditional | 4.8 | 3.2 | 3.0 | 1.5 | 0.3 |
| Government | 42.5 | 49.7 | 39.4 | 34.6 | 35.0 |
| Mission | 18.0 | 14.4 | 20.2 | 24.2 | 17.3 |
| Private | 3.6 | 8.0 | 6.4 | 9.0 | 17.3 |
| Military/Employer | 0.0 | 7.1 | 5.7 | 10.0 | 7.0 |

* Income estimates based on weekly expenditures per adult equivalent.
Source: Abel-Smith and Rawal, 1992.

We should be careful in interpreting the findings concerning for-profit facilities because the sampling approach identified households that had access to government and mission facilities but did not adjust for the availability of for-profit facilities. This means that a number of the households surveyed in rural areas probably had no access to for-profit facilities. This, along with the fact that the expenditure levels of rural households are usually lower than urban households, means that the trend shown may be due to the sampling choices. A clearer trend may emerge if the data were stratified by urban and rural residence and nonprofit and for-profit categories compared to the government services.

The provider survey offers some additional insight into this issue. With regard to nonprofit establishments, especially church-owned ones, payment can be deferred when the patient is deemed able to pay. Second, those who are subjectively judged to be too poor to pay cash are sometimes asked to pay in kind, for example, their labor on the parish farm in return for the treatment received.

Historical trends in almost all countries show that higher-income households spend more for health care. It is therefore realistic to expect that when incomes rise as a function of improvements in the Tanzanian economy, people would be able to spare more to purchase such services. There is evidence, however, that even at the

current level of income, there is a willingness to pay more for health care services if quality improvements are introduced.

A survey of 600 patients (200 each in Dar es Salaam, Morogoro, and Iringa) was conducted at public hospitals implementing cost-sharing (Vethouse Associates, Inc., 1994). The survey was intended to gauge the willingness and ability of patients to pay for health services at current cost-sharing fees and at higher fee levels. The patients were asked if they are willing to pay more if 1) services can be improved, and 2) time spent per illness visit can be shortened. The results *(Exhibit 4-20)* show a strong willingness to pay for quality improvements and can be interpreted as a willingness to pay for private sector services if there is a perception of superior quality and timely service.

**EXHIBIT 4-20**
**WILLINGNESS TO PAY MORE FOR SERVICE IMPROVEMENTS**

| | Yes | | No | | Undecided | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Willingness to pay: | | | | | | |
| 20 percent more | 270 | 45 | 156 | 26 | 174 | 29 |
| 50 percent more | 310 | 35 | 210 | 35 | 192 | 32 |
| 100 percent more | 120 | 20 | 198 | 33 | 210 | 35 |
| Total | 600 | 100 | 600 | 100 | 600 | 100 |

Source: Vethouse Associates, Inc., 1994.

# 5.0 CONCLUSIONS AND RECOMMENDATIONS

Tanzania has made a great deal of progress since independence in improving the health status of the population. It has achieved a high rate of child immunization and has increased the number of health facilities and the level health manpower to make services available to the majority of the population. But major health problems remain — particularly in the areas of "traditional" public health concerns such as malaria and respiratory diseases, as well as low contraceptive prevalence rates in the face of high population growth rates. The spread of HIV/AIDS and related increases in tuberculosis pose major problems for the public health system.

Tanzania, like most other African countries, experienced serious economic deterioration during the late 1970s and the 1980s, which resulted in severe governmental budget constraints and increasing difficulties in meeting governmental commitments to health service delivery. By 1990, the government's dependence on foreign assistance was five times higher than at independence in 1961. Although the government's health budget increased during this period, by the late 1980s it was not keeping up with inflation or with population growth, and health services deteriorated, with needed medicines becoming unavailable and health facilities falling into disrepair. Although Tanzania spends a greater share of its GDP on health than other countries with similar income levels, life expectancy in 1990 was lower than would be expected given national income and educational levels.

These conditions have indicated to the government that its capability to develop, improve, and sustain free public health services has become limited. It is in this context that the Ministry of Health (MOH) has considered and adopted several steps toward major reform of the organization, financing, and management of the health sector. Constrained public sector resources in Tanzania have made it increasingly important to look for nongovernmental sources of funding for health services such as user fees and for nongovernmental sources of health care to help fill the gap between available health services and the health needs of the population. Since the early 1990s, the government has made private sector development a cornerstone of its health sector reforms.

In this reform effort, the MOH is seeking to exploit the potential of the private sector's health service delivery capacity and to encourage private sector development in ways that can complement governmental provision of health services. This facilitating policy coincides with efforts to shift the role of government to include regulation as well as provision of health services. The change in posture toward the private sector has its roots in a recognition of current public sector financial constraints that make it necessary to look to nongovernmental sources of health care and of the changing political environment.

With growing recognition of the size, scope, and diversity of private health services in Africa, African governments and international donors have sought to better assess the potential of the private sector to contribute public sector health goals. This recognition, in turn, has focused attention on how public sector legal, regulatory, financial, and other actions affect the private sector's ability to provide quality services.

These issues have particular relevance to Tanzania, which at times deliberately restricted private sector activity in health and at others has encouraged and supported growth of certain types of private sector providers. This study provides baseline information and analysis that the MOH to use in further elaborate policies designed to enhance public-private partnerships for the purposes of expanding coverage, strengthening quality and efficiency of health services, and improving health status in Tanzania.

The following section highlights the main findings of the study, draws conclusions, and makes recommendations regarding the potential contribution that private health providers can make to the public health reform agenda in Tanzania. It also draws conclusions and makes recommendations about collaboration between the public and private health sectors in achieving these goals. Finally, it identifies several issues for consideration in the MOH's overall strategy for reform that derive from the impact that private sector development may have on the MOH's goals for strengthening the public sector.

## 5.1 PRIVATE SECTOR CONTRIBUTIONS TO THE PUBLIC HEALTH AGENDA

In the broader context of health sector reform, policies that encourage an expanded role for private sector health providers can help ministries of health to:

- improve the overall availability and accessibility of health services and medicines without having the government provide that additional care directly;
- increase the availability of health services for the underserved, hardest to reach, and lowest-income populations;
- increase the overall efficiency of health service delivery by permitting the government to take advantage of efficiencies that some private sector providers have achieved; and
- reduce government funding for health services for which people are willing and able to make out-of-pocket or insurance-based payments.

For example, one of the primary contributions church, mission, and other voluntary agency health providers make to the public sector's health agenda in many African countries is to maintain and expand their capacity to deliver high-quality services, especially priority preventive services, to poorer and underserved populations at prices they can afford. For-profit providers can contribute most by delivering care to populations that are capable of paying for this care but are currently using free, or highly subsidized, public care. In principle, expanding private for-profit services can help to free public resources for care to those less able to pay.

The Ministry of Health in Tanzania has recognized the potential contributions of the private sector and has built into its recent health sector reforms a strong role for the private sector. One cornerstone of the current reform effort includes building on the 1991 Private Practice Act to "assist and encourage the private sector to grow and provide quality health care to complement the government's efforts towards the provision of equitable and affordable health care" (MOH, 1994b).

The main purpose of this study's review of the size, scope, and distribution of the private sector is to assess its potential for making this expected contribution to public sector goals.

### 5.1.1 Using the Private Sector to Expand Access to Health Services

The overall objective of the health sector in Tanzania has been to improve the health and well-being of the population, with a particular focus on equity and access to primary health care services. The Ministry of Health emphasizes "equitable universal availability of effective essential health care at a cost the country and the community can afford" (MOH, 1994b).

Until recently, these efforts have been largely government-sponsored, -managed, and -financed. Under the sector-wide reform efforts recently launched by the MOH, private health service providers are now expected to play a significant role in achieving public sector health goals, which represents a significant change from previous MOH policy toward the private sector.

In contrast, the MOH has long recognized and taken advantage of the capacities of *nonprofit* private sector providers, primarily church-based and voluntary agency health facilities. For example, the government incorporated 17 hospitals owned by nonprofit voluntary agencies into the MOH health network as "Designated District Hospitals," or DDHs. Although these hospitals are still owned by the voluntary agencies, they are now fully funded and directed by the MOH and so are generally considered to be public facilities. In 1993, voluntary agencies owned 44 percent of the nation's hospitals registered and nearly half of all hospital beds, including those in the DDHs.

Liberalization of the laws concerning private providers has caused an explosion of for-profit facilities, which now account for 42 percent of all private facilities in Dar es Salaam, including 83 percent of all private hospitals and 57 percent of all privately owned hospital beds. The private health sector also is becoming an increasingly important employer of medical personnel in urban areas such as Dar es Salaam, where it employs a total of 3,661 people.

This study identified three major types of private sector providers currently operating in Tanzania, as classified by ownership and financial orientation: nonprofit voluntary agency facilities, employer-based facilities, and for-profit health care providers. The study also identified five subcategories of private sector providers: 1) nonprofit providers run by voluntary agencies and designated as "approved organizations;" 2) employer-based private and parastatal providers; 3) for-profit providers affiliated with "approved organizations;" 4) for-profit providers approved prior to 1991 (e.g., Aga Khan Foundation, Hindu Mandal); and 5) all other independently owned for-profit health providers approved since 1991. For practical reasons, this study did not involve data collection for a sixth subcategory — the informal health sector comprised of traditional health practitioners.

Data from this study and the survey of private health facilities in Dar es Salaam indicate that the private sector in Tanzania plays an important role in the delivery of health care, especially in urban areas. Government statistics for 1992 indicate that private sector providers owned about 25 percent of all hospitals and dispensaries in Tanzania and about 5 percent of the health centers. Nonprofit voluntary agency health facilities are fairly evenly distributed across the 20 regions of the country, including the capital. Employer-based (especially parastatal) provider hospitals and dispensaries are concentrated in six of the regions. For-profit providers are concentrated in Dar es Salaam and other urban centers.

**Recommendations**

- Given the long history of collaboration between the public sector and nonprofit private health providers in Tanzania and given the wide distribution of nonprofit providers throughout the country, the MOH should continue its strong collaboration with nonprofit voluntary agency health providers to sustain their contribution to the general availability of primary care and hospital-based health services in the country.
- Given the diversity of private sector health providers in Tanzania, the MOH will need to continue to have somewhat distinct policies for each main type of private sector provider. In the past, the MOH has made a clear distinction between for-profit and nonprofit health care providers. As the private sector continues to develop and to become more diverse, the MOH will have to further refine these policies to take account of the different practice patterns and

financial orientation of such providers, and it will have to develop different incentives, regulatory approaches, and collaborative mechanisms. (This issue is addressed further below.)

- Given the current distribution of for-profit health providers, the MOH probably can concentrate its collaborative efforts with for-profit providers in Dar es Salaam, using that experience as a pilot for extension to other urban areas. The MOH should immediately focusing on developing a systematic vision and policies to effectively channel the growth among for-profit providers — where most of the growth in the private sector has occurred since the 1991 liberalization — in order to make better use of available public sector resources.
- The MOH should assess the potential role of employer-based health services in the private provision and/or financing of health services, as they might constitute a useful contribution to the capacity of the health system in urban areas. Information available for this study suggests that employer-based health providers may be relatively neglected in the current reform efforts. Employer-based health services often represent a "hidden" capacity in early stages of private sector development, although they may also require special treatment in terms of registration, certification, and quality assurance.

### 5.1.2 Using the Private Sector to Expand Access to Priority Public Health Services

In assessing the potential contribution of the private sector to specific health services, this study focuses on key public health services that the HHRAA methodology called for in the four-country comparative study of the private sector (Berman and Hanson, 1993). These public health services include preventive and treatment services for the major public health problems facing many African countries (including Tanzania) and include childhood communicable diseases, tuberculosis, malaria, and AIDS. These services also include reproductive health services, such as family planning and maternal and perinatal services (including delivery).

Data available for this study showed that as a group almost half of the private sector hospitals and health centers in Tanzania provide treatment for tuberculosis and more than half provide maternal and child health services (MCH), including immunizations, growth monitoring, and treatment of diarrheal diseases. However, only a quarter to a third of the smaller for-profit dispensaries offer any of these services.

Different types of private providers emphasize different services. For example, although all parastatal hospitals and health centers in Dar es Salaam provide TB treatment, only half provide MCH or family planning services. Only a third of the private for-profit hospitals and health centers provide TB treatment, but half or more provide family planning and MCH services.

The MOH is still the major provider of family planning services in the country and the major source of contraceptives, supplying 72 percent of all contraceptives. Although half of the private health centers and hospitals provide family planning services, only 28 percent of private dispensaries do.

The MOH is the major provider of immunization services and has achieved among the highest coverage rates in Sub-Saharan Africa, with over 70 percent of children fully immunized before age 2 and 56 percent fully immunized before their first birthdays.

Findings from this study indicate that a more substantial portion of private health providers, especially the hospitals and clinics, provide priority public health services than may have been realized. While a precedent

and the relevant experience for providing these services thus exists, the data also show that this capacity varies by type of private provider, as well as by individual provider. In general, private hospitals and health centers are much more likely to provide priority public health services than the many dispensaries.

**Recommendations**

- The public sector in Tanzania has a well developed capacity for providing preventive services such as childhood immunizations and has a good record of coverage. Given the public sector's strong comparative advantage in this regard, it makes no practical sense to shift responsibilities for these services to the private sector. The MOH should not, however, discourage those private providers who now deliver preventive services from continuing to do so, and it might selectively provide incentives to private providers to deliver preventive services where no public provider exists.
- The MOH should consider focusing on the private sector's capacity in curative health services at the hospital level as well as at the primary care level. Since most private hospitals and health centers normally tend to provide MCH and TB services with no incentive from the MOH, there is potential for the private sector to relieve the government of some of the responsibility for these services and to help absorb the increasing demand for these services.

## 5.2 IMPROVING PUBLIC-PRIVATE COLLABORATION

Assessing private providers' potential for contributing to priority public sector services and to the general availability of health services is a major purpose of this study. Another is assessing how the MOH can use public policy to promote private sector development in ways that will contribute to public sector goals.

This study focused on three sets of public policies that affect private sector development: legal and regulatory measures governing private practice; financial incentives and disincentives; and health service pricing structures that affect both provider income from fee revenues and the population's use of and demand for health services. The following section present conclusions and recommendations related to legal, regulatory, and financial policies. The final part of this section addresses pricing policies.

The main issue in public-private sector relations in Tanzania is no longer whether to collaborate but how and what forms of collaboration and incentives are most appropriate and cost-effective.

### 5.2.1 Laws and Regulations

Tanzania has taken major steps to legalize private medical practice, and studies by the World Bank (1993a) and others have concluded that no major legal obstacles remain. Indeed, since the 1991 Private Practice Act, for-profit private providers have grown rapidly all over the country, especially in urban areas. The major issues that the MOH now faces in this regard relate to implementing, monitoring, and enforcing regulations. It is likely that regulatory efforts have not kept up with the rapid changes that followed the 1991 Private Practice Act. This study reported on at least two potential problems that require attention.

First, this study reported evidence that a large group of health facilities and individual providers use permits obtained by an "approved organization" to establish and run for-profit health care units with little or no supervision from the parent voluntary organization, a practice that started as a means to overcome restrictive laws

prior to 1991. While many such affiliated providers are changing their official status, many other for-profit facilities owned by individuals are still registered under such permits because of the tax-exempt status enjoyed by voluntary agencies and the bureaucratic difficulties individuals experience in applying to open private practices. Since several clinics can open under a single voluntary agency permit, this practice has led both to an underestimation of the number of the private facilities in the country — especially the for-profit ones — and to difficulty in locating all private providers for purposes of monitoring implementation of related licensing and quality assurance procedures.

The existence of hidden affiliates of "approved organizations" also presents serious issues for quality assurance because these loopholes also allow people who do not meet certification standards to own and operate medical and related services. Even under current licensing and registration requirements, lower-level professionals have been able to enter the private health care market, essentially as independent practitioners, by claiming to be employees of an "approved organization."

A second problem that appears to require improved government monitoring involves clinical practices in both the public and private sectors. This study reported evidence that only 45 to 50 percent of church-based health facilities and only 25 percent of government facilities in a sample in Dar es Salaam followed acceptable clinical practice. About 35 percent of both voluntary agency and government facilities were found to have potentially serious clinical errors. The voluntary agency facilities also were found to lack some essential drugs (e.g., oral rehydration salts) and did not always follow accepted treatment protocols, such as for rehydration for childhood diarrhea.

**Recommendations**

- The MOH needs to encourage individuals who own facilities under the auspices of voluntary agencies to register as independent providers, whether for-profit or nonprofit. Professional provider associations could help this process by encouraging members to register properly and by developing and maintaining current rosters that would facilitate cross-identification.
- The MOH, with assistance from professional provider associations, should complete the task of compiling a comprehensive and accurate list of all private health facilities in the country, not only to regularize the registration process but also to facilitate appropriate monitoring of licensing and quality assurance. This list should be updated regularly (e.g., once a year).
- The MOH could consider including private providers in their in-service training programs in clinical practices and procedures. Incentives could be offered to encourage participation by these providers if necessary, for example, free training or a per diem.
- The MOH, in collaboration with the provider associations, should conduct a more comprehensive study of quality in the private sector provision of health care services in order to assess the need for training and for strengthened, ongoing supervision and regulatory monitoring.
- The MOH could solicit the help of private providers in training government medical personnel in areas where private providers excel, such as interpersonal communication and management of drug supplies.

### 5.2.2 Financial Incentives

This study reviewed several aspects of the financial environment facing private sector health providers: the ease of obtaining credit, levels and types of taxation, and the prospects for earning adequate income from fee revenues, and the availability of direct government subsidies. It was beyond the scope of this study to collect and analyze information to assess the specific individual effects or the net impact of these four factors — credit, taxes, income from fees, and subsidies — on the size, scope, and distribution of the private sector. In general, however, data available for this study show that four trends are emerging under the current financial environment.

First, direct government subsidies have been targeted toward nonprofit, voluntary agency private health providers. As a result of this financial support and the preferential legal treatment they receive, private nonprofit health providers now predominate in all categories of health facility: hospitals, health centers, and dispensaries. Official MOH data available for this study on the total numbers and types of private providers show that nonprofit hospitals represent 87 percent of all private hospitals, 73 percent of all private health centers, and 70 percent of all private dispensaries.

Second, the most rapid growth in private sector health facilities has been among small dispensaries, which do not require much capital to establish. Difficulty in obtaining credit was identified by many providers interviewed for this study as a major constraint in starting any major health service operation. Many of these small dispensaries are essentially individual practices or small pharmaceutical outlets established by people without the collateral needed to obtain loans for larger health facilities.

Third, data available for this study suggest that the incentives for different forms of private practice are likely to be quite different in urban and rural areas. Most of the growth in the private sector has taken place in urban areas, and while nonprofit providers predominate in the country as a whole, urban areas show a different pattern. Available data show that for-profit doctors and other medical personnel predominate in the capital, outnumbering nonprofit and employer-based providers two-to-one. The 15 for-profit hospitals in Dar es Salaam represent 83 percent of the private hospitals, and the five for-profit health centers in the city represent half of private health centers. The 253 private dispensaries are fairly evenly distributed among for-profit, voluntary agency, and employer-based private providers.

Fourth, data from a survey in Dar es Salaam indicate that the capacity of employer-based providers, especially parastatals, is equal to or in excess of the nonprofit sector in terms of health facilities, beds, and medical personnel. Additional arrangements exist among private employers to reimburse medical services for employees.

**Recommendations**

- At this stage in the growth of the private sector, it is important that the MOH base any financial incentives offered to encourage private sector development on a solid assessment of 1) the impact of current financing arrangements on the pace and direction of growth, and 2) whether current trends are proceeding in a direction deemed most useful to the overall development of the health sector.
- In developing policies for providing financial incentives, the MOH should be clear about 1) what level of private health facility (hospital, health center, dispensary) and what type of ownership or financial orientation (profit or nonprofit) it most wants to encourage, and 2) what mechanisms (taxes, credit, subsidies) — or combination of mechanisms — are most cost-effective for encouraging growth of that level of health facility. If the MOH wants to maintain

a neutral stance toward some types and levels of providers, it should ensure that the financial incentives that the government controls also are "neutral." If private providers are already delivering services that the MOH wants to encourage without any government financial incentives, the MOH need not introduce any.

Once the MOH resolves these policy issues, details can be worked out regarding the specific financial policy tools and incentives to be used for providers it chooses to encourage, perhaps including: providing government-funded, low-cost rental premises; establishing a government-backed credit facility that makes soft loans for private health providers; targeting direct subsidies or tax incentives to certain types of providers, for specific health services, for maintaining a certain bed or staff capacity, for specific medical equipment, supplies, medications, or vaccines, or for locating in underserved areas.

- The MOH should continue its efforts to assess the feasibility and potential benefits of different forms of health insurance and the likely impact of such insurance on private sector development as well as on people's use of health services. Experience elsewhere in the world has shown that the availability of health insurance has a significant effect on the growth and financial viability of private sector health providers.
- The MOH should separately analyze the financial incentives that may be needed for employer-based health providers, as opposed to those appropriate for other private sector providers. Employer-based reimbursement for health services needs to be considered separately from more general health insurance issues.

## 5.3 IMPACT OF PRIVATE SECTOR DEVELOPMENT ON PUBLIC SECTOR REFORM

Because of the key role that the private sector plays in the MOH's overall health sector reforms, it is important to assess the potential impact of private sector development on the MOH's goals for strengthening the public sector. An expanded private sector offers alternatives to the public sector that can have both positive and negatives — and intended and unintended — effects on the government's goals for health sector reform. Data from this study illustrates at least two such situations.

### 5.3.1 Public and Private Sector Competition for Patients

Many ministries of health in Sub-Saharan Africa fear that their relatively poor populations will be unwilling or unable to pay the prices charged by private sector health care providers. Evidence has increasingly begun to demonstrate, however, that price is only one of several factors that affect people's use of health care in African countries or their use of one provider over another. People's perceptions of quality are at least as important in making decisions about alternative health care providers. And a great deal of evidence exists in Tanzania, as well as elsewhere in Africa, that people will bypass free government health services and travel longer distances to use services they must pay for if they perceive them to be of higher quality. This phenomenon only increases once government health facilities start to charge for services unless they make the necessary quality improvements.

The availability of private providers whom people perceive to provide higher quality care can draw patients away from the public sector. This can benefit the public sector to the extent that it frees public resources to serve a smaller number of patients more effectively, but it also can have negative effects to the extent that it

draws away precisely those people who are most able to pay for health services. This latter effect is particularly important in the context of the cost-recovery effort that the MOH has initiated. If a large majority of paying patients leave the public sector for the private sector, it would have a significant impact on cost-recovery revenues, which the MOH needs to improve public sector services.

This study found evidence that such a shift to the public sector is beginning to occur, although the relative size of the shift remains unclear. Patients interviewed for this study indicated their perception that the private sector provides higher quality services (better drug availability; "better treatment") than public health facilities and that such perceptions were often the basis on which they chose a private over a public provider.

Data presented in this study on measures that patients use in comparing quality between the public and private sectors is somewhat mixed. One survey showed, for example, that although overall drug availability was similar among public and private providers in the sample, people perceived it to be higher in the private sector. Physical facilities and interpersonal skills of staffs at private clinics were better than at public facilities. Public perceptions in general were much more favorable concerning private rather than public facilities, but the study demonstrated a critical need for significant improvements in diagnostic skills and other measures of "technical quality" in both public and private facilities. This study also found that in other patient surveys in Tanzania, distance and waiting times appear to be key indicators the public uses to judge quality.

**Recommendations**

- These trends mean that it is especially important to the success of cost recovery and efforts to strengthen the public health sector that the MOH continue its efforts to improve and maintain the quality of care in government health facilities. These improvements should be pursued across the board in the public sector, which now competes with the private sector in providing a full range of curative services at all levels of care in hospitals, health centers, dispensaries and in providing preventive and other high-priority public health services. This competition can be a positive factor in improving the quality of care and thus health status.
- In making quality improvements in the public sector, it is important to give priority to those factors the population uses to judge quality — particularly in the context of cost recovery. Experience with the introduction of user fees in government health facilities in many African countries demonstrates that people's willingness to pay for health services, and hence the success of cost recovery, depends on making needed quality improvements.
- The MOH will need to monitor the impact of fees on the use of health services in both the public and private sectors and to coordinate its pricing strategy to take account of these effects on higher- and lower-income households.
- It is also important that fees for services in the public sector be adequate to produce revenues that, along with MOH budget funding, are sufficient to make the desirable quality improvements. At least one recent review of cost-recovery efforts in Tanzania suggests that prices are not now related closely enough to the cost of services and that they do not reflect well people's willingness and ability to pay (Vethouse Associates, Inc., 1994).
- The MOH also should consider ways to best take advantage of the population's willingness to use, and to pay for, private sector health services so that over time the private sector might absorb a large percentage of patients suffering from certain illnesses, especially those requiring more expensive secondary- and tertiary-level curative care.

### 5.3.2 Public and Private Sector Competition for Health Personnel

An expanded private sector also can attract health manpower away from the public sector because of the potential for higher incomes. Provider interviews conducted for this study also found evidence that providers think people will be more willing to pay for services in the private sector and that private practice therefore offers even greater possibilities for higher incomes.

This trend means that the MOH will need to address the issue of incentives, monetary and other, for work in the public sector. One solution the MOH has tried in this regard is to require public sector medical personnel to seek permission to "moonlight." While this arrangement permits government employees to supplement their incomes, this study found evidence that in practice this arrangement draws more provider time away from public sector work than intended. Experience in Tanzania and elsewhere in Africa suggests that "moonlighting" and permitting private wings to exist within public hospitals can have mixed benefits for the public sector. While they may represent reasonable short-run solutions, other alternatives are probably needed in the long run.

It was beyond the scope of this study to collect information that would help resolve the issue of personnel incentives in the public sector. While the issue is relatively widely recognized in Sub-Saharan Africa, as yet there are no widely accepted solutions. Tanzania has included managerial and organizational elements in its health sector reform plans that can help to address the problem.

**Recommendation**

- Findings from this study indicate that a sharp focus on personnel incentives is important not only for managerial issues already recognized in the MOH reform plan, but also because of the competition for health personnel exerted by an expanded private sector represents for public sector.

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# APPENDICES

# APPENDIX 1
# CONTACT LIST

- USAID/Dar es Salaam
- The Ministry Of Health, which included:
  —Office of the Principal Secretary
  —Private Sector Hospitals Division
  —Voluntary Agency Hospitals Division
  —Planning Division
  —Preventive Services Division
  —Pharmacy Registrar
  —Nursing Registrar
- Religious Association (Christian Medical Board of Tanzania)
- Medical Association of Tanzania
- Dental Association of Tanzania
- University of Dar es Salaam
- Muhimbili University College of Health Services
- The World Bank mission in Dar es Salaam
- Oversees Development Agency
- DANIDA
- Urban Health Project (Swiss Tropical Institute)
- Dar es Salaam City Council
- Moshi/Arusha Regional Medical Office
- Chairman, Red Cross Organization, Kilimanjaro region
- Chairman and Executive Secretary, Bahai Sect, Kilimanjaro
- Chairman, Holy Leaf Sect, Kilimanjaro

# APPENDIX 2
# PROVIDER INTERVIEW QUESTIONNAIRE

**STATEMENT OF RESEARCH PURPOSE**

- The purpose of this study is to better understand the factors that help or hinder the development of a private sector in the provision of health services in Tanzania and Senegal. Based on the information collected and analyzed, the study hopes to develop policy options.

- The purpose of this questionnaire is to understand the perceptions of private providers of the socioeconomic trends and of government actions that may influence the development of the private sector. Providers will be asked about the factors determining their decision to enter the private sector, the day to day constrains, and about their ideas regarding the growth of the sector.

**PERSONAL CHARACTERISTICS**

1. Age

2. Gender

3. Specialty

4. School(s) attended

5. Years practicing

6. Years in private practice and public sector

7. Nature of practice (type of facility) and services provided. Estimate the percentage of services that is preventive vs curative (list preventive services offered)

8. How available are private laboratories, diagnostic centers, in your area of practice? Do you use them? Is there a need for more services than currently available?

9. Why did you chose to work in the private sector
   [If respondent was not forthcoming, prompt on the following:
   —Financial (pays better)
   —Work environment
   —Choice of location (rural-urban, neighborhood)
   —Quality of clients (richer, more educated, etc)
   —No public jobs available
   —Better hours (more control)]

10. I am going to go through a list of steps a doctor has to go through to start up a practice. I am interested in the level of difficulty you experienced going through them and your perception of whether the level of difficulty has changed since then.

10A —Licensing and certification for practicing medicine. (is it different from public sector providers, if so how?)

10B —Attracting clients.

10C —Licensing for the clinic.

10D —Start-up cost. (was if easy to secure financial resources from the banking sector or did you have to seek personal and informal arrangements to secure resources for initial costs?) (Has this situation changed since you started?)

10E —Medical equipment (not financial). (was easy to purchase/import medical equipment needed for practice?) (Has this situation changed since you started?)

10F —Drug procurement (not financial). (were drugs available for purchasing/was it easy to import needed supplies?) (Has this situation changed since you started?)

10G —Was there any governmental encouragement (subsidies) or discouragement (business taxes) at the time you started? (has the situation changed since you started?)

10H —Was there any governmental direct or indirect control of the type of services to be provided at the time you started? (has the situation changed since you started?)

(a) direct control may include legal restrictions on the provision of services, the purchase of certain equipment or drugs, the charging of levels of prices, etc..

(b) indirect control may include taxation on equipment or drugs.

OPT. Do you feel that since you started this practice it has become easier of harder to start up a new practice similar to yours or is it about the same level of difficulty.

11. Do you believe that the Government in general and the MOH specifically has helped or hurt the development of the private sector? How?

12. In your judgment, have the following factors helped or hindered the development of the private sector: (this is a check list for the questioner, the provider may have addressed most of these points in the previous answers)

12A —Availability of comparable public services (in the general area of your practice).

12B —Quality of public services (in the general area of your practice).

12C —Prices (real) in public services (under the table, waiting time, travel)

12D —Taxes or subsidies on private provision

12E —Regulation by the government

12F —Willingness to pay by the public

12G —Availability of private insurance

13. What do you think the government can do to encourage the provision of preventive services by the private sector.

14. What do you thing the government can do to encourage start up of private clinics in rural areas and in poor urban areas?

15. Your practice charges for services and yet patients choose it over "free" public provision. Why? (try for quality of care, under-the-table charges at the public sector).

## APPENDIX 3
## SELECTED MACROECONOMIC DATA FOR TANZANIA

**EXHIBIT A3-1**
**BALANCE OF PAYMENTS**
(millions of US$)

| | 1988 | 1989 | 1990 |
|---|---|---|---|
| Trade balance | | | |
| Merchandise exports f.o.b. | 386.5 | 415.1 | 407.8 |
| Merchandise imports f.o.b. | -1,033.0 | -1,070.1 | -1,186.3 |
| Balance | -646.5 | -655.0 | 778.5 |
| Current Account balance | | | |
| Exports of services | 117.4 | 119.5 | 135.8 |
| Imports of services | -263.4 | -246.6 | -245.6 |
| Other income received | 3.2 | 3.8 | 4.3 |
| Other income paid | -207.7 | -232.6 | -235.5 |
| Private unrequited transfers (net) | 231.9 | 182.4 | 164.5 |
| Government unrequited transfers (net) | 389.3 | 469.8 | 529.0 |
| Balance | -375.8 | -358.8 | -426.0 |
| Capital (net) | 33.9 | 21.7 | 126.5 |
| Net errors and omissions | -42.5 | -114.9 | 133.1 |
| Overall balance | -384.4 | -452.0 | -166.3 |

Source: *International Financial Statistics.* Washington, DC: International Monetary Fund.

**EXHIBIT A3-2**
**GROSS DOMESTIC PRODUCT BY ECONOMIC ACTIVITY**
(at factor cost)

| | 1987 | | 1988 | | 1989 | |
|---|---|---|---|---|---|---|
| | Amount | Percent | Amount | Percent | Amount | Percent |
| Agriculture, hunting, forestry and fishing | 117,982 | 58 | 178,760 | 59 | 207,059 | 56 |
| Mining and quarrying | 645 | 0.3 | 723 | 0.2 | 1,129 | 0.3 |
| Manufacturing | 14,792 | 7 | 24,453 | 8 | 30,353 | 8 |
| Electricity, gas, and water | 2,963 | 1 | 4,103 | 1 | 4,831 | 1 |
| Construction | 3,543 | 2 | 4,800 | 2 | 5,904 | 2 |
| Trade, restaurants, and hotels | 25,963 | 13 | 43,800 | 14 | 53,572 | 15 |
| Transport, storage and communications | 11,815 | 6 | 15,621 | 5 | 23,345 | 6 |
| Finance, insurance, real estate and business services | 11,062 | 5 | 14,132 | 5 | 20,641 | 6 |
| Community, social and personal services | 13,291 | 7 | 17,163 | 6 | 22,437 | 6 |
| **Subtotal*** | 202,055 | 99.3 | 303,555 | 100.2 | 369,271 | 100.3 |
| Less Imputed bank service charge | 6,444 | — | 12,888 | — | 18,043 | — |
| **Total** | 195,611 | — | 290,667 | — | 351,228 | — |

* Subtotal may not equal 100.0 percent because of rounding.
Source: *National Accounts Statistics.* New York: United Nations.

## APPENDIX 4
## NUMBER AND DISTRIBUTION OF HEALTH FACILITIES BY OWNERSHIP, ACCORDING TO OFFICIAL GOVERNMENT STATISTICS

**EXHIBIT A4-1**
**DISTRIBUTION OF HEALTH FACILITIES BY OWNERSHIP AND REGION, MINISTRY OF HEALTH STATISTICS, 1993**

| | | Hospitals | | | | Health Centers | | | |
|---|---|---|---|---|---|---|---|---|---|
| Region | Population | Government | Voluntary | Parastatal | Other | Government | Voluntary | Parastatal | Other Private |
| Arusha | 1,628,765 | 7 | 7 | - | - | 11 | - | - | - |
| Coast | 707,877 | 4 | 1 | 1 | - | 10 | - | - | - |
| DSM | 1,720,096 | 4 | 6 | 1 | 2 | 4 | - | 2 | - |
| Dodoma | 1,393,660 | 5 | 1 | - | - | 16 | 1 | - | - |
| Iringa | 1,381,171 | 5 | 6 | 2 | - | 16 | - | - | - |
| Kagera | 1,515,150 | 1 | 9 | 1 | - | 12 | - | - | - |
| Kigoma | 981,383 | 3 | 2 | - | - | 10 | - | - | 1 |
| Kilimanjaro | 1,230,105 | 5 | 7 | 1 | - | 13 | 3 | - | - |
| Lindi | 713,843 | 4 | 3 | - | - | 12 | - | - | - |
| Mara | 1,120,134 | 3 | 4 | - | - | 11 | - | - | - |
| Mbeya | 1,719,642 | 5 | 6 | - | - | 17 | - | - | - |
| Morogoro | 1,390,176 | 4 | 4 | 3 | - | 16 | 1 | - | - |
| Mtwara | 953,526 | 3 | 2 | - | - | 13 | - | - | - |
| Mwanza | 2,135,477 | 4 | 7 | - | - | 26 | - | - | - |
| Rukwa | 857,808 | 2 | 1 | - | - | 11 | 1 | - | - |
| Ruvuma | 925,860 | 2 | 5 | - | - | 13 | - | - | - |
| Shinyanga | 2,044,914 | 5 | 2 | - | - | 18 | - | - | - |
| Singida | 895,864 | 2 | 4 | - | - | 11 | 1 | - | - |
| Tabora | 1,166,762 | 4 | 3 | - | - | 10 | 1 | - | - |
| Tanga | 1,424,198 | 5 | 5 | - | 2 | 15 | - | - | - |
| Total | 25,906,411 | 77 (44%) | 85 (49%) | 9 (5%) | 4 (2%) | 265 (96%) | 8 (2%) | 2 (1%) | 1 (1%) |

Source: Ministry of Health

**EXHIBIT A4-2**
**DISPENSARIES BY OWNERSHIP AND DISTRICT,**
**MINISTRY OF HEALTH STATISTICS, 1993**

| Region | Population | Hospitals | | | | |
|---|---|---|---|---|---|---|
| | | Government | Voluntary | Parastatal | Other | Total |
| Arusha | 1,628,765 | 115 | 39 | 18 | 8 | 180 |
| Coast | 707,877 | 90 | 8 | 15 | - | 113 |
| DSM | 1,720,096 | 66 | 27 | 42 | 11 | 146 |
| Dodoma | 1,393,660 | 148 | 21 | 3 | - | 172 |
| Iringa | 1,381,171 | 91 | 44 | 4 | 2 | 141 |
| Kagera | 1,515,150 | 132 | 13 | - | - | 145 |
| Kigoma | 981,383 | 94 | 14 | 1 | - | 109 |
| Kilimanjaro | 1,230,105 | 93 | 37 | 5 | - | 135 |
| Lindi | 713,843 | 88 | 8 | 4 | - | 100 |
| Mara | 1,120,134 | 92 | 25 | 4 | 2 | 123 |
| Mbeya | 1,719,642 | 149 | 24 | 10 | 3 | 186 |
| Morogoro | 1,390,176 | 131 | 38 | 12 | 2 | 183 |
| Mtwara | 953,526 | 99 | 13 | - | - | 112 |
| Mwanza | 2,135,477 | 204 | 24 | 7 | 3 | 238 |
| Rukwa | 857,808 | 73 | 15 | - | - | 88 |
| Ruvuma | 925,860 | 93 | 35 | 1 | - | 129 |
| Shinyanga | 2,044,914 | 143 | 31 | 2 | - | 176 |
| Singida | 895,864 | 97 | 32 | - | - | 129 |
| Tabora | 1,166,762 | 84 | 21 | 1 | - | 106 |
| Tanga | 1,424,198 | 136 | 16 | 46 | 5 | 203 |
| Total | 25,906,411 | 2,218 | 485 | 175 | 36 | 2,914 |

Source: Ministry of Health

**EXHIBIT A4-3**
**DISTRIBUTION OF BEDS IN HOSPITALS AND HEALTH CENTERS BY REGION, MINISTRY OF HEALTH STATISTICS, 1993**

| | | Hospitals/Health Centers | | | | Beds/100,000 Population | | | |
|---|---|---|---|---|---|---|---|---|---|
| Region | Population | Government | Voluntary | Parastatal | Other | Government | Voluntary | Parastatal | Other Private |
| Arusha | 1,628,765 | 913 | 622 | - | - | 56 | 38 | - | - |
| Coast | 707,877 | 600 | 55 | 141 | - | 84 | 8 | 20 | - |
| DSM | 1,720,096 | 593 | 30 | 18 | 38 | 34 | 2 | 1 | 2 |
| Dodoma | 1,393,660 | 1,789 | 250 | - | - | 128 | 18 | - | - |
| Iringa | 1,381,171 | 846 | 909 | 66 | - | 61 | 66 | 5 | - |
| Kagera | 1,515,150 | 615 | 1,409 | 50 | - | 40 | 93 | 3 | - |
| Kigoma | 981,383 | 582 | 200 | - | - | 59 | 20 | - | - |
| Kilimanjaro | 1,230,105 | 1,074 | 1,128 | 91 | 1 | 87 | 92 | 7 | 0.1 |
| Lindi | 713,843 | 686 | 294 | - | - | 96 | 41 | - | - |
| Mara | 1,120,134 | 638 | 386 | - | - | 56 | 34 | - | - |
| Mbeya | 1,719,642 | 942 | 712 | - | - | 54 | 41 | - | - |
| Morogoro | 1,390,176 | 917 | 678 | 220 | - | 65 | 49 | 16 | - |
| Mtwara | 953,526 | 957 | 500 | - | - | 100 | 52 | - | - |
| Mwanza | 2,135,477 | 1,147 | 1,720 | - | - | 53 | 80 | - | - |
| Rukwa | 857,808 | 664 | 75 | - | - | 77 | 9 | - | - |
| Ruvuma | 925,860 | 502 | 913 | - | - | 54 | 99 | - | - |
| Shinyanga | 2,044,914 | 1,187 | 350 | - | - | 58 | 17 | - | - |
| Singida | 895,864 | 376 | 320 | - | - | 41 | 36 | - | - |
| Tabora | 1,166,762 | 886 | 436 | - | - | 75 | 37 | - | - |
| Tanga | 1,424,198 | 1,309 | 554 | - | 72 | 91 | 39 | - | 5 |
| Total | 25,906,411 | 17,223 (58%) | 11,541 (39%) | 586 (2%) | 111 (0.4%) | 66 | 44 | 2 | 0.4 |

Source: Ministry of Health