HEALTH CARE FINANCING STRATEGY OPTIONS PAPER:

OPTIONS FOR EXPANDING PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

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OPTIONS FOR EXPANDING PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

DISCLAIMER
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### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDO</td>
<td>Accredited drug dispensing outlets</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>APHFTA</td>
<td>Association of Private Health Facilities in Tanzania</td>
</tr>
<tr>
<td>BG</td>
<td>Block grant</td>
</tr>
<tr>
<td>CBO</td>
<td>Community based organization</td>
</tr>
<tr>
<td>CDH</td>
<td>Council-Designated Hospitals</td>
</tr>
<tr>
<td>CSR</td>
<td>Corporate social responsibility</td>
</tr>
<tr>
<td>CSSC</td>
<td>Christian Social Services Commission</td>
</tr>
<tr>
<td>CTI</td>
<td>Confederation of Tanzania Industries</td>
</tr>
<tr>
<td>DDH</td>
<td>District-Designated Hospitals</td>
</tr>
<tr>
<td>DED</td>
<td>District Executive Director</td>
</tr>
<tr>
<td>DHS</td>
<td>District Health Service</td>
</tr>
<tr>
<td>DPG</td>
<td>Development partners group</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith based organizations</td>
</tr>
<tr>
<td>FDI</td>
<td>Foreign direct investment</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GOT</td>
<td>Government of Tanzania</td>
</tr>
<tr>
<td>HFS</td>
<td>Health Financing Strategy</td>
</tr>
<tr>
<td>HSSP III</td>
<td>Health Sector Strategic Plan of 2009-2015</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Authorities</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MBP</td>
<td>Minimum benefits package</td>
</tr>
<tr>
<td>MKUKUTA</td>
<td>National Strategy for Growth and Poverty Reduction</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organizations</td>
</tr>
<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
</tr>
<tr>
<td>NPPPSC</td>
<td>National PPP Steering Committee</td>
</tr>
<tr>
<td>NSSF</td>
<td>National Social Security Fund</td>
</tr>
<tr>
<td>OOP</td>
<td>Out-of-pocket</td>
</tr>
<tr>
<td>PFP</td>
<td>Private for profit</td>
</tr>
<tr>
<td>PHSDP</td>
<td>Primary Health Services Development Program 2007-2017</td>
</tr>
<tr>
<td>PMO</td>
<td>Prime Minister’s Office</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
</tr>
<tr>
<td>PNFP</td>
<td>Private not for profit</td>
</tr>
<tr>
<td>PPP</td>
<td>Public private partnership</td>
</tr>
<tr>
<td>PPPSC</td>
<td>Public Private Partnership Steering Committee</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>PRINMAT</td>
<td>Private Nurses and Midwives Association of Tanzania</td>
</tr>
<tr>
<td>SHIB</td>
<td>Social Health Insurance Benefit</td>
</tr>
<tr>
<td>SHMH</td>
<td>Shree Hindu Mandal Hospital</td>
</tr>
<tr>
<td>SLA</td>
<td>Service level agreements</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TCCIA</td>
<td>Tanzania Chamber of Commerce, Industry and Agriculture</td>
</tr>
<tr>
<td>TIC</td>
<td>Tanzania Investment Center</td>
</tr>
<tr>
<td>TIKA</td>
<td>Tiba kwa Kadi</td>
</tr>
<tr>
<td>TNBC</td>
<td>Tanzania National Business Council</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>TPSF</td>
<td>Tanzania Private Sector Foundation</td>
</tr>
<tr>
<td>USD</td>
<td>United States Dollar</td>
</tr>
<tr>
<td>VfM</td>
<td>Value for money</td>
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EXECUTIVE SUMMARY

Tanzania has made rapid economic progress over the past decade, including sustained increases in GDP and foreign direct investment (FDI). However, Tanzania’s stronger economy has not translated directly into improved health outcomes for the average Tanzanian. While there have been improvements in the extension of HIV counseling and testing, reductions in malaria related child-mortality, and efforts to strengthen health service provision at the local level through decentralization of decision making to local government authorities (LGAs), a number of challenges continue to restrict the Government of Tanzania’s (GOT) response to national health threats such as HIV and AIDS, malaria, and persistently high maternal mortality. The GOT is therefore seeking ways to improve health financing and service provision efforts, and is in the process of developing a new Health Financing Strategy (HFS) to guide more efficient resource mobilization, allocation, and use in the health sector. Given that Tanzania already possesses a relatively well developed and diverse private health sector – broad in both clinical scope and geographic reach - there is significant potential to leverage the resources, skills and capacity of the private not-for-profit (PNFP) and private for profit (PFP) health sectors to this end. Over one-third of general health services in Tanzania can currently be accessed through private sector health facilities, and there is a wide range of existing and potential private sector contributions – both formal and informal- that could be employed to strengthen the multi-sectoral provision of essential health services to all Tanzanians.

In pursuing the more effective and efficient delivery of high quality health services for the benefit of all Tanzanians, the GOT has the opportunity to partner with the private sector (both in health and other sectors) in a number of ways. These partnership options will vary in terms of the cost of partnership, degree of private sector involvement, risk to both parties, and relative use of private and public financing. The private sector is often noted as a key stakeholder in Tanzania’s health and development goals, and the GOT has already developed a number of guiding health policies, strategies and legislation that support an increased private sector role in the health system through PPP or direct private sector investment. Despite a conducive private sector policy environment in the health sector, implementation of these policies and strategies face a number of challenges that have constrained the potential for public private collaboration in health. Some common challenges include:

- Private providers are undercapitalized and have limited access to finance, which restricts their ability to initiate partnership dialogue or make capital developments for expanded service provision.
- Limited public funds are already stretched to meet existing public demand, and the formula and regulations for the provision of donor basket funding to private sector subcontractors is unclear.
- Limited use and traction of public health insurance options has limited the number of private providers engaged in the provision of public health services.
- National PPP strategies and policies for health have not effectively trickled down to the local level.

Options to improve implementation of policies aimed at enhancing private sector contributions to health are presented in this paper; they include establishing and strengthening institutions and processes for PPP dialogue, involving the PMO-RALG in key MOHSW initiatives, strengthening the capacity of the MOHSW PPP unit and PPP-TWG, focusing efforts to improve communication of PPP strategies and priorities to all levels of the health system.
There are several options for the GOT to expand private sector contributions to the health system, whether for financing or strengthening service provision as part of the reformed HFS. Improving the structure, cost effectiveness, efficiency, and responsiveness of national and community public health insurance schemes can support the involvement of private health sector providers in the delivery of essential health services. This will most definitely be linked to other HFS reform options solicited by the Inter-ministerial Steering Committee (ISC), such as a minimum benefits package (MBP) or reform of National Health Insurance Fund (NHIF). Ensuring that public health sector insurance schemes are easy for providers and patients to access and use, as well as strengthening public health insurance components of PPP strategies, such as contracting-out or service level agreements (SLAs), can support provider sustainability through mixed revenue efforts, and can improve private sector access for the poor. In terms of facilitating partnerships, councils could examine possibilities of using a small percentage of their health block grants to complement public health service provision with private sector care at the local level depending on local priorities. As with donor basket funding, directing even a small percentage of health basket grants to private sector providers as part of performance based or capped reimbursement schemes could have an immediate impact on increasing the coverage of publically supported essential health services.

Successful private sector contributions to health, whether directly or through PPPs, often rely on investments to ensure they can deliver efficient and high quality services. The private health sector’s ability to access finance for capital investment is essential to its long-term sustainability, growth, and ability to contribute to the public good. While private provider access to credit has improved over time in Tanzania, there is still a significant need to increase private provider knowledge on access to finance and commodities, to sensitize financial institutions to small-scale and health sector lending, and to promote and potentially invest in private sector micro-credit mechanisms that are emerging in several private provider associations.

Corporate investments in health can also play a significant role in improving Tanzania’s health system. Employers and owners in the private sector have a considerable responsibility and fiscal interest to contribute to health in the workplace; employers face growing economic losses due to workplace injury, lost productivity to illness and mortality, and employee training and replacement costs. Financial investments to expand health coverage or promote wellness and prevention offer potential to improve employee health and improve corporate productivity. Corporate investments in health can also expand the fiscal space for financing health services and thereby reduce the public sector burden, which currently accounts for the majority of total health spending. Private sector contributions to health financing may allow public funds to be directed to other priority health areas.

SLAs represent one of the primary mechanisms through which PPPs in Tanzanian health have been attempted. The SLA structure in Tanzania was developed in 2007/08 so that management contracts, designated council and district hospital agreements and other private health sector engagement for service provision could be standardized and improved. In theory, these agreements should strengthen coordination and collaboration between public and private actors, but in practice, are much more difficult to implement due to the broad and unpredictable nature of health service provision. There are several ways in which the GOT can intervene to strengthen the SLA structure at all stages of the contracting-out life cycle. For example, improvements in the contract provisions of staff and commodity access, clarification and improvement of reimbursement mechanisms and flow of funds, and reducing or eliminating delays in payment will all significantly improve the application and outcome of SLAs in Tanzania. In addition, formal SLAs may not be necessary for all public private engagement, and simple service contracts should be explored as part of a maturing and refined SLA and contracting-out approach at the local level, depending on the context and need.
Several overarching challenges related to quality, equity, public capacity to regulate, value for money (VfM) and the complexity of many PPP approaches have all impacted the outcomes of existing SLAs and PPPs. As LGA leaders become more familiar with PPP mechanisms and options, experiential evidence and knowledge exchange at all levels of the health system could lead to more sophisticated, cost-effective, and impactful PPPs for health. Learning from existing challenges related to the financing of PPPs will also assist in improving the VfM of future PPP efforts in the health sector.

In addition to the sources of investment for in health, there are a number of ways in which direct private sector investment of finance or capacity can improve health service provision in Tanzania. Private sector investments in human resources for health (HRH) through private medical training institutes, continuing professional development, or knowledge exchange can all improve the capacity and number of trained health personnel in Tanzania. In addition, the use of leasing, affermage or concessions could mobilize private sector investments into improving health infrastructure – particularly in the case of under-utilized public dispensaries and clinical space. Efforts to pursue a public-private service mix – such as the colocation of public and private care at the same public facility – can also be an effective strategy in retaining private talent in the public system, while subsidizing the improvement of public care through the provision of private fee-for service at the same location. Such efforts have ethical and operational considerations that must be carefully addressed as part of public private mix (PPM) project design. However they can be extremely effective in mitigating the negative impacts of provider dual practice and providing a sustainable source of private revenue to support on-going improvements of public care.

In summary, there are a number of options the GOT can pursue in strengthening private sector contributions towards Tanzania’s health system. These efforts all require effective planning, open and transparent multi-sectoral dialogue, and careful monitoring of impacts and outcomes. The conducive national policy environment in Tanzania’s health sector has set a stage for improved public-private partnerships as well as private investments in health to expand fiscal space and enhance service delivery. However, there is a need for continual development of LGAs’ capacity to engage with the private sector, and the need to develop ever more sophisticated and mature mechanisms to finance investments for improved service delivery in health. In terms of PPPs for health, Tanzania is a regional leader, with existing expertise and experience that can be drawn upon as part of the HFS reform. This paper presents various options and considerations on PPPs as well as broader private sector investments, as well as seeks to provide the GOT with strategies to improve the utility, cost-effectiveness, and resource mobilization of public funds for private health sector engagement. Through effective dialogue, a commitment to mutual benefit, an improved understanding of PPP mechanisms and careful application with effective monitoring the GOT can significantly improve health outcomes as part of the reformed HFS.
I. INTRODUCTION

Rapid economic growth over the past decade – thanks to focused political leadership and increasing multinational investment in a diverse range of local industry – has propelled Tanzania to the status of one of East and sub-Saharan Africa’s fastest growing economies. Between 2006 and 2011, total gross domestic product (GDP) increased from 14.4 to 23.87 Billion USD, with a five-year average real GDP growth rate of 6.9 percent. An attractive investment climate and high confidence among foreign investors has Tanzania attracting almost 47 percent of all foreign direct investment (FDI) inflows in the five East African countries (Mnali 2012).

This rapid progress has yet to translate into significant change for the average Tanzanian, or to reduce health system reliance on international donor support. In the health sector, there have been significant gains in increasing the number of people tested and treated for HIV and AIDS, and joint-venture malaria control and treatment programs have significantly reduced malaria related child mortality. Still, nearly 460 mothers out of every 100,000 die during childbirth and the country faces an adult HIV prevalence rate of 5.8 percent (15-49 years) with an estimated 105,000 new infections every year (World Bank 2010). Malaria morbidity and mortality alone cost Tanzania an estimated $240 million USD every year in lost GDP (Makundi et al. 2007).

As outlined in the Terms of Reference (TOR) for this paper, overall domestic spending in health will need to increase to finance a minimum benefits package (MBP) of essential health services, reformed public health insurance scheme or other mechanism to extend the reach of public health services. Given the scope of the health challenges facing Tanzania and the growing number of private partners who share an interest in preserving public health, it is unreasonable to expect the public health sector to shoulder this burden alone. New strategies are needed that leverage the technical and financial assets of the private sector. This entails effective public-private partnerships (PPP) that improve health financing mechanisms and expands existing private health sector clinical capacity to strengthen services. Beyond PPPs, solutions to encourage greater private corporate investment in health are also essential for the sustainability and growth of Tanzania’s health system. The Government of Tanzania (GOT) has recognized this in the Health Sector Strategic Plan III 2009-2015, highlighting the role of PPPs and other private sector mechanisms in achieving health sector goals (MoHSW 2009).

To this end, with oversight from the Inter-Ministerial Steering Committee (ISC), the GOT is in the process of developing a new Health Financing Strategy (HFS) to guide more efficient resource mobilization, allocation, and use in the health sector. This strategy will require options that address user fees and equity, accountability and transparency through effective regulation, quality and VfM. To analyze Tanzania’s most pertinent health financing issues, the ISC has identified key areas for reform and commissioned nine studies to inform the HFS. One of these studies is to develop options for expanding private sector contributions to health, whether through corporate investments or the financing of PPPs to impact service provision. This paper attempts to fulfill this objective and the scope of work, as outlined in the TOR (Annex 1).
1.1 THE PRIVATE HEALTH SECTOR IN TANZANIA

A wide range of facilities managed by the private health sector are making significant contributions to health service provision in Tanzania. The Tanzanian private health sector is diverse, broad in both clinical scope and geographic reach, and involves a wide range of actors from a number of health cadres, sectors and industries. It includes a wide range of faith-based (FBO) and private not-for-profit organizations (PFNPs), a robust and growing private for-profit (PFP) sector, and a number of community based organizations (CBOs) engaged in outreach and home-based care.

In order to inform effective public private collaboration, this section provides a brief overview of the private health sector stakeholders active in Tanzania’s health system.

Figure 1: Public and private health facilities by District Health Service (DHS) zone

MoHSW 2012

As Figure 1 demonstrates, public sector facilities outnumber PNFP and PFP facilities across all seven DHS zones, with the largest number of health facilities concentrated in the Northern and Eastern Zones. The Southern and Central Zones contain the least number of facilities. The most populous zones – Lake and Western – have fewer health facilities, public or private, than other zones with fewer inhabitants.
The private health sector is present in all seven zones of mainland Tanzania, including remote and rural areas. In some geographic areas, the private sector (PFP and PNFP) is the principal supplier of health services. For example, a reported 11 of 63 health facilities in Moshi municipal council are operated by the government, leaving more than 82 percent of council health services provided by FBOs and some for-profit health facilities. The PNFP sector – mainly FBOs – operates in both rural and urban areas; it has an equally strong presence in rural areas as the public facilities. For instance, in the Central Zone there are nine PNFP hospitals compared to eight public hospitals (MOHSW 2012). In the Lake Zone there are 21 PNFP hospitals and 15 public, and in the Southern Highland Zone there are 17 PNFP hospitals and 15 public (MOHSW 2012). In several cases, the PNFP sector has more hospitals in rural areas than does the public sector. In many of these rural or hard to reach areas, public sector service level agreements (SLAs) with FBO operated council and district designated hospitals have been critical in extending the reach of government health services into rural and hard-to-reach areas. Figure 1 also demonstrates that the public sector operates more health clinics and dispensaries overall than do the PNFP and PFP sectors, individually or combined.

As indicated in Table 1 below, of the estimated 6,342 health facilities operating in Tanzania, 1,924 are run by parastatal, PFP, or PNFP organizations – meaning that over one-third of general health services in the country can be accessed through private sector health facilities (MOHSW 2012).

**Table 1: Total number of health facilities in Tanzania**

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Government</th>
<th>Parastatal</th>
<th>PNFP</th>
<th>PFP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>95</td>
<td>8</td>
<td>101</td>
<td>36</td>
<td>240</td>
</tr>
<tr>
<td>Health Centers</td>
<td>434</td>
<td>10</td>
<td>134</td>
<td>55</td>
<td>633</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>3889</td>
<td>168</td>
<td>625</td>
<td>787</td>
<td>5469</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4418</strong></td>
<td><strong>186</strong></td>
<td><strong>860</strong></td>
<td><strong>878</strong></td>
<td><strong>6342</strong></td>
</tr>
<tr>
<td><strong>Percent of Total</strong></td>
<td><strong>69.7%</strong></td>
<td><strong>2.9%</strong></td>
<td><strong>13.6%</strong></td>
<td><strong>13.8%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Source: MOHSW 2012

Barriers of mistrust between the sectors persist over consistency of healthcare quality and regulation, pricing schemes and equity of access. However, both the PNFP and PFP health sectors have been critical in extending the availability of general curative, diagnostic, and specialized care in Tanzania. As per the TOR for this paper, the private sector presents important sources of healthcare knowledge and capacity, including financial and human resources that can supplement public efforts.

### 1.1.1 THE PRIVATE NOT-FOR-PROFIT SECTOR (PNFP)

The PNFP sector is the second largest system offering healthcare and support services in Tanzania. The PNFP sector includes faith-based organizations, charitable not-for-profit organizations, non-governmental organizations (NGOs), and CBOs.

**Faith Based Organizations**

The Christian Social Services Commission (CSSC) is the largest FBO coordinating body in Tanzania, which comprises 15 national churches and 14 para-church organizations and ministries. CSSC members participate in MOHSW policy and planning initiatives at the central and regional levels. CSSC member facilities are a principal source of preventive and curative health services in Tanzania – particularly at the health system district level and above, and in rural areas beyond the reach of public facilities.
The CSSC’s five zonal offices have national reach, linking individual owners of faith-based health facilities with local government. CSSC currently administers 897 facilities run by member churches.

An identified group of CSSC facilities, known as Council- or District-Designated Hospitals (CDH/DDHs), also serve to cover areas where there is no public facility in 34 districts. As government partners, CSSC facilities receive financial grants from MOHSW basket funding (excluding salaries or capital development) and share staff through personal emoluments or staff seconded but paid for from MOHSW coffers. The vast majority of FBO facilities are financed by user fees, as well as through international and local donors, income generation projects, and/or NHIF.

While CSSC represents the largest collective group of FBOs, there are a number of other faith-based associations and networks of clinics, such as BAKWATA and others that operate groups of dispensaries, health facilities, and/or larger hospitals. Shree Hindu Mandal Hospital (SHMH) and the larger SHM range of community education and social welfare projects represent one such network.

Community Based Organizations
CBOs typically provide a specific package of services related to a focal health area. For example, the Private Nurses and Midwives Association of Tanzania (PRINMAT) operates a network of maternity homes delivering key family planning, antenatal care (ANC), and delivery/post-natal reproductive and child health (RCH) services. They are also increasingly becoming involved in national nursing efforts to prevent mother to child transmission (PMTCT) of HIV. Other examples of CBOs active in Tanzania include:

- Pathfinder International's network of community-based family planning and reproductive health services.
- PATH's integrated TB/HIV work at the community level.
- Population Services International's Familia program, focused on extending community-based access to affordable contraceptive commodities.
- Marie Stopes/Tanzania delivering family planning and other essential RCH services.

In addition to delivering health services in both urban and rural areas, CBOs play an important role in the provision of non-clinical health and social services, such as health education, policy research, and advocacy.

1.1.2 THE PRIVATE FOR PROFIT (PFP) SECTOR
One can characterize the PFP sector as predominately solo practitioners working in health clinics and dispensaries, with a wide range and scope of clinical services offered, and varied staff and inpatient bed numbers. As indicated by Figure 1 they are located mostly in major urban areas such as Dar es Salaam, Arusha, Mwanza and their outlying areas where income levels and population concentration can produce adequate patient volumes to sustain operation. In the Eastern Zone, the PNFP and PFP show numbers of health facilities (of all types) comparable to the public sector, underscoring the larger issue of health facility overconcentration in Dar es Salaam and its suburbs: hospitals (19 public and 33 private), health clinics (51 public and 37 private), and dispensaries (552 public and 522 private).

PFP Health Sector Service Delivery
In addition to solo practice, the PFP health sector in Tanzania is comprised of a number of PFP hospitals and referral clinics. In the Eastern Zone for instance, there are more PFP hospitals than public and PNFP hospitals combined. Although the PFP sector is mainly concentrated in urban areas, there are PFP
hospitals in predominantly rural areas as well, such as the Western and Lake Zones, although none in the Southern or Central Zones.

According to the Association of Private Health Facilities in Tanzania (APHFTA), there are approximately 878 PFP facilities in mainland Tanzania offering limited or wide-ranging curative or specialist health services. This includes 36 hospitals, 55 health centers, and 787 dispensaries. The PFP sector is providing approximately 15 percent of hospital services in the country (MOHSW 2012), and is an important source of clinical support services, such as radiology and laboratory diagnostic services.

**Medical Products and Technology**
The PFP sector is also heavily active in the field of medical technologies, equipment, and products, including a large number of wholesalers and distributors that supply retail pharmacies as well as accredited drug dispensing outlets (ADDOs) and FBO/NGO facilities in remote areas of mainland Tanzania.

**Human Resources for Health (HRH)**
The private sector employs a significant number of doctors, nurses, and pharmacists, indicating possibilities for the MOHSW to leverage PFP sector staff and expertise to address some of the coverage gaps in the public system. The PFP sector also contributes to the production of HRH, albeit with only three Private Medical Training Institutes (PMTI).

**Private Health Financing and Corporate Social Responsibility (CSR)**
Private financing is a major contributor to total financing of health services in Tanzania, mostly through individual out-of-pocket (OOP) payments. However, most agree that OOP expenditures (i.e., user or consultation fees) are not the most equitable or effective way to finance health or achieve better health outcomes. To address these system gaps, the government, as part of the new HFS process, is exploring reforms and strengthening of NHIF and CHF (public health insurance schemes) that allow for more private commercial providers to deliver a minimum benefit package of publicly financed health services to all Tanzanians. Moreover, there exists an array of private health insurance options, although still limited, used primarily by large public and private employers as an employee benefit.

### 1.2 OVERVIEW OF REPORT CHAPTERS

Following the introduction, this report begins by outlining methodology used in this paper and defining PPP in the Tanzanian context (Section 2). Section 3 presents the policy landscape, the factors and guiding documents contributing to an enabling environment for PPPs, as well as the policy and institutional challenges facing the implementation of private sector initiatives. Section 4 presents several mechanisms to finance PPPs by source – namely public, private and donor investments. For each source of financing, the manner in which these options develop differs according to the various challenges and opportunities tied to the flow of funds or partnership structure. Section 5 presents options for expanding fiscal space in the private sector, specifically regarding access to finance and corporate contributions to health. Section 6 presents means by which government can contract with private health providers through Service Level Agreements. Section 7 discusses private sector investments in human resources and health infrastructure. In this section, options are presented on (a) private sector investments in human resources, (b) co-location PPPs for health, and (c) leasing and affermage agreements for public health facilities. Various cases studies and examples are presented in Sections 5 through 7 to illustrate and support the options presented. In Section 8 and 9, challenges across all private options are considered along with considerations for effective monitoring and evaluation of such
options. Sections 10 and 11 summarize the primary options for expanding the private sector’s role in health, to discuss recommendations on mechanisms by which to finance and implement these options, and general conclusions.


2. METHODOLOGY

As per the TOR, the consultants conducted a review of all relevant documents related to health financing in Tanzania. For information that was not captured in already published reports, the consultants conducted interviews with public and private sector officials to inform the PPP and private sector options recommended. This data collection was conducted with the aim of reviewing best practices on expanding private sector contributions to health and using lessons learned to inform options for Tanzania’s HFS.

2.1 OBJECTIVES AND SCOPE

As outlined by the TOR (Annex 1), the overall objective of this paper is:

…to develop comprehensive, adequate and feasible reform strategies / options for financing public-private partnerships in health and social welfare that are effective, efficient, reliable, affordable, and equitable. The strategies/options will be presented to the ISC for feeding into the Tanzanian HFS (MoHSW 2012).

The specific objectives and tasks of this policy option paper include:

1. Assessing the availability and adequacy of financing products currently available for private sector expansion or PPP projects.
2. Assessing the role of private investment in health sector development.
3. Analyzing investments made in the private health sector to identify challenges, bottlenecks, and main factors for making investment decisions.
4. Assessing the use of SLAs as a payment mechanism for contracted services.
5. Identifying opportunities and challenges in developing a regulatory and institutional framework for the effective and efficient use of private sector resources, with specific emphasis on PPPs.
6. Assessing the use of different options of public contracting modalities with the private sector.
7. Discuss the monitoring and evaluation of options for expanding private sector contributions to health.
8. As a primary deliverable, this paper provides to the ISC, MOHSW and GOT with summary recommendations/options for private sector reforms, both PPP and corporate financial investments, that can be easily included in the HFS, and that aim to provide high quality and cost effective solutions in improving the health and welfare of all Tanzanians.

The options and recommendations explored in this paper are meant to serve as opportunities for further exploration by the ISC in development of the HFS. As the ViM measurement of private sector initiatives is highly subjective to partners involved, desired outcomes and judgments of value outside of costs, more rigorous analysis on the cost-effectiveness and impact of particular options is encouraged prior to or as part of policy implementation.
2.2 DEFINING PPPS FOR HEALTH IN TANZANIA

This paper uses a broad definition of PPP as provided by Tanzania’s Health Sector Strategic Plan III 2009–2015 (HSSP III); which states:

*PPPs in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public.*

Such a definition allows for a wide exploration of diverse options for financing of PPP to improve health service delivery—both formal and informal—that are resourced and delivered through a number of mechanisms largely determined by context, the partners involved, the scope of desired outcomes, and the structure of the agreement itself. For this options paper, the definition of the private health sector includes the broad categories of: FBOs and NGOs operating as PNFP; the PFP sector; and civil society and CBOs engaged in outreach and advocacy.

In pursuing the more effective and efficient delivery of high quality health services for the benefit of all Tanzanians, the GOT may choose to partner with the private sector (both in health and otherwise) in a number of ways. These options will vary in the cost of partnership, degree of private sector involvement, risk to both parties, and relative use of private and public financing.

PPPs should not, however, be confused with private sector investments in health. The latter will be explored in Section 5 and 7; they will focus on means by which the private sector can independently expand fiscal space for health or invest in Tanzania’s health delivery system. Such initiatives and options are not PPPs by definition, though they aim to achieve similar goals – notably expanding private sector involvement in the acquisition and utilization of resources for health.
3. THE POLICY LANDSCAPE FOR PPPS

This section presents an overview the policies in Tanzania designed to cultivate and regulate the growth of PPPs. Section 3.1 summarizes the various high level policies in place that have implications for the role of the private sector in the health system. Section 3.2 provides an overview of the institutional arrangements that govern how PPPs are created and regulated after they have been implemented. Section 3.3 presents key challenges hindering the policy landscape for PPPs and Section 3.4 presents recommendations for overcoming those challenges.

3.1 POLICY AND ENABLING ENVIRONMENT TO MOBILIZE THE PRIVATE SECTOR IN HEALTH

The main policies at the national level that recognize and support the role of the private sector in the country’s socio-economic development are: the National Development Vision 2025, the National Strategy for Growth and Poverty Reduction (MKUKUTA), and the Five Year Development Plan. Table 2 summarizes how these policies reference the role of the private sector in health care delivery in Tanzania.

Table 2: Private sector references in Tanzania’s economic development policies

<table>
<thead>
<tr>
<th>Description</th>
<th>Key issues referenced to the private sector</th>
</tr>
</thead>
</table>
| The National Development Vision 2025 | • Encourages the private sector to undertake investments in socio-economic goods and services.  
• Recognizes that high quality livelihood for all Tanzanians can only be achieved through public and private health interventions. |
| National Strategy for Growth and Poverty Reduction (MKUKUTA) | • Recognizes the health sector as a key factor in economic development with the ultimate goal of achieving improved quality of life and social wellbeing through increased private participation in social-economic activities.  
Directs all ministries, departments and agencies to promote PPPs in the implementation of projects and programs. |
| Tanzania Five Year Development Plan 2011/12 -2015/16 | • Requires implementing government organizations to fast track realization of Vision 2025.  
• Supports the creation of an enabling environment for the private sector to invest and participate in a wide range of business opportunities. |
The private sector is often noted as a key stakeholder in Tanzania’s health development goals. The health policies, strategies and legislation that support an increased private sector role in the health sector are outlined in Table 3.

**Table 3: Tanzanian health policies supporting increased private sector role**

<table>
<thead>
<tr>
<th>Description</th>
<th>Key issues referenced to the private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Policy 2007</td>
<td>• PPP projects are to be promoted for the delivery of reliable and affordable socio-economic services.</td>
</tr>
</tbody>
</table>
| Health Sector Strategic Plan III (2009–2015) | • PPPs are important for achieving health goals.  
• PPP forums will be installed at national, regional, and district levels.  
• All local government authorities will use SLAs to contract private providers for service delivery.  
• Private training institutions will be increasingly involved in HRH. |
| Primary Health Services Development Program - 2007-2017 (PHSDP) or MMAM | • Foster private sector participation at district level to improve service delivery and health infrastructure.  
• Develop PPP mechanisms for joint planning, training and capacity building.  
• Strengthen district PPP forums.  
• Support and ensure effective and better performance of SLA.  
• Support establishment of private health service providers. |
| The Second National Multi-Sectoral Strategic Framework on HIV and AIDS (2008–2012) | • Provide financial, human, and technical resources for the implementation of the HIV national response and combined, coordinated, and sustained efforts by the GOT, the private sector, and donors. |
| The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania (2008–2015) | • Foster partnership to implement promising interventions among the government (as lead), development partners, the private sector, and other stakeholders engaged in joint programming and co-funding of activities and technical reviews. |
| Human Resources for Health Strategic Plan (2003-2013): | • Guides the health and social welfare sector in efficient planning, development, management and utilization of HRH. |
Table 4 summarizes the policy and enabling environment for implementation of all types of PPP arrangements in Tanzania.

Table 4: Policy environment for PPPs

<table>
<thead>
<tr>
<th>Description</th>
<th>Key issues referenced to the private sector</th>
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</thead>
<tbody>
<tr>
<td>PPP policy, November 2009</td>
<td>• Confirms government commitment to collaborate with the private sector.</td>
</tr>
<tr>
<td></td>
<td>• Provides regulations and implementation framework of PPPs.</td>
</tr>
<tr>
<td></td>
<td>• Provides guidance on PPP involvement in health financing.</td>
</tr>
<tr>
<td></td>
<td>• Acknowledges PPPs as efficient vehicle for improving health service delivery in the country.</td>
</tr>
<tr>
<td>PPP Act 2010</td>
<td>• Identification of PPP projects.</td>
</tr>
<tr>
<td></td>
<td>• Feasibility and pre-identified and unsolicited PPP projects.</td>
</tr>
<tr>
<td></td>
<td>• Selection and tender issues.</td>
</tr>
<tr>
<td></td>
<td>• Contractual issues.</td>
</tr>
<tr>
<td></td>
<td>• Assessment and registration of PPPs.</td>
</tr>
<tr>
<td></td>
<td>• Financial guidance.</td>
</tr>
<tr>
<td></td>
<td>• Procurement process.</td>
</tr>
<tr>
<td></td>
<td>• Arbitration and related matters.</td>
</tr>
<tr>
<td>PPP Strategic Plan 2010-2015</td>
<td>• Ensure PPPs are being used in all relevant national strategies at all levels through advocacy, lobbying,</td>
</tr>
<tr>
<td></td>
<td>studies, capacity building, fund mobilization and monitoring and evaluation.</td>
</tr>
<tr>
<td></td>
<td>• Ensure conducive policy and legal environment for operationalization of PPP.</td>
</tr>
<tr>
<td></td>
<td>• Ensure effective operationalization of PPP.</td>
</tr>
<tr>
<td></td>
<td>• Enhance PPP in provision of health and nutrition services.</td>
</tr>
<tr>
<td></td>
<td>• Establishes a PPP Steering Committee at national level.</td>
</tr>
<tr>
<td></td>
<td>• Appoints PPP coordinators in the regions.</td>
</tr>
<tr>
<td></td>
<td>• Supports PPP policy forums.</td>
</tr>
</tbody>
</table>

The implementation of the policies and strategies presented in the preceding tables is facing a number of challenges. Private providers are undercapitalized and have limited access to finance, which restricts their ability to initiate partnership dialogue or make capital developments for expanded service provision. Limited public funds are already stretched to meet existing public demand, and the formula and regulations for the provision of donor basket funding to private sector subcontractors is unclear. In addition, limited use and traction of public health insurance options has limited the number of private providers engaged in the provision of public health services. While challenges, these are significant areas of opportunity to bear in mind in relation to the HFS reform.
3.2 REGULATORY AND INSTITUTIONAL FRAMEWORK FOR EFFECTIVE AND EFFICIENT USE OF PPP IN HEALTH

PPP implementation takes place within the overall institutional support structures for Tanzania’s private sector. Important in this regard are public institutions, such as the PPP Coordination Unit under the Tanzania Investment Centre (TIC), and the PPP Finance Unit at the Ministry of Finance (MoF). Private sector organizations that actively support PPPs include the Tanzania Private Sector Foundation (TPSF), Tanzania Chamber of Commerce, Industry and Agriculture (TCCIA), the Confederation of Tanzania Industries (CTI), and the Tanzania National Business Council (TNBC). Development Partners also actively support PPPs in their respective projects and programs and have formed the Development Partners Group (DPG) to harmonize and coordinate policy dialogue in the management and administration of aid in Tanzania.
Figure 2 presents a summary of the various public and private stakeholders for health according to the various levels of the health system.

**Figure 2: Mapping of Public and Private Stakeholders for Health by Level**

- **National**
  - Representatives of FBO, Professional Associations, Private Health Insurance, Private Health Companies, NGO, CSO and all others
  - National PPP Health Forum
  - PPP Office MoHSW
  - PPP Office PMORALG
  - Health Insurance Funds

- **Regional**
  - Representatives of Private
  - Regional PPP Health Forums
  - PPP Regional Authorities

- **Council**
  - Representatives of Private
  - Council PPP Health Forums
  - PPP LGAs Authorities

- **Village**
  - Community/NGO All other Private
  - Community PPP Health Forums
  - PPP Village Authorities

MoHSW 2011

The stakeholders above are governed by institutional structures that facilitate the implementation of effective and efficient PPPs in health. Figure 3 illustrates the external relationships between the MOHSW and other government agencies as well as the internal relationships.
The Prime Ministers’ Office (PMO), through TIC and MoF, oversees all PPPs in Tanzania. TIC recently established a PPP Coordinating Unit to perform an advisory role for all ministries including health. This unit is available to assist the MOHSW established PPP Unit that is responsible to oversee and coordinate all ministerial activities relating to PPPs in health. In addition to advice, the PPP Coordinating Unit performs technical review and oversight. Once the MOHSW PPP Unit has structured a PPP deal and it has been approved by the ministry leadership, the MOHSW PPP Unit must submit all PPP proposals to the PPP Coordinating Unit. The PPP Coordinating Unit analyzes the PPP proposal to ensure that it is technically sound and compliant with the law and guidelines. It is important to note that the PPP Coordinating Unit does not have the authority to reject a PPP proposal. Its role is strictly advisory, and it can only make recommendations on strengthening the proposal and on whether to proceed with the PPP. The MOHSW PPP Unit must also submit all PPP proposals to the MoF. The MoF performs fiduciary oversight and focuses on risk, finances, and due diligence. Even though some of the PPPs may not require government financing, each and every one must be submitted to the MoF for review. As noted, the PPP Guidelines are currently in review, and many of these process details are under discussion.

3.2.1 REGULATORY FRAMEWORK OVERSEEING PPP AT LOCAL AND NATIONAL LEVELS

Tanzania has a large number of regulatory stipulations and guidance on private sector engagement as outlined in Annex 2. Overall, the regulatory framework is exemplified by the Public Private Partnership Act (2010) and the accompanying Public Private Partnership Regulations of 2011, which encourage review of existing legislations, and adoption of new or reformed regulations and operational guidelines. The existing legal documents provide the institutional and judicial framework for the implementation of PPP agreements in Tanzania’s health system. They also set rules, guidelines and procedures governing PPP procurement, development and implementation.
The PPP Act defines contracting authority as any ministry, government department or agency, LGA or statutory corporation. At the national level, this would most often be the Permanent Secretary for the MOHSW. However, at the LGA level, the contracting authority would most often be the District Executive Director (DED), bringing the function under the scope of PMO-RALG. The MOHSW PPP Unit is responsible for identifying, structuring, vetting, financing, and monitoring PPPs. It is important to note that the MOHSW is one of the first ministries to establish a PPP Unit (others include Finance, Agriculture, and Transportation). Based on history, the MOHSW PPP Unit resides within the Department of Curative Services (DCS) as the first formalized PPP arrangements were for the delivery of hospital based services. MOHSW leadership is discussing moving the PPP Unit to the Department of Policy and Planning, which is a more common location for health PPP Units.

The MOHSW PPP Unit is small, yet has major responsibilities. Currently the PPP Unit has only one staff person, supplemented by DANIDA's long-term resident adviser, and has minimal resources to hire short-term consultants to help with its scope. The Unit's primary roles and responsibilities include:

1. Provide advice on strategic use of PPPs;
2. Raise awareness on and advocate for PPPs in health; and
3. Assist MOHSW departments to implement PPPs.

The Health PPP Strategy plans to create regional capacity in PPPs by assigning a PPP focal person, first at the regional level and eventually at the council level. When this strategy is in place, the PPP focal person will be responsible for identifying, negotiating, designing, vetting, and implementing (including monitoring and evaluating) the health PPPs, with help from the PPP Unit. In addition to providing these advisory services to MOHSW staff, the PPP Desk Officer is also responsible for managing the health PPPs through the approval processes with the MoF and for coordinating with the PPP Coordinator at the TIC.

### 3.2.2 FORUMS FOR PUBLIC-PRIVATE SECTOR

There are three main forums that focus on public-private sector dialogue. The purpose of these forums is to promote the development of public-private collaboration in health by reaching as many stakeholders as possible. The forums also ensure private health providers have a voice in all health related issues. In addition, the forums have been instrumental in fostering implementation of the PPP policy and legislation. These forums are:

1. **The National PPP Steering Committee (NPPSNC).** Active since 2004, the NPPSNC played an integral role in several initiatives, such as incorporating private sector perspective into HSSP III, developing and pioneering the SLA, and drafting the first-ever Strategic Health PPP Plan in 2009. Since then, the PPP-TWG has taken a greater lead in drafting its own terms of reference and identifying the 20 participating stakeholder groups to promote dialogue and development of public-private collaboration in health.
2. **The TC-SWAp.** The TC-SWAp is the comprehensive government-development partner coordination mechanism. The Permanent Secretary for Health and the leader of the Donor Group co-lead the TC-SWAp process. The TC-SWAp sets the agenda and direction for the annual work plan between donor partners and the government. There are 11 technical working groups (TWGs) formed around the priority areas identified by the Permanent Secretary. The TWGs draft annual work plans with specific targeted results and are obligated to report twice a year on progress towards achieving the established milestones.
3. **The PPP-TWG.** The 2009 Health Sector Review discussed the possibility of establishing more health PPPs to address service delivery gaps and recommended forming a coordinating body between the public and private sectors. In response, the TC-SWAp created the PPP-TWG in 2010. The PPP-TWG deals with national PPP issues and processes as they relate to health. In addition, sector guidelines are being aligned with the national PPP policy framework as the MoHSW drafts procedures for the establishment, implementation, coordination, mobilization, mainstreaming and monitoring and evaluation of PPPs within existing laws and policies. There are 12 members. The MoHSW PPP designated officer, with assistance from the private sector, chairs the PPP-TWG. PNFP and PFP organizations actively participate, including APHFTA, BAKWATA, CSSC, and TPHA. Development partners who support the private sector, such as DANIDA, GIZ, and USAID (representing the DPG for Health) are also very active.

These forums allow for public and private stakeholders to initiate in dialog and planning as it relates to the development of inclusive policies, allocation of funds and investments, as well as the design of actual partnership agreements.

### 3.3 CHALLENGES FACING PPP POLICIES AND INSTITUTIONAL ARRANGEMENTS

Through strong leadership and the prioritization of PPP as an area of exploration in health reform, Tanzania has developed a strong regulatory and institutional basis for effective and efficient use of PPPs in health. However, the well-recognized challenge of translating policy in action continues to limit attempts at operationalizing PPPs for health at the local level and disseminating lessons learned:

1. **Lack of PPP knowledge and practice in health PPPs at the community level - where impact could potentially be greatest.** While the impact of PPPs for health is still very much in discussion, almost all can agree that effective PPPs have been context specific, built on mutual trust, and consistent with local health planning and priorities. As such, the PPP Unit relies on the regional and county units to propose PPP opportunities. However, PPPs are not included in CHMT’s scope of work and routine activities. As a result, these units do not actively involve private sector stakeholders, particularly PFP stakeholders, to participate in policy and planning. If private actors are invited to a meeting, it has historically been done in a way that makes it difficult for them to actively participate and contribute to planning. Moreover, there is still considerable confusion on whether basket funds can be used for PPP with PFP partners.

2. **Key segments of the private sector are under-represented in health policy and planning at the local level.** The diversity of the PNFP, PFP, insurance and corporate sectors, along with the sense that NGO’s and for-profit entities operate outside the MOHSW’s capacity of jurisdiction, makes it so that umbrella organizations in the PNFP and PFP sectors cannot adequately represent the diversity of private sector providers, employers and investors. While there are several public and private professional health associations, there has been no formal umbrella body for joint HRH activities. There are over 26 associations representing a wide range of health cadres such as the Medical Association of Tanzania (MAT), the private nurses and midwives association of Tanzania (PRINMAT), and the Medical Laboratory Scientists Associations of Tanzania (MeLSAT). Interviewees from these associations expressed a keen desire to be more formally involved in policy and planning, but observed that there is no easily accessible forum or mechanism for dialogue with the various bodies of MOHSW. More inclusive involvement of insurers and employers from a number of private sector industries would also assist in diversifying health sector investments.
3. **The PPP Unit is insufficiently resourced to maximize potential of PPPs for health.**

The PPP Unit receives a modest budget from the MOHSW, supplemented by donor funds. The budget covers the salary for one full-time person, and a full-time resident adviser is sponsored by DANIDA. As a result of the limited resources:

- **The PPP Unit is missing basic tools and systems.** Other African PPP Units have simple instruments to guide the PPP Unit’s operations, such as terms of reference, a working definition of health PPPs to fit the national context, job descriptions for PPP Unit staff at the central and regional level, and an organization chart explicitly linking the PPP Unit to other government agencies and establishing lines of authority and communication between the Central PPP Unit and the PPP Focal Persons.

- **The PPP Unit staff require new skills and competencies such as health economics, financing, contract law, dialogue and facilitation, and program management.** The MOHSW capacity in these areas resides in the Department of Policy and Planning, and the PPP Unit has difficulty tapping these resources given its current location in Curative and Hospital Services.

These challenges are not insurmountable. The following section presents key recommendations for addressing these challenges in order to strengthen the PPPs policy landscape.

### 3.4 OPTIONS FOR STRENGTHENING THE PPP POLICY LANDSCAPE

Tanzania’s new HFS can participate in addressing these challenges by strengthening the regulatory and institutional framework for implementation of PPPs in health in the following ways, as stated in Tanzania’s 2013 Private Health Sector Assessment (White et al. 2013):

1. **Establish and strengthen institutions and processes for effective public-private dialogue.** In the case of the public sector, the government needs to invest in building the systems and capacity of the PPP Unit. The private sector, on the other hand, needs to create new structures that represent key sub-groups. Finally, the National PPP Steering Committee should transform to operate at a sector-wide level.

2. **Involve the PMO-RALG actively and systematically in key MOHSW functions and processes.** This will help strengthen the relationship and improve coordination between policy and implementation of health services. The PPP Unit can work more closely with PMO-RALG to ensure that the guidelines include other key stakeholders in health, such as the private sector.

3. **Strengthen MOHSW PPP Unit and PPP-TWG capacity.** The MOHSW has put into place a comprehensive policy framework supporting PPPs in the health sector, but it has been slow to develop a substantial number and broad range of health PPPs. The primary constraint is the PPP Unit’s limited capacity. MOHSW and donors should fully invest in the health PPP Unit in the following areas: 1) increasing the number of PPP Unit staff; 2) training a core group in new skills; 3) standardizing operating systems to build, track, and assess PPPs; 4) training central- and regional-level staff in new operating systems; and 5) assisting PPP Unit staff to broker the first round of health PPPs. The MOHSW should develop standardized processes for key PPP support functions. Support functions may include processes related to a PPP tracking system; a consistent approach to due diligence, risk analysis, costing, and evaluation of PPPs; and PPP performance monitoring. The MoHSW
should also work with other Government authorities to develop a uniform and efficient PPP tendering process.

4. **Support an umbrella organization for the private health sector.** The success of public private dialogue and local planning in operationalizing PPPs for better health outcomes rests on two crucial assumptions: 1) an organized, high quality and effectively regulated private health sector and 2) strong member organizations that adequately represent diverse private sector interests at all levels of the health system. There is still considerable room to further organize the private health sector. Many of the recommendations proposed in HERA 2005 to structure the private sector have not been implemented, primarily due to lack of trust and suspicion between the sectors. Lack of organization of the private health sector will jeopardize the National PPP Steering Committee’s ability to foster dialogue and create meaningful exchange between the sectors. The PPP-TWG could evolve to include periodic or regular representation from the Association for Tanzanian Employers (ATE), and conduct additional outreach through members to encourage private sector investment in health partnerships.

5. **Elevate public-private dialogue to a sector-wide level.** Even though the PPP-TWG has been an effective and productive forum for public private dialogue (PPD) in health, there is a need to formally establish a national level PPP health dialogue forum that is sector-wide. Formalizing a national PPP health dialogue forum will address many of the PPP institutional and organizational gaps identified in the analysis.

6. **Strengthen information sharing and networking at all levels.** The public and private sectors must agree on key health indicators that they will regularly report on to the MOHSW. In exchange, the MOHSW will agree to share ministry plans and reports to help inform the private sector on government priorities. It is important to review annual meeting and planning processes at the national and district levels (such as CCHP) to identify opportunities to more fully involve the private sector. Two examples include inviting a wider range of private sector groups to participate in the Annual Health Sector Review and to clarify the norms guiding the CCHP process to identify and involve key private sector groups in each council and district. Likewise, the MOHSW should deliver training to council, regional, and country units.

Sensitizing regional and country units to propose PPP opportunities should improve the involvement of private sector stakeholders to participate in policy and planning. After sensitization, the MOHSW may consider formally including the implementation of PPPs within the CHMT, which would leave the design and monitoring within the purview of the PPP Unit. Involving a wide range of private stakeholders in existing MOHSW planning processes or utilizing additional local forums that can feed directly into MOHSW planning could significantly enhance private sector investments in health through PPPs.
4. **FINANCING OF PPPS FOR HEALTH BY SOURCE**

This section describes the various sources for investment for PPPs and how those investments have developed into different types of partnership in Tanzania. For each source of investment, this section discusses how the type of financing affects the development of a PPP and describes how the PPPs have fared. Where available, Tanzania specific case studies are used to provide specific examples of how a specific PPP financing strategy has either succeeded or failed to improve health service provision, equity and access as part of the broader health system. In Tanzania, sources of PPP investment can be placed within six broad categories of source as illustrated by Table 5. The following sections (Sections 4.1 – 4.6) are organized in this same manner, by source of investment.

**Table 5: Sources of investment for PPPs in Tanzania**

<table>
<thead>
<tr>
<th>Source of Investment</th>
<th>Type of Investment</th>
<th>Private sector Responsibility</th>
<th>Public Sector Responsibility</th>
<th>Key Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public health insurance schemes</td>
<td>Public</td>
<td>Provides care to patients with public health insurance and meets certain quality standards.</td>
<td>Consistently reimburses set of services delivered in private health facilities and monitors quality of private providers.</td>
<td>Patients access care where it is most convenient and of highest quality, rather than where insurance provides coverage.</td>
</tr>
<tr>
<td>2. Block grants</td>
<td>Public</td>
<td>Expands services according to public sector stipulations.</td>
<td>Ear marks funding for private sector for delivery of services or specific health campaigns.</td>
<td>Using public sector investment, private provider expands access to patients that the public sector may not be able to reach.</td>
</tr>
<tr>
<td>3. Access to finance (Direct investment, loan or other credit)</td>
<td>Private</td>
<td>Applies for and using financing products – such as loans – to expand service reach.</td>
<td>Expands access to finance by lobbying banks and investors to amplify investments or subsidization of PPP care. Establishes or encourages small scale revolving credit funds in health.</td>
<td>Using private investment, private provider expands access to patients that the public sector may not reach.</td>
</tr>
<tr>
<td>Source of Investment</td>
<td>Type of Investment</td>
<td>Private sector Responsibility</td>
<td>Public Sector Responsibility</td>
<td>Key Advantages</td>
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<tr>
<td>4. Company/Employer investments in worker health</td>
<td>Private</td>
<td>Provides health and wellness services to employees to reduce health risks as part of core business.</td>
<td>Provides incentives or payment to private companies to offer wellness programs.</td>
<td>Employees are more productive and have greater access to health services. Can be stronger PPP if tied to public health insurance schemes.</td>
</tr>
<tr>
<td>5. Basket funding</td>
<td>Donor</td>
<td>Expands services according to donor stipulations.</td>
<td>Ear marks funding for private sector service delivery.</td>
<td>Using donor investment, private provider expands access to patients that the public sector may not reach.</td>
</tr>
<tr>
<td>6. Direct or vertical program funding (on- or off-budget)</td>
<td>Donor</td>
<td>Expands services according to donor stipulations.</td>
<td>Ear marks funding for private sector service delivery.</td>
<td>Using donor investment, private provider expands access to patients that the public sector may not reach.</td>
</tr>
</tbody>
</table>

Adapted from IFC 2011, Taylor & Blair 2011 and Burduja et al. N.D.

Depending on the source, partnerships are created, which include arrangements of varying complexity and formality between the government and private sector partners who will each invest specific assets – whether they are financial, facilities or skills. The level of risk and responsibility that is transferred from the public sector to the private sector, as dictated by the terms of the PPP contract, varies depending on the type of PPP and scope of services. In this paper, we explore options that fit into three broad types of contracting modalities for financing PPPs for improved service delivery in health:

1. **Service Contracts:** Service contracts define the provision of short or long-term health related goods and services by a private third party on behalf of the government (World Bank 2013). These can range from broad and long-term SLAs to more flexibly applied service contracts or purchasing agreements at local level depending on the size and scope of the contract.

2. **Management and Operations Contract:** In a management and operations contract, a private third party manages a series of activities that are usually implemented over a shorter term period (2 to 5 years for example). The contract specifies specific tasks to be managed rather than outputs to be produced, and there is usually minimal to no user payment risk (World Bank 2013).
3. **Leasing and concessions**: In a leasing or affermage contract, the private third party occupies and operates a public facility and provides a fixed rental payment to the government for use of infrastructure (World Bank 2013). The private provider would typically not receive a fixed fee from the government, but a lease could accompany or be contained within an SLA or service contract. Concessions refer to long term contracts where the private third party is responsible for all investment and operations in a health facility, but the fixed asset generally remains owned by the public sector (World Bank 2013). Here lease rehabilitate and operate (LROs) are explored as a concession or leasing option depending on the preferred arrangement.

Table 6 presents each approach in more detail, and describes the specific responsibilities of each sector and key advantages of the approach.

### Table 6: Options for Tanzanian private sector participation in health

<table>
<thead>
<tr>
<th>Option</th>
<th>Private sector Responsibility</th>
<th>Public Sector Responsibility</th>
<th>Key Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Contracts</strong></td>
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</tr>
<tr>
<td>Contracting-out for clinical or specialist services</td>
<td>Provides clinical services for specific health campaigns (such as RCH or HIV) or clinical support services such as radiology and laboratory diagnostic services.</td>
<td>Manages public care and continues to provide clinical services while outsourcing to fulfill excess service or disease specific needs.</td>
<td>Relieves burden of care on public sector, and provides private providers with consistent volume of patients to ensure sustainable operation and public collaboration.</td>
</tr>
<tr>
<td>Contracting-out for non-clinical services</td>
<td>Provides nonclinical support services (cleaning, catering, laundry, security, building maintenance) and employs staff for these services.</td>
<td>Provides all clinical services, staff and hospital management. Manages outsourced contracts for nonclinical services.</td>
<td>Managing contracts with external private firms for nonclinical services may reduce the burden on LGAs and DMOs. May also prove more cost effective based on LGA capacity.</td>
</tr>
<tr>
<td>Company service contracts</td>
<td>Provides outsourced services to employees to reduce health risks.</td>
<td>Provides incentives or payment to private companies to offer wellness programs.</td>
<td>Employees are more productive and have greater access to health services.</td>
</tr>
<tr>
<td>Colocation of private wing within public health facility</td>
<td>Operates and cooperatively manages private wing (for fast-track or private patients). Often contracted to provide clinical services to public patients as well.</td>
<td>Manages public hospital for public patients and contracts with the private wing for sharing of joint costs, staff and equipment.</td>
<td>Can be used to address dual practice and subsidize public care if arranged with physicians and nurses as part of public-private intramural practice with profit-sharing.</td>
</tr>
<tr>
<td><strong>Management and Operation Contracts</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private management contracts and broad</td>
<td>Manages public designated hospital (i.e. contracts with private firm for provision of public sector makes use of existing infrastructure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option</td>
<td>Private sector Responsibility</td>
<td>Public Sector Responsibility</td>
<td>Key Advantages</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>SLAs</td>
<td>CDH/DDH) to provide clinical and nonclinical services.</td>
<td>public hospital services, pays private operator for services provided, and monitors and regulates services and contract compliance.</td>
<td>infrastructure and administrative structures to expand access to services through the private sector.</td>
</tr>
<tr>
<td><strong>Leasing or Affermage, and Concessions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private provider leasing</td>
<td>Provides specialized clinical services within a designated area of a public hospital for private patients.</td>
<td>Manages public hospital for public patients and contracts with specialist to use idle or underutilized public clinical space at specified times.</td>
<td>Structured as a lease, affermage or profit-share agreement, this option could retain specialized private sector medical capacity within the public system while allowing for intramural private practice.</td>
</tr>
<tr>
<td>Lease rehabilitate and operate (LRO)</td>
<td>Leases facility from government, rehabilitates infrastructure, then operates and maintains facility for contract period.</td>
<td>Pays private operator for services provided,* collects lease payments, monitors and regulates services and contract compliance.</td>
<td>Government can make use of existing facilities, without having to staff them or invest in their physical maintenance. Private operator retains revenue collected from patients and does not have to invest in up front construction.</td>
</tr>
</tbody>
</table>

Adapted from IFC 2011, Taylor & Blair 2011 and Burduja et al. N.D.

*Government payment for services provided depends on structure of contract. Private provider is responsible for reporting and following government regulations.*

The above mentioned options for entering into a PPP are driven by investment decisions and incentives that are created by the source of the financing for the arrangement. The following sections present each source of financing, an example of the primary partnership arrangement, and recommendations for improving each arrangement.

### 4.1 FUNDING PPP THROUGH PUBLIC HEALTH INSURANCE SCHEMES

The first source of PPP financing is in the form of public health insurance schemes. Tanzania’s guiding PPP and health policies envision a mixed-model of healthcare that will allow patients to obtain services.

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1 See more details in the health insurance market report (Jan Bultman and Anselmi Mushy, June 2013).
where care is most convenient and of highest quality regardless of the provider type. In this pursuit, as part of the reform of the HFS, the ISC has commissioned separate options papers on a MBP, Community Health Funds (CHF) reform, and the public/private insurance market structure. However, since public insurance repayment serves as a critical financing tool in many of the options proposed in this paper, it would be remiss to discuss financing of PPPs for improved service provision without a brief exploration of the public health insurance market within which PPPs will be attempted.

The main public health insurance schemes in Tanzania are: the NHIF, National Social Security Fund (NSSF)/Social Health Insurance Benefit (SHIB), and CHF/Tiba kwa Kadi (TIKA) – the urban equivalent of CHF. The status of these schemes is discussed briefly below.

4.1.1 NATIONAL HEALTH INSURANCE FUND

The NHIF was established in 1999 by an act of Parliament. The MOHSW oversees the functioning and operations of this scheme. Initially, the scheme covered only public employees, but in 2010, NHIF was extended to the private sector. As of 2012, the NHIF had coverage of 2.3 million people, with an annual growth rate of about 11 percent. Premiums are 6 percent of the basic salary, shared 50-50 between employer and employee. Service coverage is comprehensive and the provider network includes all public facilities as well as selected private facilities. It uses fee-for-service for reimbursement of claim. Income has consistently exceeded expenditure and the NHIF has accumulated substantial financial reserves. For example, in 2011/12 NHIF collected Tshs 199.1 billion, but spent only 39.2 percent or Tshs 78.1 billion. Interviewed stakeholders using NHIF insurance packages indicated generally low satisfaction with the NHIF services.

Challenges facing NHIF include moderate to low traction among existing private health providers, unsatisfactory delivery of health benefit services to its members and unwarranted accumulation of large reserves. In addition, the application process and costs for private providers to involve themselves in the NHIF are unclear, and providers have not adapted payment options into their triage to identify NHIF or otherwise insured patients.

There are two key opportunities to improve the use of the NHIF as a source for financing PPPs. Firstly, the GOT, may restructure the NHIF to make the fund more cost effective, efficient and responsive to its beneficiaries. The MOHSW has initiated this process as part of the HFS, but should undertake a thorough review of NHIF and its operations to determine the challenges facing the fund and ways in which the fund could be structured to enable financing of PPP mechanisms such as private sector service contracting.

Secondly, the GOT may use NHIF accumulated reserves to scale up CHF/TKIA country-wide. This may require the MOHSW to hold extensive discussions with the NHIF management and Board to work-out how the reserves can be used to facilitate public-private health financing through the NHIF/CHF/TKIA schemes. Since under the NHIF Act (Section 36 (2)) the stipulations do not allow for the maximizing of financial reserves, it is important for the government to consider more efficient operationalization of the fund to protect NHIF members from being either overcharged or having unnecessarily limited benefits, despite the organizations’ healthy yearly income outturn. This reserve could provide the pool of funds needed to engage private sector providers in extending both service and NHIF coverage (see CCBRT case below).
4.1.2 NATIONAL SOCIAL SECURITY FUND (NSSF) AND SOCIAL HEALTH INSURANCE BENEFIT (SHIB) IN TANZANIA

This public insurance scheme was introduced in 2006 under the Minister of Labor. The scheme is for formal private sector employees, including companies, non-governmental organizations, embassies employing Tanzanians, international organizations and organized groups in the informal sector. It also covers government ministries and departments employing non-pensionable employees, parastatal organizations, self-employed or any other employed person not covered by any other scheme. The SHIB premium is included in the general 20 percent deduction by NSSF (split 50-50 between employer and employee). As of 2012, the scheme had only 51,300 beneficiaries, which are about 0.12 percent of all enrollees in the NSSF. The scheme offers comprehensive health benefit services to its members. Like the NHIF, the NSSF/SHIB scheme has accumulated high reserves and beneficiaries are not satisfied with the health services being provided. The main challenges therefore relate to increasing the number of beneficiaries, which currently is very low, and using accumulated reserves to improve service delivery and expand coverage.

There are currently two opportunities for improving the NSSF and SHIB as a source of financing for PPPs. Firstly, the Ministry of Labor, which is responsible for proper functioning of this scheme, is urged to undertake a thorough review of the Fund to determine why membership is so low and devise a strategy to scale-up membership and improve beneficiary service satisfaction. Secondly, the Ministry of Labor should hold a high level discussion with the MOH to strategize how the NSSF/SHIB can be merged into the reformed NHIF. This will increase efficiency and cost effectiveness, particularly as the country begins to move towards universal health care coverage with a guaranteed MBP.

4.1.3 COMMUNITY HEALTH FUND AND TIBA KWA KADI (TIKA)

This scheme was established by an Act of Parliament in 2001 and provides basic health insurance coverage to low income households. The funds are managed at the district level and have been rolled out to 70 percent of the districts in Tanzania (112 districts out of 165). As of 2012, about 593,643 households had been enrolled in the scheme (or coverage of 3.8 million beneficiaries), which is about 8.6 percent of the country’s population. The district councils define premiums as well as the benefit package. Primary health level services are included in all districts and services at the first referral level in most districts. Premiums vary by council from Tshs 5,000 to Tshs 15,000 per family of six persons per year. The government pays a 100 percent matching grant for each member to the council. All funds are channeled and administered through the council budget and there is no direct reimbursement to health facilities. Since 2009, the scheme has been administered by NHIF, thus it faces largely the same weaknesses as NHIF.

Challenges faced by the CHF and TIKA revolve around traditional health financing functions, notably revenue collection, risk pooling, and purchasing of health services. Because CHF / TIKA schemes are fragmented and regional, the size of each pool is markedly lower than would be the case if pools were merged. This, coupled with low, voluntary enrollment among informal sector workers and low income households, has contributed to inadequate revenue and higher costs than is needed to sustainable operate such funds. This is in large part due to households’ inability to pay premiums or lack of regulation or incentives to encourage informal sector workers to join. Finally, inefficiencies also arise from poor purchasing mechanisms and weak payer-provider networks. The unsustainable and inefficient manner by which CHFs and TIKAs operate has inhibited private sector participation in the schemes, particularly high quality health providers.
Other than restructuring Tanzania’s entire health financing system (a discussion beyond the scope of this paper), several opportunities are available to improve the performance of CHFs / TIKAs and thereby stimulate greater private sector participation. First, there exists a significant need to improve governance of CHF / TIKA insurance schemes. This entails improving public financial management, defining roles, responsibilities, and other decision-making structures, as well as expanding institutional and technical capacity. Second, schemes must find innovative mechanisms to increase resources for health so as to expand the benefit package for secondary and tertiary level medical care. Schemes should also invest in information technology to improve accountability and feedback as well as the efficiency and effectiveness of payment systems. For the latter, better data and information would allow the schemes to move away from retrospective-based fee-for-service or salary to more prospective payment mechanisms. For the government, this includes becoming an active purchaser of medical care rather than a passive one. Finally, the public sector must build on existing networks and improve the performance of public health facilities and professionals through accreditation systems. All of these options are likely to spur interest in private sector involvement while simultaneously expanding fiscal space for better quality, lower cost health services.
There are significant opportunities for public health insurance to increase access to private sector points of care through full or partial subsidization of services, as defined by the MOHSW and individual private providers. Such agreements could enable a broad range of Tanzanians (including the poor) to access high quality or specialized services in the private health sector while also providing private providers with a differentiated source of revenue as part of sustainability efforts. One such effort has been demonstrated by Comprehensive Community Based Rehabilitation Tanzania (CCBRT). CCBRT, a locally registered NGO, established in 1994 has grown to become one of the largest providers of disability and rehabilitation services in the country. In partnership with the government under a broad memorandum of understanding (MoU), since 2005, CCBRT provides a high standard of care in the treatment of club foot, bowed legs, congenital deformities and birth defects, pediatric and adult eye care, and physiotherapy. They provide a wide-range of inpatient, outpatient and community based services – including the operation of a 250 bed home facility in Msasani in Dar es Salaam. In addition, CCBRT plans to significantly increase their provision of maternal and newborn care at a public-private mixed MCH facility in the same location. The new CCBRT Maternity and Newborn Hospital, which began construction in December 2011, will have the capacity for up to 14,000 deliveries annually, including 5,600 c-sections. This will drastically reduce maternal and newborn mortality and morbidity in Tanzania's Eastern Zone.

CCCBRT represents the type of established private sector partner who could benefit immediately from increased coverage and streamlined processes for CHF and NHIF. They have already effectively built public insurance options into their mixed revenue plan for sustainability, and they are already in partnership with the MOHSW through an existing (albeit less formal) MOU. CCBRT also represents the number of FBOs and NGOs (and some PFP entities) operating as not-for-profit and essentially cost recovery organizations. CCBRT does not deny services and adheres to the exempted services guidelines (i.e. for under 5s and pregnant mothers) as required by the MOHSW. Many such organizations face an immediate decline in international donor funding. As part of their long term approach to sustainability, CCBRT has developed a mixed revenue model utilizing a number of cost recovery mechanisms such as CHF/NHIF, private insurance, and private care co-location (discussed further on in section 5).

Since partnering with the MOHSW in 2007 a number of finance considerations have been central to CCBRT’s success:

- The Government (through MOHSW) pays 90 percent of CCBRT’s staff salary remunerations. This is a sizable public investment in CCBRT’s operations given the high relative cost of human resources in any health facility operating budget. Public HRH investment has allowed CCBRT to direct their donor investments and other direct revenue towards the cost of specialty care and improved operations. The MOU provides CCBRT with tax exemptions status and a code to procure approved medicines and medical commodities at no cost from the Medical Stores Department (MSD). This too has allowed CCBRT to direct revenue toward private

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2 In June 2013, Tanzania signed a Euros 8 million (Sh17bn/) grant agreement with Germany under which the latter will support the CCBRT Baobab Maternity and Newborn Hospital which currently is under construction in Dar es Salaam.
procurement of high quality hip implants, prosthetics, and specialty eye care and lenses for children and adults.

- Direct revenue from the provision of private ‘fast-track’ care (contributing approximately 25% of their current operating costs) has significantly subsidized more traditional sources of funding such as donor support from INGOs and others such as CBM Germany and CBM Canada, the Bank of Africa, Tigo, Smile Train USA, Kupona Foundation USA, Light for the World Austria. Both private and donor based revenue are strategic sources of CCBRTs’ sustainability effort.

- Although most patients can and are willing to pay for an initial consultation of Tshs 8,000, most cannot afford the long term curative or surgical interventions necessary to recover. Enhanced identification of patients covered by CHF/NHIF, private insurance and those willing to pay for private fast track care has enabled CCBRT to more consistently identify opportunities for cost-recovery and to provide the interventions necessary knowing the patient is financially protected.
4.1.4 OPTIONS FOR IMPROVING PUBLIC HEALTH INSURANCE AS A SOURCE OF PPP FINANCING

The following recommendations may be pursued in order to improve public health insurance as a source of financing for PPPs.

1. **Explore more explicit inclusion of CHF/NHIF roles and responsibilities as part of MOUs and SLAs.** If deemed appropriate, organizations like CCBRT may benefit from a more specific contract or service level agreement with the MOHSW that clarifies issues pertaining to existing staff and MSD commodity provisions, and also outlines service provision and reimbursement options. Expanding the coverage and provider traction of CHF/NHIF, and addressing public insurance options as a focal point in all PPPs for health can increase sustainable sources of private provider cost recovery that promote equitable access and do not exclude the poor.

2. **Ensure all staff payment and service reimbursements are made consistently, on time and in full.** All successful PPPs prioritize transparency and efficiency of the payment and reimbursement mechanisms employed. In CCBRT’s case, for example, they often have to utilize their own funds to cover for late MOHSW payroll. If CHF/NHIF are to be successful the repayment process, they must not suffer from the same delays and frustrations that have plagued other ministry disbursement mechanisms.

3. **CHF/NHIF enables the poor to access private quality care.** Through CHF and NHIF, CCBRT is able to reach the poorest of the poor through care and treatment subsidized heavily by a mixed revenue model that includes public insurance. There are still a number of facilities that have not maximized the potential of CHF and NHIF, and ways to enroll and identify additional clients are still being discussed and piloted.

4. **Encourage CHF/NHIF as part of a mixed model of revenue for health providers in both sectors.** Streamline the process of registering CHF/NHIF as a provider and make payment and repayment terms as clear and consistent as possible. Wider coverage of CHF and NHIF, with greater traction among private providers can equate to effectively financed PPPs for health – particularly if clarified as part of strengthened SLAs or service contracts.

In sum, public health insurance funds may be used to in cases when public health facilities are limited in their capacity, resources, or reach to deliver benefits to populations covered by the public health insurance scheme. In these instances, the public health insurance funds may contract to private facilities that are located in strategic regions or have higher capacity to serve covered beneficiaries. However, these PPP arrangements can only attain sustainability if the payment processes, services, and contractual terms are clearly defined and implemented.
4.2 BLOCK GRANTS FOR PPPS IN HEALTH

The second source of financing PPPs is through block grants. Block grants are the most important financing source for LGA activities. The intergovernmental transfer system finances about 90 percent of all LGA spending, or 3 percent of the total government budget.\(^3\) The remaining 10 percent is financed through own sources of revenues. The Health Block Grant (HBG) is part of the total block grant that finances more than 50 percent of the health resources in LGAs. The allocation of the HBG to all 165 Councils is based on an agreed disbursement formula\(^4\) based on population, number of poor and key indicators such as under-five mortality. The HBG funds are budgeted under Regional Votes, but planning for the use of the HBG resources is done by the Councils and the Ministry of Finance disburses the funds directly to the Councils. The allocation of HBG by cost centers is shown in Table 7. The HBG finances human resources, personal emoluments and other operational costs such as allowances, transport, maintenance of equipment and other health infrastructure. Drugs are financed through the general budget. While block grants have historically been used to finance public facilities and public infrastructure, it was included in this report as a potential source of financing for PPPs.

4.2.1 OPTIONS FOR USING BLOCK GRANTS TO IMPROVE FINANCING OF PPPS

In terms of facilitating partnerships, councils could examine possibilities of using a small percentage of their operating costs to sensitize counselors and other stakeholders on the importance and potential contribution of the private health sector to complement public health service provision in that area. In addition to supporting a PPP focal person in the district to coordinate partnerships, if even a very small percentage of the HBG was directed to support approved PPPs with private providers, the impact could be significant. As with donor basket funding, directing even a small percentage of HBGs to private sector providers as part of performance based or capped reimbursement schemes could have an immediate impact on increasing the coverage of publically supported essential health services.

4.3 DIRECT OFF-BUDGET OR VERTICAL PROGRAM FUNDING

Since 2007/08, development partner’s health support through non-basket funding has increased significantly from about Tshs 100 billion to Tshs 300 billion in 2011/12. Most of these resources are channeled through direct vertical programs, some of which have a large private sector component.

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\(^3\) The total government budget in 2012/13 was Tshs 15.2 trillion or USD 9.5 billion.

\(^4\) HBG formula: 70% by population, 10% each by the number of poor residents, number of under-five deaths, and district medical vehicle route, respectively.
The largest single donor in the health sector - the US Government – provides off-budget health related interventions using a large number of PEPFAR Partners and local NGOs. The amount of support provided to Tanzania, which averages about USD 300 million per year, is channeled largely through private health providers. Other donors also support the private health sector through direct funding of NGOs or CBOs, but the support is not reflected in the donor’s funding frame in-country. For example, Marie Stopes has funding from DANIDA, but it is allocated directly from a program managed from Denmark, so it does not appear on DANIDA-Tanzania program budget. DFID also funds a number of health-related programs via this modality.

The challenge in analyzing donor off-budget support to the private sector is that there is no routine system or obligation for donors to report on what funding they are providing to non-state organizations in health in Tanzania. Also, none of the current health sector financial planning reports or resource tracking tools provides information segregated by type of provider – an issue which is likely to be resolved through the new National Health Accounts (NHA) production tool.

Thus, as future options for enhancing transparency in health resource mobilization, allocation and use, the following recommendation could be adopted:

4.3.1 OPTIONS FOR IMPROVING THE USE OF DIRECT OFF-BUDGET OR VERTICAL PROGRAM FUNDING TO FINANCE PPPs

The following options provide recommendations for using direct off-budget or vertical program funding to finance PPPs.

1. Urge donors to report total private health sector funding: During donor joint program reviews and discussions on health support to Tanzania, consideration might be made to implore all donors to report total funding to the private sector via the Aid Management Platform in the Ministry of Finance. If submitted as a ‘Dummy,’ even if the funding is off-budget and is not reflected in the Government’s exchequer system, this will facilitate capturing all health financing support to the country for more effective planning and approach to financing PPPs for improved service delivery in health.

2. Enhance health resource tracking tools such as public expenditure review (PER), NHA and NASA: Existing health resource tracking tools should track all spending disaggregated by provider type in order to capture actual funding going to the private health sector. Doing so will help LGAs determine where basket fund earmarked for the private sector and other public resources can be directed for the most impact.

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5 Although the US government support is off-budget the resources are known because the two governments have a ‘Partnership’ agreement which shows the level of support.

6 ‘Dummy’ referring to ‘off-budget’ donor funds that are reported to the MOHSW for accounting and information purposes but the funds are not transferred to the ministry of Finance.
5. EXPANDING FISCAL SPACE FOR HEALTH IN THE PRIVATE SECTOR

5.1 PRIVATE SECTOR ACCESS TO FINANCE

The private health sector’s ability to access finance for capital investment is essential to its long-term sustainability, growth, and ability to contribute to the public good through investments in health. As outlined in the TOR and confirmed by multiple stakeholders, one of the major constraints in developing viable PPPs or broader private investments in health has been limited opportunities for private sector partners to adequately access funds for PPP projects, capital investment and service expansion. In the case of PPPs, private sector investments require funds or assets from during project design and often require private providers to invest in upgraded facilities, new equipment and training. Unreliable, inadequate or late repayments from public or private insurance have also made it difficult to predict revenue flows, which in turn negatively impact the success of PPPs in health and reduce provider incentives to participate.

Private providers can work with financial institutions (e.g., banks, investment firms, pension funds, etc.) to access short-term loans and long-term capital investment, which enables them to (among others): upgrade and increase the size of their facilities; extend and strengthen health training opportunities; lease and purchase equipment; hire additional staff; purchase commodities; and participate in government health campaigns. However, global experience in a number of credit schemes has demonstrated that banks are not familiar with lending to the health sector, desired loan repayment terms are often too long and value of loans too low to incentivize banks to lend (White et al. 2013). If a loan is available, interest rates or collateral are often too high, or tenors too short to incentivize providers to borrow (White et al. 2013). In Tanzania, the majority of private health practices are established with personal saving or loans from friends and family (White et al. 2013). Therefore, expanding the size and scope of their practice to take a more active role in delivering public goods is no small endeavor that can jeopardize sustainable operation of the business.

Supporting approaches that improve private health provider access to finance as part of the HFS have the potential to increase the number of private sector providers that are able to invest in the provision and financing of health, partner with the MOHSW in joint-public health campaigns, service contracts or larger service agreements. The approaches below require limited or moderate investment of funds or infrastructure on behalf of the GOT while stimulating greater access to financing (and ultimately greater investments in health) for the private sector.

5.1.1 OPTIONS FOR PROMOTING PRIVATE SECTOR ACCESS TO FINANCE
Private health provider’s access to finance has been improving in Tanzania (IMF 2010). The 2012 Private Health Sector Assessment in Tanzania determined that private providers found the current loan size and loan repayment terms sufficient, and that the average duration of a medium term loan (three to five years) was appropriate (White et al. 2013). However, for loans used to acquire more costly infrastructure or diagnostic equipment, private providers reported that it would be beneficial if the duration of a loan repayment terms could be increased to up to 10 years (White et al. 2013).

Overall, health investments amount to less than one percent of most bank loan portfolios. With such a small weight relative to other sectors, very few banks have experience with lending to the private health sector (although this is changing in Tanzania). Factors that limit health sector lending by financial institutions include:

- Stress tests show that payment failure of largest debtors would lead to many banks needing more capital (IMF 2010)
- Limited space to offer meaningful loans to the private sector while staying within the loan-to-deposit ceiling (IMF 2010)
- Lack of a reliable credit information system that enables banks to view credit history (IMF 2010)
- Private health providers usually lack audited financial statements or business plans (White et al. 2013)
- Enforcement of claims can be slow (IMF 2010)

Two options to improve private health sector access to finance are outlined below:

1. **Increase private provider knowledge on access to finance and commodities:**

Private health providers are often highly trained medical professionals. However, they are typically unequipped with the business acumen needed to navigate loan agreements or maximize the financial efficiency of their practice. From the provider perspective, high collateral, complex loan application procedures, and high interest and inflation rates make bank lending unattractive to a small to medium health providers (White et al. 2013). Despite progress in recent years, the private health sector’s ability to access finance is still a challenge. As Box I demonstrates, the need to access finance in Tanzania varies by the size of the health facility and type of operation. However, experience demonstrates that only half of health businesses that apply for loans are successful (Dalberg Global Investment Advisors 2009). Larger dispensaries, health centers, and hospitals are more likely to succeed in obtaining loans if they have access to collateral. The success rate for obtaining a loan matters because unsuccessful applicants usually do not try to obtain another loan (Dalberg Global Investment Advisors 2009).

To this end, providing (or linking) private providers with basic business training as part of the MOHSW’s broad regional engagement strategy could enable more private providers or networks to develop financing strategies that facilitate their PPP participation or the independent growth in private sector financing and service delivery.

**Box 1: Need for finance in the health sector**

**Hospitals:** In general, hospitals have need between 50 million Tsh and 150 million Tsh ($27,027 to $81,081) for equipment upgrades and infrastructure investments.

**Smaller facilities (i.e. dispensaries):** In general, dispensaries need about 15 million Tsh ($8,108), for working capital such as drugs and commodities, and for larger investments in equipment and infrastructure.

White et al. 2013
Business training should promote the use of financial management and administration best practices at private health facilities to help document their financial status, to demonstrate their long-term feasibility, to identify them as viable PPP partners, or to improve their financial performance more broadly.

Recent experience has also demonstrated that when subsidized with MOHSW staff, vaccines and refrigerators, HIV test kits, or other tangible service inputs, the private sector has been able to utilize other sources of revenue for training and operating costs, partnership projects, and specialized service costs. Scaling up the public provision of essential commodities to the private sector via MSD or vertical programs (i.e. such as HIV test kits, microscopes, beds, and other tangibles) could enable providers to make investments required for their efficient and effective participation in PPPs.

**Challenges:**

Training and equipping private sector health providers with business administration and financial management skills will not likely be as technically challenging as other private sector options – at least with regards to capacity. However, the public sector must still consider how it will institute training programs. Implementation first requires that the public sector understand its intended audience and their existing skills levels, which entails conducting surveys of the private sector to determine who needs training and what training is required. Moreover, the public sector must also consider the courses, educators, and infrastructure necessary to follow through with training.

Alternatively, Tanzania’s government could partner with private sector associations to provide education and business training to health providers. While collaboration with private organizations presents different challenges for the public sector, these mechanisms offer greater opportunities to outsource the implementation of training programs. The Association of Private Health Facilities in Tanzania (APHFTA) currently offers a three-day course on basic financial management for members interested in participating in its innovative Medical Credit Fund loan program. This program could serve as the basis for an expanded, more comprehensive effort using other examples of community micro-credit funds currently in operation throughout Tanzania. LGAs and private associations (e.g., APHFTA, CSSC, or PRINMAT) could jointly finance, develop, and implement courses on contracts management, project financing, and human resource management for their collective members.

2. **Promote and invest in private sector credit mechanisms:**

In response to the access to finance challenge, a number of small to medium micro-credit mechanisms have been established by the private health sector associations in order to increase their members’ access to capital. Two being observed by members and iNGO donors alike are the APHFTA owned Afya Microfinance Corporation Ltd. and the PRINMAT-SACCO community savings and credit society (discussed further in the case study on in section 5).

**Benefits:**

Small start-up funds of US$100,000 ceiling or less have been able to produce significant results for a number of members. Not restricted to capital investments, members have taken out loans of all sizes for purposes ranging from capital investment to clinical and business training to personal healthcare costs. The internal peer and reputational pressures created by the professional networks have led to high repayment of loans in both cases. The details, strengths and weakness of each pilot are discussed below, but the experience in both cases suggests that private health sector lending and rotational credit mechanisms may provide an attractive avenue to expand access to finance.
Challenges:

Global evidence suggests that implementing successful, micro-credit schemes often require public support. During the initial stage of development, micro-credit schemes typically lack the financial or technical capacity to establish information systems and lend sufficient resources. As such the MOHSW can support these efforts by financially investing in private health sector credit mechanisms. Moreover, the public sector must ensure that health sector policies and regulatory efforts are put in place to support rather than hinder such efforts.

Case Study 2: Responding to the Access to Finance Challenge: Lessons from APHFTA and PRINMAT Provider Credit Mechanisms

Given the constraints and challenges in private provider access to finance, several private health provider networks have recently launched micro-credit mechanisms, which extend small to medium capital or personal development loans to private provider members (and some to community members as well). Two such efforts are the APHFTA Afya MicroFinance Company Ltd., and the PRINMAT SACCO initiative.

The Association of Private Health Facilities in Tanzania (APHFTA) – founded in 1994 with the vision to “strengthen the health and well-being of all Tanzanian citizens by establishing the private health sector as a recognized, committed, and equal partner capable of delivering high quality and affordable health care services” – represents over 500 private sector member facilities (mainly PFP but also some PNFP) who are more effectively engaged and coordinated as part of APHFTA’s support programs. APHFTA support to its member includes multiple forums for dialogue and meeting opportunities, and APHFTA sits on the PPPTWG as a primary PFP representative. APHFTA also provides members with trainings on basic business skills, sustainable finance and access to finance. Members are also more extensively engaged in priority health areas such as HIV prevention and treatment, reproductive and child health, and NCD response via APHFTA’ service delivery and disease specific member programs. Despite the strong coordination of partners via APHFTA and overall effective coordination with the public sector, APHFTA members continue to face severe shortages in discretionary revenue or capital investment, which effectively limits their ability to expand services or scale-up their provision of subsidized care.

The Private Nurses and Midwives Association of Tanzania (PRINMAT) is a PNFP entity coordinating the activities of its 105 members in the operation of 75+ independently owned and operated MCH maternity facilities – mainly in underserved poor or rural areas of Tanzania. While the facilities are owned by individual nurse or midwife members, PRINMAT provides coordination and capacity development support to its’ membership and represents them at national forums and to senior MOHSW nursing leadership. PRINMAT member facilities provide high quality antenatal, delivery, and postnatal care, family planning and child health, health education, community mobilization for behavior change, home based care and sensitization for HIV prevention. They will soon be engaging with the
MOHSW and DHMT nursing authorities to scale-up their involvement in HIV testing and treatment activities. As with other private sector PNFP and PFP facilities, PRINMAT facility managers face extreme challenges in access to finance, both for facility operational needs and investment in required continuing professional development (CPD).

Access to Finance
In the past, limited availability of collateral, too much risk to the bank or borrower, limited loan size, lack of business skills and other barriers have limited Tanzanian private health providers to access capital or loans from financial institutions. Several models of lending complicate matters for private medical professionals, and although sensitization of Financial Institutions over the past few years has resulted in higher access to loan opportunities and actual loans disbursed to the private health sector, collateral requirements remain high and interest rates remain average 20-30 percent. APHFTA and its’ partners have made significant progress in Financial Institutions sensitization efforts over the past few years, and APHFTA is in dialogue or has cooperation agreements with several Tanzanian commercial banks (KCB Tanzania, NMB, BANK Abc, Commercial bank Africa) to improve APHFTA provider access to finance opportunities. However, both PRINMAT and APHFTA leadership stated that more reliable and accessible financing opportunities were needed for Tanzania’s small-scale private health providers. As such, both have created innovative micro-lending credit mechanisms for the benefit of their memberships.

Innovative Private Health Sector Credit Mechanisms
APHFTA Afya MicroFinance Company Ltd. was licensed by APHFTA’s board and leadership in March 2013. Afya Co. Ltd. is a privately owned company with 99 percent APHFTA ownership that was officially launched in August, 2013. Specific details about APHFTA include:

- Four full time staff dedicated to Dar es Salaam and Mbeya, with intent to scale-up staff commensurate with the growth of the fund.
- APHFTA created the fund by using its’ own surplus revenue of USD $100,000, and market demand for the fund is estimated at well over US $1 million based on the rate of applications already submitted by APHFTA membership.
- The fund allows for any private facility or member to access the fund for broad use, which is not restricted to infrastructure, can be used for professional trainings and student loans, and can be used for discrete personal uses such as home repair or personal expense.
- Predicated on the idea that private health providers do not have the same access to banks as other private sector industries.
- Loans start from $500 upward at 17 percent interest.
- Six month to two year repayment terms of any loan size.
- Loans for exempted and social services, equipment purchase and other investments in provision are given priority.

Did APHFTA’s Afya MicroFinance Company Result in Early Success?
While still in its infancy, APHFTA’s Afya microcredit endeavor looks to be promising. With zonal rollout planned, the manuals and legal advisors in place to develop the fund over time, and IFC and other donors closely monitoring it as a potential focal point for investment, the fund is starting in a strong position. Since its pilot and launch, there have been no defaults in early short term loans, which is attributed largely to the fact that the person or physician is known as part of the APHFTA community and their professional reputation is at risk. Medical and provider associations may be the ideal
organizations through which to run such schemes given the internal peer pressure and reputational risks that already exist.

**PRINMAT SACCO Community Savings and Credit Society**
PRINMAT SACCO was started by 31 initial members in March 2009 as the PRINMAT “loan and credit scheme,” which restricted borrowing entitlements to PRINMAT membership. Specific details about PRINMAT SACCO include:

- Initial experience was difficult with about 50 percent initial default in repayment.
- McKnight Foundation (USA) injected startup capital to rejuvenate the model and promote:
  - Financial sustainability to private midwives without capital to renovate or equip existing but underutilized maternity or nursing homes.
  - Private nurse and midwife capital investments in their existing facility.
- Initial membership of 31 has grown to 105 and has recently opened to community investment outside the PRINMAT membership as part of a broad community sensitization and engagement strategy.
- New repayment is high because of association peer pressure.

**PRINMAT SACCO Terms, Conditions and Loan Repayment Mechanisms**

- Loan committee is responsible for identifying the residence and working place of the member who is expected to receive a loan.
- Two referees should be identified by the loaner and approved by the loan committee before issuing the loan. The two referees should be members of the SACCOS with savings of at least half or more of the requested amount. Moreover, a member who is expected to receive a loan should present an asset that is equal to the requested amount.
- After issuing of the loan, there should be a two month grace period.
- Duration for loan repayment should range between 6 to 12 months, with interest of 8-16 percent, respectively.
- Any delayed repayment is charged a penalty of one percent per month for the extended months
- Loan will be offered twice of the saved amount.

**Did PRINMAT SACCO Result in Success?**

- The revised PRINMAT saving and credit scheme has been a solution to Nurses and Midwives who wish to establish maternity/nursing homes but face financial constraints.
- PRINMAT SACCOs have played a great role to private Midwives through renovating their buildings and makes the facilities look beauty.
- PRINMAT SACCOs is playing part also as one of the income generating activities of the organization for its sustainability and at the same time bringing community closer to PRINMAT services through empowering them financially as well as providing them with quality health services.

**PRINMAT SACCO Challenges**
• Competition with other micro-credit institutions,
• Deterioration/drop out of members due to inadequate skills, entrepreneurship knowledge and limited experience with savings and credit or SACCOS,
• PRINMAT member and community participation still limited or weak as majority do not have regular saving habit,
• Only 41 out of 105 PRINMAT members involved as yet
• Communication barriers restrict Sacco participation for nursing in remote areas, and
• Initially high default rates on smaller loans have improved due to improved monitoring and collection process, as well as improved community and reputational peer pressure

Future Plans
• Increase participation to 300 members (PRINMAT and wider community),
• Increase public sector nurses and midwives’ participation, and
• Inspire a nursing and community focused Sacco saving and credit scheme that is widely used within PRINMAT membership and nearby communities.
5.2 CORPORATE CONTRIBUTIONS TO HEALTH

Although PPP typically implies financial investment from the public and private sectors, corporate investments in health play a significant role in improving Tanzania’s health system. Employers and owners in the private sector have a considerable responsibility and fiscal interest to contribute to health in the workplace. Tanzania faces a myriad of health challenges, including increasing prevalence of non-communicable disease (NCD) and chronic conditions (such as diabetes and HIV). The public health system shoulders the majority of this service provision burden (including financial commitments as part of the workers’ Compensation Act of 2008 and the National health policy), but employers also face growing economic losses due to workplace injury, lost productivity to illness and mortality, and employee training and replacement costs. Employees spend the majority of their day at the workplace, and many of the day to day exposures in the workplace lead to the development of chronic diseases (including high blood pressure and high cholesterol), as well as workplace injury. In Tanzania, a cross sectional study of 201 health workers at Tumbi and Dodoma hospitals found that almost half of all workers had encountered one or more occupational injuries over the past year (Rongo et al 2004).

“The health of employed Tanzanians is a shared responsibility and of mutual interest to the GOT and private sector employers.”

The TIC has also worked diligently to create a favorable investment climate for multinational trade and industry in Tanzania over the past decade, and has outlined clear guiding principles on the linkage of FDI to the domestic economy and on corporate contribution to health (TIC 2006). However, there is weak capacity to enforce such contributions in part because of awareness that heavy enforcement could damage relationships with investors. Supporting strategies are therefore needed. Furthermore, companies and employers must be made more aware that the health of employees has a direct effect on the bottom line of private companies across all sectors of the economy. Investments in health should be made part of core business strategies as a matter of sound business practice.

According to WHO a healthy workplace is “one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace by considering the following:

- Health and safety concerns in the physical work environment;
- Health, safety and well-being concerns in the psychosocial work environment including organization of work and workplace culture;
- Personal health resources in the workplace (support and encouragement of healthy lifestyles by the employer);
- Ways of participating in the community to improve the health of workers, their families and
members of the community” (WHO N.D.).

Improving workplace health and wellness are a win-win for the MOHSW and for companies. Table 8 summarizes the main benefits to employers, employees and the government.

Table 8: Benefits of employer investment in health

<table>
<thead>
<tr>
<th>Employer Benefits</th>
<th>Government Benefits</th>
<th>Employee Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Evidence shows ROI is 3:1 on effective WWP</td>
<td>• Healthier population results in less health care provided and paid for by the government</td>
<td>• Better health</td>
</tr>
<tr>
<td>• Lower voluntary attrition (studies show 9% vs. 15% for companies with effective WWP$s$)</td>
<td>• Increasing preventative care and managing chronic diseases upfront will reduce the burden of an aging population</td>
<td>• Better work life balance</td>
</tr>
<tr>
<td>• Less absenteeism and higher productivity</td>
<td></td>
<td>• Decreased health spending</td>
</tr>
<tr>
<td>• Greater employee pride</td>
<td></td>
<td>• High productivity</td>
</tr>
<tr>
<td>• Better brand, enables recruitment and retention of talent</td>
<td></td>
<td>• Less concern on financial burdens</td>
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Companies that realize the business case for improving workplace wellness have become increasingly interested in financing health or providing care by expanding coverage of company paid insurance, outsourcing care to preferred private providers, or in some industries partnering with private providers to establish on-site company clinics. The following section briefly discusses these options in accordance with domestic and global evidence.

5.2.1 OPTIONS FOR PROMOTING CORPORATE INVESTMENTS IN HEALTH

1. Contribute Premiums to NHIF/NSSF/PHI

This option would entail employer contributions towards the health insurance premiums of their employees and their families. Two public insurance schemes exist in Tanzania, of which the National Health Insurance Fund (NHIF) and the National Social Security Fund (NSF) are the most logical social health insurance agencies for private, formal sector employees to join. Alternatively, employers could contract with private health insurance (PHI) companies which represent a small share of Tanzania’s health insurance market.

Insurance premium contributions are a means to collect greater revenues for health, thereby expanding the fiscal space by which health services are financed. Such an option (a) opens the door for greater insurance coverage in the private sector and (b) can greater reduce the burden on public sector health spending.

Because each insurer offers a unique benefit package, varying premiums, and contracts with different health providers, the strengths and weaknesses of these funds will vary and so will implications for
decision makers. The NHIF offers the widest range of benefits and contracts with all public health providers, regardless of quality. The NHIF accredits private facilities, and their quality standards are considerably higher than the public sector. Private providers account for a varying share (9 to 47 percent) of NHIF health providers. Employee premiums make up 3 percent of their base salary and are matched by employers, though there is no additional cost sharing mechanisms (i.e. co-pays). In addition, employers receive tax exemptions for contributing to employee premiums.

Contrary to the NHIF, the NSSF – or more specifically the Social Health Insurance Benefits (SHIB) contained within the NSSF social security package – requires the same employer/employee matching agreement for premiums. Yet because contributions pay for broader social security benefits and comprehensive health benefits, 10 percent of an employee’s base salary is taken out for premiums. Provider networks are more restricted than in the NHIF, as they contain mostly urban providers, and patients’ choice of provider is limited due to capitation payments.

Private health insurers cater to private corporations and are both small and diverse. Benefit packages vary widely across plans (though typically offer premium benefits not included in the NHIF/NSSF packages) and premiums are higher than for the NSSF or NHIF; however, employees have greater choice. Private insurance is also not tax deductible for employers, and employer-run health insurance schemes lack any regulation – most notably consequences for insolvency.

2. Contribute Premiums to CHF

Such an option would supplement the above contributions to insurance premiums, whereby a portion of revenue collected for employee insurance premiums cross-subsidizes the publically administered community health fund (CHF). The CHF is the primary insurance fund for the poor and informal sector workers. Given its volatile revenue stream and high costs, contributions from formal, private employers could (a) increase the CHF’s long term stability and (b) could be used to increase the CHF’s benefit package to include secondary and tertiary level care. In turn, these would likely attract larger populations and increase the size of CHF pools. Such an option would aim to improve coverage for the broader community rather than formal sector employees or their families. Private sector corporations and their employees would not directly benefit from such a contribution. Unless the cross subsidy is mandated by law or attached to incentives, it is unlikely that corporations would voluntarily contribute to this fund.

3. Contract with Health Providers

While not a true PPP, private corporations could directly contract with health providers to delivery medical care to employees. These would most likely include private for profit providers and non-governmental organizations (NGO). Rather than contribute towards premiums for larger insurance pools, this option would entail private corporations becoming their own purchaser of health services. They would also have the flexibility to set their own benefits, cost sharing rates, and contract with providers that offer higher quality or specific medical services.

4. Deliver Care through On-Site Clinics

This option would allow private companies to deliver medical care through on-site clinics and become their own provider of services. Corporations could target and expand coverage for employees, their families, or the broader community – depending on the strategy and goals of each organization. Like the preceding option, this would allow corporations to select their own benefits, financing contributions,
and provider quality. However, it would not be viable for all organizations given the complexities of purchasing and providing care.

5. Investment in Workforce Wellness Programs

The MOHSW and GOT can play a strong role in advocating for increased private sector investment in workforce wellness programs and other company sponsored investments in health. The regulatory and legal framework in Tanzania already encourages this. The Occupational Health and Safety Authority (OSHA), which was established under Executive Agencies Act No. 30 of 1997 and is the custodian of Occupational Health and Safety Act No. 5 of 2003, calls for the promotion of occupational health and safety to “reduce accidents and occupational diseases, and ultimately achieve better productivity.” The 2006 Tanzanian Investment Report (TIC 2008) also acknowledges a 417 percent increase in CSR contributions in Tanzania between 2002 (US$4.7 million) and 2005 (US$23.4 million), and calls upon investors to make further commitments in the health and socio-economic wellbeing of rural communities.

5.2.2 GOVERNMENT’S ROLE

To promote private sector investment in company service provision, the GOT should consider the following options:

1. **Conduct a mapping exercise to identify existing employer investments and company based health services**: Given the mutual benefits of corporate social responsibility and employer investment in health, the GOT should consider national or regional mapping of existing company based health services to determine the scope, strengths, and weaknesses of existing workplace based private health services. Knowing which companies are already engaged in health could reveal opportunities for scale-up, knowledge sharing and replication through PPPs in health.

2. **Engage CEOs and industry leaders on the cost-benefit of investments in health and other service provision**: The GOT should partner with the Association of Tanzanian Employers (ATE) and groups or donors to complete a cost benefit analysis of existing employer health programs, and then communicate those results to the private sector. An information campaign based on hard evidence of VfM and cost-benefit of company sponsored services may help corporations see the business advantage of investing in health promotion or direct service provision, and the need to value health as a part of their core business. In Ghana, the government worked with multiple development partners to implement a CBA tool that compares productivity losses (such as number of work days lost and lost wages for common diseases and conditions) with the cost-benefit of different preventive and treatment interventions across the range of health promotion activities and service provision (Ojinnaka 2011). Identifying and sharing existing examples in Tanzania can help scale up, streamline or cut existing programs as well as test new interventions.

3. **Strengthen enforcement of existing CSR guidelines and design additional incentives for employers to invest in employee health**: A more direct approach for the GOT to stimulate private sector investments in workplace health is to design incentive schemes as part of the overall TIC investment

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7 GIZ ReCHT/Ghana, Swiss Tropical and Public Health Institute, GIZ Applied Research in Health Programm
and tax incentive structure. The government could reward companies who provide health promotion activities or services by tax-empting a percentage of revenues allocated towards these services, or by designing a health and safety award program that provides exemptions or other fiscal reward for meeting agreed health outcomes. In addition, non-financial incentives could include interventions to recognize employers with strong investments in employee health. For example, South Africa has an employer recognition program that ranks employees and provides awards to the country’s companies with the greatest health, highest motivation to improve health, greatest health knowledge, healthiest eating habits, best shape, most physically active, most smoke-free and most conducive working environment (Kolbe Alexander et al 2012).
As outlined above, although not a true PPP by definition, efforts to increase corporate investments in health could potentially offset costs to the public sector in maintaining the health of employed Tanzanians. Greater corporate investment in health would allow the government to redirect resources to additional priority health areas in the public sector. Efforts to broker increased corporate investment in health have been largely undertaken by The Association of Tanzania Employers (formerly the Federation of Tanganyika Employers). Formed in 1960 by a number of companies, industries and employer associations, the A.T.E. has become the most representative employers' organization in Tanzania. The A.T.E. represents employers in all sectors of the national economy (excluding the civil service), and at present, has over 1000 registered members. Seventy percent of the members are based in Dar es Salaam and the remaining 30 percent are in other regions of the mainland. The A.T.E. represents its membership on various tripartite labor and health forums and has a strong working relationship with GOT’s Ministry of Labor and Employment (MoLE) and MOHSW. It is also affiliated with the International Organization of Employers (IOE) and Pan African Employers Confederation (PEC), and works closely with donors such as the ILO, and the DANIDA and Dutch Employers Cooperation Program (DECP).

In Tanzania, the A.T.E. and its partners have recognized the importance of attracting greater employer investments in health, and have established a formal Health Coordinator position to oversee health and workplace wellness outreach with employers, with the aim of all employers providing some form of workplace wellness program, or in partnering with government and other private sector partners through to expand workplace provision of health services through PPPs. At present, most A.T.E. companies have put in place some form of workplace health messaging, but A.T.E. is advocating for employers to broaden their investment as part of the core business strategy. A.T.E. is advocating for its membership to invest more heavily in workplace interventions that include:

- A care and curative component
- An HR component (such as the hiring a full or part-time health coordinator)
- A community outreach component
- A strong prevention and safety component
- A component that mitigates injury and illness to lessen the impact on the employee and workplace.
Most employers in Tanzania, whether affiliated with A.T.E. or not, have not implemented programs that address all of these areas. For example, while there are a few breweries and cigarette manufacturers that have started providing on-site HIV testing and counseling, few employers have initiated a care or curative component that involves on-site company operated care. Most care and curative services provided to employees are sourced through the private sector as part of preferred provider insurance agreements, in particular with FBOs in upcountry regions. Some companies, such as Portland Cement, have started offering gym facilities to their employees as part of preventative general health and wellness.

**PPP for Women’s Health in Mtwara**

As part of scaling up its advocacy efforts with employers, the A.T.E. is drawing lessons and experience from a recent PPP for women’s health carried out in partnership between A.T.E., OLAM Tanzanian Ltd. (Mtwara), and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). OLAM Mtwara – part of leading global agricultural product and food ingredient company OLAM International – operates a cashew processing factory in Tanzania with over 4,500 estimated daily laborers per day processing up to 72 metric tons of product. Ninety-eight percent of these workers are rural women, whom are paid weekly based on their efficiency and productivity. As a result, illness and injury are of equal concern to OLAM and their employees as part of ensuring worker safety, productivity and efficiency. The A.T.E., GIZ and OLAM Mtwara entered into partnership to improve rural women’s health through improved access to health services and education. The program is heavily tied to a sensitization and an enrolment campaign for the local CHF and linking the workforce to services and care as part of CHF enrolment. It is reported by GIZ and OLAM that workers expressed an improvement in overall access to basic health services and education, prevention, testing and treatment related to HIV and AIDS, family planning, sexual health, malaria and TB interventions.

**Financing and Value for Money**

The cost drivers for the partnership in Mtwara were largely:

- The cost of services and education provided to workers
- The cost in management time for ATE, G.I.Z and OLAM to design, implement and monitor the partnership.

The direct cost of services was largely redirected via a link to the local CHF. OLAM paid the premiums for members working at the OLAM factory in Mtwara. The costs in management time to A.T.E., G.I.Z. and OLAM will likely become increasingly important if the project is scaled-up or expanded in scope.

**Successes and Challenges of the Partnership**

The partnership to date is a success, with over 20 peer educators trained (mainly women) to actively raise health awareness in the workplace. Furthermore, workers have reported significantly improved access to curative and preventative services and have stated that the program (through on-site services and care accessed off-site through CHF) has significantly improved their ability to access “preventive measures like condoms for dual protection (against HIV/STI and unwanted pregnancies), and to factory and public health services, e.g. HIV-testing, antiretroviral treatment, treatment of other infections, malaria and TB, as well as reproductive health services” (School of Public Health and Social Sciences, Muhimbili University of Health and Allied Science 2012). In addition, OLAM sponsored open “health days” for their employees, family and surrounding community as part of their community outreach commitment. This included a company-wide recognition of World AIDS Day and the health day on hygiene drew more than 4,000 workers and their children. Based on these initial successes, the A.T.E., GIZ and OLAM are considering preparing MOUs with other facilities such as OLAM Tanzania Ltd.’s coffee plantations to reach out with similar proposals to the mining and agriculture sector.
Challenges to Scaling-up

1. **Work employers will need to truly see the incentive for investing in worker health as part of their core business strategy:** If employers (and other partners) do not see this as both a social good but also good business, they will have no sense of ownership and sustainability will suffer. Increasing CEO knowledge of workplace safety and disease specific policies and laws (such as the Occupational Health and Safety Act, 2003 (No. 5) and the HIV and AIDS Prevention and Control Act, 2008) is of vital importance. TIC investment guidelines and other guiding conditions on investment should be more heavily enforced. While it is beyond the scope of MOHSW to make all Tanzanian employers aware of their social commitment, partnering with organizations such as A.T.E. will assist in increasing CEO awareness of their commitment to health in Tanzania. Increasing workplace concessions, tax benefits related to worker health outcomes, or other incentives could also assist by promoting employer self-regulation and voluntary contribution.

2. **Public and private partners must clearly see the incentive to act:** By openly discussing the social and financial benefits to employer investments in the health of their workforce, partnerships can be built for collective benefit.

Lessons Moving Forward

- PPP members must be held collectively responsible to manage and fund the technical assistance and on-going maintenance of the partnership.

- Almost all companies have links to some form of private or public insurance. Encouraging workplace involvement in PPP to be tied to public insurance options (like NHF/CHF in the OLAM case) strengthens the PPP and can promote sustainability at low cost to the employer. Linking employer investments to premiums in public insurance could make CSR more attractive to employers.

- Connections with trade unions, umbrella organizations such as A.T.E., and other partnership forums will be critical to success, as these partnership structures or contracts can change over time. In this case study, the A.T.E.’s role as facilitator has been critical, in that they have assigned a permanent health coordinator, and convened a forum on health involving the MOHSW and unions.
6. CONTRACTING WITH PRIVATE SECTOR HEALTH PROVIDERS

6.1 SERVICE LEVEL AGREEMENTS (SLAS)

The SLA structure in Tanzania was developed in 2007/08 as a mechanism by which management contracts designated council and district hospital agreements and other private health sector engagement for service provision could be standardized and improved. These mechanisms are able to formalize agreements in the provision of staff, services and commodities exchange between public and private actors, while remaining broad enough to allow for a wide range of inclusions. In theory, these agreements should strengthen coordination and collaboration between both sectors, but in practice, are much more difficult to implement due to the broad and unpredictable nature of health service provision.

Signatories and Structure

SLAs are contracts signed between LGAs and private sector health facilities. The signatory from the LGA side is the chairperson of the Council, the District/Municipal Executive Director (in the presence of DMO) and the legal officer of the council. From the health facility owners’ side, the signatory is the owner of the health facility. Health facility advocacy organizations, such as CSSC, report providing technical assistance to individual member facilities to negotiating SLAs, but it is individual facility owners that sign the agreement locally. The technical assistance consists of advising and sensitizing facility administrators about the terms in the SLA and completing cost studies that determine if rates in the SLA template are adequate to meet the facility’s costs.

LGAs may use SLAs to create PPPs that allow the government to expand their service delivery via a private sector proxy, and to access populations in rural regions where public healthcare infrastructure lacks capacity. The National Health Service Act authorizes the MOHSW to establish coordinating mechanisms between public and private health actors. The NPPPSC developed and pioneered the first forms of SLAs between private sector healthcare facilities in 2004. SLAs were standardized in the form of a template by the MOHSW in collaboration with other stakeholders in 2007, and after the approval of the template, implementation began the following year in 2008.

As directed by a PMO Circular in 2008, in the CCHP Guidelines, and in the HSSP III, LGAs may enter SLAs with private providers in exchange for council funding. With regard to CCHP guidelines, there are reported discrepancies at the local level on whether funds can be used for PFP facilities and in the CHMTs, and there is disagreement around whether basket funds may be used to finance PFP providers. As of 2012, there are approximately 65 reported agreements nationally, with only one known agreement with a for-profit provider (White et al 2013).

Comprehensive Council Health Plans (CCHP) Guidelines support the concept of PPPs in health, directing councils to make rational budget allocations among public and private providers. In practice, councils do not fully consider private providers, particularly PFP providers, in their budget allocations because there are disagreements around whether PFP can receive financial transfers from the government. Councils have a mechanism for output-based financing of PNFP and PFP providers through
the new SLAs, but they are misunderstood and under-utilized. Issuing further guidance on CCHP Guidelines and training councils on how to use SLA structures to achieve regional health objectives will help maximize opportunities in working with private providers in under-served areas.

Although there has been a history of management and operations contracts with FBO hospitals through the Council and District-Designated Hospital (DDH) agreements, the SLA template differs in that it ties funding to outputs. Output-based financing therefore links financial and cost information to the number of units of service that is produced through the SLAs (e.g. the attendances made by children under 5). This differs from input-based financing, which considers the cost of the resources consumed irrespective of the number of service units delivered (e.g. the cost of all drugs, diagnostics, and human resources required to administer the SLA, regardless of the number of people served). This mode of financing shifts the risk of serving the population to the service providers, and thereby makes them more accountable. However, without setting realistic caps on what the government can afford for exempted or reimbursed services, providers are vulnerable to excess costs. CDH/DDH agreements, on the other hand, may not have specified funding levels; where there were funding agreements, they are based on budget inputs instead of service outputs.

**6.1.1 THE CONTRACTING-OUT LIFECYCLE**

The SLA structure is organized around the contracting-out lifecycle as presented below.

*Figure 4: Contracting-out lifecycle*

The contracting out life-cycle is classified into the following steps:

1. Evaluating feasibility of the SLA
2. Designing the contractual relationships
3. Implementation of the contract
4. Monitoring and evaluation of the contract
5. Decision to renew or terminate the contract
Assessment of Need and Feasibility

SLAs have the potential to expand priority services in areas where public health infrastructure, human resources or clinical capacity is lacking. A GIZ study on SLAs found that low-income and marginalized communities were unable to afford user fees, which created further issues. For example, patients (including the elderly, pregnant women and children under 5 years old) would have to walk long distances or pay transport costs in search of public health facilities where they could have free access to RCH and other exempted services. SLAs allow the government to extend the coverage and scope of public-affiliated services through contracting providers in regions where there are no public health facilities, particularly by tying agreements to public health insurance or MBPs. SLAs may also contract private facilities where public health facilities lack specialists to administer services that are required and prioritized by the government.

Before SLAs are signed, stakeholders must determine if there is a need for an SLA, if it is the appropriate mechanism of partnership given other options, and if MOHSW has the fiscal space to contract out or purchase the services from the private health sector. Likewise, the PNFP or PFP health facility must determine if it can effectively and efficiently manage the delivery of services on behalf of the MOHSW.

As part of the feasibility and needs assessment, the MOHSW is responsible for accrediting facilities and setting quality standards before signing a SLA with a private facility. Accreditation and quality standards have been set, but inspection guidelines and regular monitoring is lacking. It is unclear if a thorough assessment of feasibility is conducted among facilities beyond assessing the demand for health services. Using information gathered from costing studies may also be helpful for facilities to consider whether or not the rates and service caps offered by the SLAs are sufficient. Because the MOHSW has created a standardized SLA template, there is little room for adaptability in the design of the SLA itself. Given these considerations, public health managers and providers may choose more simple service contracts, purchasing agreements or other forms of partnership with more narrow scope or service inclusions. Efforts by the MOHSW and development partners to adequately cost public, PNFP and PFP facilities are ongoing and will surely assist in this determination. However, it is imperative that all public and private partners agree on the relative cost savings and drivers for each sector if appropriate SLA or service contract choices will be made.

Designing the Contractual Relationship

The table below provides a summary of roles and responsibilities reflected in the standardized GOT SLA template. However, the implementation of the contractual relationship can vary. One cause of variation can be attributed to the understanding of the SLA template design among the key stakeholders.
Table 8: Government of Tanzania Service Level Agreement (SLA) template

<table>
<thead>
<tr>
<th>MOHSW Roles</th>
<th>Service Provider Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide health facilities with all relevant policy directives, planning</td>
<td>Recruit train and pay qualified employees.</td>
</tr>
<tr>
<td>guidelines, and standard treatment guidelines.</td>
<td></td>
</tr>
<tr>
<td>Approve health plans and budgets relating to the SLA.</td>
<td>Deliver the agreed upon services in accordance with the</td>
</tr>
<tr>
<td></td>
<td>terms and conditions of the SLA.</td>
</tr>
<tr>
<td>Facilitate acquisition of resources (human, financial, and material) by</td>
<td>Adhere to National Health Policy and other related policies,</td>
</tr>
<tr>
<td>the service provider.</td>
<td>planning guidelines, and quality standards.</td>
</tr>
<tr>
<td>Disburse funds to service provider.</td>
<td>Deliver resources to the intended population notwithstanding delay of disbursement of funds. If a delay exceeds 21 days, the service provider will provide emergency services only.</td>
</tr>
<tr>
<td>Accredit facilities and set quality standards.</td>
<td></td>
</tr>
<tr>
<td>Conduct regular monitoring.</td>
<td></td>
</tr>
</tbody>
</table>

After a need for an SLA to be established, and the partnership agreements have been designed, the stakeholders implement the SLAs. While little data is collected in aggregate, studies have shown that instituting the SLAs has led to the uptake of priority health services. For example, the expansion of RCH services in private facilities through SLAs has demonstrated a significant increase in utilization of such services. This is compared to situations where private facilities formerly charged user fees to cover the cost of delivering services (Mwangu et al 2012). For example, in Bumbuli Hospital in the Lushoto district, patient attendances for RCH increased from around 1,000 visits in 2006 and 2007 to more than 14,000 attendances in 2011 after an SLA was signed in 2009. Kipamo Hospital in the Kilwa District presented similar figures. In 2008, coverage for children under five had 2,300 attendances, and after the SLA agreement was signed in 2009, attendances increased to 3,000 attendances in 2010. These facilities reported that the increased support from the MOHSW in the form of human and financial resources also helped to generate demand from paying customers (Mwangu et al 2012).

6.1.2 CHALLENGES WITH SLA DESIGN AND IMPLEMENTATION

In seeking to develop best practices in the use of SLAs, it is important to look at existing examples to identify challenges, weakness in design, or areas for improvement. A list of the challenges reported by stakeholders and revealed in SLA monitoring and evaluation efforts is presented here.

1. **Issues in confirming informed consent from the signatories designated to sign the SLAs**: Some councils report that council chairpersons were not involved in signing the SLA, which raises a potential problem of ownership of the agreement. Furthermore, the English language used for the templates was not understandable to some of the signatories. To solve this problem, various town councils have translated the document into Kiswahili, but other councils and health facilities may be having issues interpreting the document. The lack of understanding of the SLA template’s terms creates disincentives for both councils and health facility managers to participate in SLAs.

2. **Weakly defined public staff secondment provisions**: One of the ways in which the public sector contributes to PNFP and PFP facilities through all agreement types is through staff secondment. A number of PNFP facilities under SLAs with the MOHSW employ and manage MOH personnel paid for by the public sector. Such provisions have been substantial, but are
typically loosely defined in the SLA in terms of number, length of guaranteed service, or risk of recall to a public facility. In addition to the risk that MOH staff provided under an SLA can be recalled at any time (taking with them any educational or training investments made by the PNFP or PFP facility), it was also reported that staff are difficult to manage because they are held more accountable to council authorities than the health facility management where they are working. Additional dialogue between the LGA and private facility managers is therefore needed during the design or strengthening of SLAs to ensure staff secondment inclusions, benefits and risks are adequately understood by all parties.

3. **Weakly defined provisions on commodity access:** Signatories of some SLAs reported that while the public sector had made critical commodity investments to their facility via the SLA, the terms and protections offered to both parties regarding inclusions were not adequately laid out in the agreement. Access to medicines and medical supplies via MSD are not adequately addressed or extended to all service providers under an SLA. Several PNFP and PFP facilities cited concern over having to use discretionary operating funds to purchase medical commodities from private outlets at inflated prices, which they had not anticipated as part of service expansion at the outset of agreement. Such limitations in the language and inclusions in existing SLAs compromises the accessibility and quality of services to clients, and in turn, negatively affects the service’s providers operating costs and incentive to participate.

4. **Disagreement around service capitation:** The MOHSW or LGA leadership has the ability to set the maximum number of services that can be delivered through an SLA. However, there are reports that LGAs have not set these limits. The limits are meant to protect the LGAs from spending beyond their budgets, and to prevent the service providers from delivering too many services that the government cannot afford to reimburse. SLAs need to be more pro-active in using adequate costing data to set reasonable service caps at the LGA level for all SLAs. Increased transparency, and understanding how many services are typically provided and how many can adequately be reimbursed by the public sector can assist facilities in adequate planning and service provision projections. To date, PFP facilities have been prevented from receiving funds in the form of direct transfers, and such policies have prevented the PFP sector from participating in the SLA structure. Dialogue between the MOHSW and the PFP is ongoing in this regard, and reforms of relevant policies and local procedures at the local level to allow for PFP engagement through SLAs is encouraged.

5. **Delayed and variable payments to PNFP facilities:** Payments to individual SLA facilities are made by the LGA. However, the system involves several stages of reporting, allocation and disbursement that are susceptible to delays on the part of all parties. There are known delays and multiple challenges with the central allocation and disbursement system for payments from central government, to LGAs, and finally to facilities. Having unpredictable cash flow throughout the system makes it difficult to forecast the number of outputs the LGAs can afford to pay for during any given month. Delayed or inadequate invoicing processes from the health facilities to the LGAs, and late LGA reporting and requests for disbursement to regional and central level further delay the process. There have also been instances of over-reporting utilization to increase the size of reimbursements, which has added a new level of monitoring and regulation that can prolong invoice processing.

6. **Limitations in national fiscal space to provide adequate human, material and financial resources for implementation of SLAs:** Although SLAs include language that the service provider is responsible for ensuring that the expenditure agreed upon in the SLA remains within budget limits, abiding by this policy puts the health providers at great risk. To
illustrate, consider the instance when a health facility has agreed to delivery free services, but the LGAs do not have enough financial resources available to reimburse the services. In this situation, the health care facility may bear either the ethical or public relations risk of turning away patients, or the financial risk of continuing to deliver the care for free without receiving the required reimbursements. These situations significantly threaten the sustainability of private facilities and make SLAs less attractive to providers.

7. **Weak private sector ownership of SLAs**: A GIZ study found that in the Mbeya region, respondents claimed that they were asked by the LGA officials to sign the SLA as a pre-condition for their facilities to obtain support from the councils, including grants from the basket funds, allocation of human resource and medical equipment and supplies (School of Public Health and Social Sciences, Muhimbili University of Health and Allied Science 2012).

8. **Limited synergy between CCHP and SLA processes**: The same GIZ study reports that there is weak collaboration between LGAs and the private health sector (particular PFP providers) during the annual CCHP process, which limits the potential of SLAs to extend service coverage (School of Public Health and Social Sciences, Muhimbili University of Health and Allied Science 2012). In addition, opportunities throughout the lifecycle of the SLA to review and reassess inclusions is lacking. Initial SLA terms of 3 years (and more recent SLAs of 5-10 years with established and trusted partners) could be enhanced by increasing opportunities to review performance and inclusions of both parties annually, perhaps to coincide with the CCHP process. SLAs already have a clause stating that the agreements will be automatically renewed based on satisfactory performance, and therefore built in opportunities for flexible and multiparty review of agreements and participation in planning. LGAs could mandate that SLAs be reviewed for consistency with LGA annual health objectives and the CCHP process, where SLA annual terms, service caps and conditions are refined or discussed as needed.

6.1.3 **MONITORING AND EVALUATION OF SLAS**

According to the SLA template, the MOHSW is responsible for conducting regular inspections of the service provider’s health facilities to verify staffing adequacy, equipment quality, adherence to quality standards, and structural condition of buildings. The CHMT or RHMT reserves the right to conduct spot checks in the health facility at any time. The SLA template decrees that the parties should hold quarterly meetings with senior members who represent each party to monitor the progress of the agreement. Furthermore, the SLA template outlines that the SLA will be reviewed annually to evaluate the adequacy of costing the services. Despite this language, studies suggest that monitoring activities do not occur on a regular basis. The lack of monitoring significantly threatens the ability for managers at facilities and policy makers with the MOHSW to decide how best to respond to issues arising from the implementation of the SLAs.

**Budget Performance of SLAs**

In terms of budget performance, the lack of regular monitoring mechanisms prevents service providers and the MOHSW from monitoring the adequacy of the budgets allocated to finance SLAs. A GIZ evaluation conducted in 2012 identified that the Bumbuli Hospital was not being paid Tsh 4,800,000 (USD $2,961) per month that it claimed from the MOHSW during the 2011/12 fiscal year. Moreover, the St. Matins Kipatimo hospital reports that the MOHSW has an outstanding debt of Tsh 17,657,775
(USD $10,894) for fiscal year 2008/09. It is important to note that there is no aggregate analysis of how much outstanding debt the MOHSW carries from its active SLAs. Measuring these financial gaps is necessary to qualify the budget performance of SLAs on a system-wide basis (School of Public Health and Social Sciences, Muhimbili University of Health and Allied Science 2012).

Instances of underpayment raise important concerns around whether the current SLA financing framework is sufficient or if the amounts claimed by service providers are inflated. The unpaid amounts from the SLA claims submitted by providers to councils indicate that the SLA financing framework may not mobilize enough funds for SLA implementation.

Local health councils have no independent budget to implement SLAs, leaving them dependent on donor funding through basket funding. Council own finances are raised in the form of dues and taxes. No reliable aggregated data was available to estimate the total of these funds and the share allocated to health. Councils' health budgets are also dependent on intergovernmental transfers and funding from development partners.

Councils report concerns with the delays in disbursing the basket fund from the central Government. Delays in disbursement of basket fund to councils affect the reimbursement process. Financial support from council own sources is almost none. Thus, most of the councils with active SLAs have no guarantee that they will have budget from their own sources to support SLA implementation.

Given the lack of monitoring mechanisms for the SLAs, it is difficult to judge if the fiscal space exists through health basket funding or through regular budget allocation. Evaluating this against the fiscal space analysis is necessary to determine if SLAs may be expanded.

### 6.1.4 CONTRACTING-OUT THROUGH SIMPLE SERVICE CONTRACTS OR PURCHASING AGREEMENT

As outlined in the section above, standardized SLA form and structure may require for LGAs to be empowered to pursue more flexible, small-scale and local options of service contracting than the existing SLA structure. Contracting-out (also known as outsourcing) of both clinical and non-clinical services to private entities has become an increasingly popular way for countries to involve the private sector in health. Evidence suggests that contracting-out for curative, diagnostic or specialist services can have an immediate and substantial impact on access to health services, and if done as part of a public health financing scheme, can positively improve equity (Lagarde & Palmer 2009). As contracting-out is in its infancy of application, most studies have been defined as part of pilot projects with little information for or against its impact on broader health system strengthening efforts. Contracting-out is perhaps still best approached at the local level where existing relationships and systems of operating can be employed. However, broader health system involvement can be accomplished by tying SLAs or simple service contracts to public health insurance or MBP to achieve the core deliverables of more accessible and efficient service that is subsidized at the point of care (Lagarde & Palmer 2009). Contracting-out via simple service contracts or other forms of purchasing agreement allow LGAs or facilities to make use of existing local private sector resources to fill service gaps or address excess need. It can also meet the broad national health system goals of strengthening decentralization and responsiveness of services, and diversification of sources and methods of health financing. Considerations for contracting out through simple service contracts or purchase agreements include the following:
1. **Using a range of contracting instruments from simple to complex:** Moving from a centralized to decentralized management option in health relies on LGAs being able to utilize public and private sector capacity and assets to meet local health priorities. Variability in environment and resources suggests that PPP contracting tools should be flexible in design and application, streamlined for implementation at the local level, and easy to monitor and maintain. It is unclear if contracting-out relieves or burdens management constraint, so it will be imperative to keep in mind the institutional capacity at local level for outsourcing and service contracting. It might be most appropriate to start small with specific purchasing agreements or service contracts at the facility level for set limits of diagnostic or surgical services (i.e. to alleviate long public wait times for MRI and radiology, or surgical theatre).

2. **Success with service contracts is highly contextual:** Careful analysis of the local context, available resources, supply and demand are necessary before deciding if contracting-out will be preferable to direct public provision. Local relationships between the purchaser and provider will be an important determinant in the success of the contracting process (Siddiqi 2006), and clear understanding of the terms and conditions of the contract is essential before final implementation. Clear payment and reimbursement mechanisms are also essential, and will minimize the time required by both parties post-procurement to maintain the contract.

3. **Value for money and budget performance:** As health systems mature and adapt to global fiscal constraints, the WHO suggests that there will be an evolutionary process where countries pass through a learning phase to determine if contracting is an effective health management and regulatory tool (Siddiqi 2006). Given the local application, highly contextual, and specific nature of effective service contracts, it is difficult to state whether they provide VfM. As suggested below, the simpler the contract terms, the more likely it will reduce rather than increase demands on LGA management capacity. More research is needed on whether contracting-out will provide savings through efficiency and enhanced capacity. LGAs have existing experience with such modalities in the area of rubbish removal, and learning could begin there.

4. **A method to be used with caution:** Without further pilot application of service contracts at the LGA level, it will be difficult to determine whether it would be better to improve public provision or scale-up the outsourcing and contract management function of LGAs. Contracting-out is not a cure all for public health systems and not all services clinical or otherwise should be contracted out. Improving the capacity of LGA leadership to make that determination and to use PPP service contracts methodically as part of improving local health outcomes will be critical. It will also be essential to ensure private providers are ready to meet the standard of care required by the contract.

### 6.1.5 CONSIDERATIONS IN SCALING UP CONTRACTING-OUT

Service contracts for **clinical services** will be most effective when the service can be easily defined, costed and measured. Pharmacy services, radiology and laboratory services and equipment, and allied health services have been handled this way. In the provision of specialized services, or services with a high variability of outcome, contracting-out may be more difficult given the flexibility required in the agreement to accommodate for multiple outcomes or clinical interventions. The public sector must have a specific and defined need for services (i.e. as identified by wait times or lists for MRI, laboratory or surgical) and the private sector must have an identified excess capacity to provide that service at a regulated standard of care. Private partners must be ready and willing to work with government as part of clinical service contracts, maintaining MOHSW standards and regulations in the provision of care, and reporting information into the national HMIS.

Service contracting for **non-clinical services** is somewhat more straightforward and potentially less controversial as a starting point, as it does not involve the direct provision of care. LGAs have pursued
this type of private sector engagement in the area of rubbish removal. Learning from this experience and further exploration of potential VfM in contracting-out for other services is warranted, such as maintenance and sanitation, distribution or collection of samples and equipment, supplies and catering, security or janitorial services. For contracting to be successful, the service provided must be sufficiently standardized and transparent so that it is easy to monitor and regulate post-procurement and the contract can be easily maintained. This works best when satisfaction with service can be easily measured.

6.1.6 OPTIONS FOR USE OF SLAS AS A METHOD OF FINANCING PPPS

The following options may be pursued to improve the use of SLAs funded through basket funds to finance PPPs.

1. **Refine the assumptions used to plan for and implement SLAs.** This will involve the following steps:
   - **Conduct an actuarial study to estimate the predicted utilization of services.** An actuarial study uses statistical analysis to predict how many outputs (e.g. units of care such as the number of attendances made by children under five years old) can be expected with the coverage of services through SLAs.
   - **Agree on a cost basis for services.** In order to estimate the predicted budget required to finance SLAs, private service providers must agree with MOHSW representatives on the rates for services. CSSC, for example, conducted a cost analysis that estimated the cost of a normal delivery to be Tshs 38,074. However, NHIF tariffs only reimburse at a rate of Tshs 5000. GIZ analysts have concluded that the discrepancies are a result of different methodologies used to complete the cost analysis. This calls for harmonization of the costing process between the two parties (i.e LGAs and HFs) involved in the SLAs.
   - **Calculate the total budget envelop required to administer SLAs.** Multiplying the predicted utilization with the predicted costs for each service will estimate the total amount that requires financing. Having the total budget estimate can then be used to determine where to source funds from public sources.
   - **Measure the total debt owed by the MOHSW to private facilities.** This may involve using umbrella groups such as CSSC and APHFTA to gather information from their member facilities concerning how much is owed to them by the MOHSW. It is also important to consider repayment strategies that may have been negotiated between councils and service providers. This total debt should either be foregone by the services providers or paid by the MOHSW. It should be considered in addition to the budget required to administer the SLAs.
   - **Evaluate VfM for SLAs.** The above analysis will give policy-makers the information required to measure whether engaging in different types of SLAs is cost-effective. Other options may include rationing the use of SLAs and investing in expanding public health care infrastructure.

Following the above steps will allow the MOHSW to determine if there is budget available from basket funds, general budget allocations, or other sources to service the SLAs. In cases where there is not sufficient budget available, SLAs should not be signed.

For future planning, it may be better to assign the management of budget decisions for SLAs to the councils. Councils may be responsible for setting aside funds from their own sources to
finance health care services in their area of jurisdiction, subsidized by the health basket fund. This can be achieved if councilors in the respective councils are sensitized to the PPP, in particular, the SLA benefits to the community.

2. **Identify more funding for SLAs:** Despite having a limited view of the total amount owed by the MOHSW to service providers under SLAs, the available evidence suggests that the current method of financing SLAs through basket funds is insufficient for covering the total costs of implementing SLAs. Councils and other responsible bodies should consider alternative funding mechanisms for the SLA. The following presents a list of alternative funding sources:

   - **NHIF cross-subsidization.** After an actuarial analysis has been completed to cover the predicted utilization costs for SLA-covered services, this amount (a portion or in total) may be covered through the premium contributions for NHIF. Another analysis would be needed to determine whether an increase in premium charged to NHIF members would be necessary, or if there is room in the NHIF funds to cover the costs.
   - **Institute a tax.** At a national scale, different forms of taxes and levies can be instituted to earmark funds for servicing the SLAs. This approach comes with significant political repercussions and must only be considered if the SLAs require a budget that is too large to be accommodated by any other financing mechanism.

   It is important to note that evaluating the best option for financing SLAs depends on the analysis of how much money needs to be raised to service the SLAs.

3. **Control the Use of SLAs:** SLAs are meant to increase access to priority populations (i.e. vulnerable populations and populations in areas out of reach by public facilities). Given the higher cost structure of private facilities, it is important that the MOHSW identify instances when their government subsidy is not reaching their target population, or is instead being used to subsidize a non-targeted population. For example, for instances when SLAs are being used to target lower-income or destitute populations, a means-test may be instituted to verify that persons meeting certain eligibility criteria (e.g. maximum income or age requirements) be allowed to obtain subsidized services. Depending on the priorities of the MOHSW and the goals that the MOHSW wants to achieve, monitoring mechanisms that account for these targets must be instituted to prevent wasteful unnecessary spending use of resources.

4. **Ration the Use of SLAs:** To avoid debt and over spending, it may be possible for the MOHSW to limit the services covered by SLAs. Using an actuarial analysis, MOHSW can then evaluate which services it can then afford to pay for and set limits. For example, in instances where maternity care is covered, the MOHSW may evaluate if it can afford the full range of maternity services or if it should limit it to services to certain priority concerns (e.g. complicated maternity cases). Such decisions can be controversial and difficult to operationalize, but it sets accurate expectations for what service providers can deliver and what the MOHSW can promise it will subsidize. This will involve a great amount of training to estimate budget obligations arising from SLAs to ensure that adequate budget is set aside for these service-based payments.

5. **Consider Other Partnership Arrangements Apart from SLAs:** In light of the issues presented in the SLA template such as the minimum year requirement and other responsibilities, it may benefit LGAs and health facilities who have never engaged in SLAs, to test other methods of partnership. Memorandums of Understanding (MOUs) may allow for more flexible terms that each stakeholder can tailor to fit their needs. Such alternative forms of partnership requires a
great amount of sensitization so as to avoid the same challenges confronting SLAs, but may provide the stakeholders with the flexibility that they require.

In sum, while it appears that there are not enough resources to finance the growth of SLAs, these gaps in resources must be measured. It is important to identify greater resources to finance SLAs, but it is also important for SLAs to attain greater efficiency. Completing analysis and working to generate greater efficiencies are the only options to ensure that SLAs meet their intended goal to increase access to priority services for communities with the greatest need.

6.1.7 CONSIDERATIONS FOR PERFORMANCE-BASED SLAS

The World Bank defines performance-based contracting is a type of contracting with (1) a clear set of objectives and indicators, (2) systemic efforts to collect data on the progress of the selected indicators, and (3) consequences, either rewards or sanctions for the contractor, that are based on performance (Loevinsohn 2008). Rewards can include continuation of the contract in situations in which there is a credible threat of discontinuation, provision of performance bonuses, or public recognition. Sanctions can include termination of the contract, financial penalties, public criticism, and being prohibited from receiving future contracts. In theory, performance-based contracts create incentives for contractors to reach their objectives more efficiently.

The SLA template notes that its intended objective is to extend the reach of exempted services in regions areas where the public healthcare infrastructure lacks capacity. However, the SLA template lacks the language to measure if these objectives have been met. For example, the following indicators are examples of indicators that may be useful to track in light of the objectives noted in the SLA template:
- Number of consultations per person per year provided by the contractor.
- Percent of children residing in priority areas age 6 – 59 months who received vitamin A supplements within the past year.
- Percent of children residing in priority areas age 12 – 23 month who received measles immunization coverage.

Such indicators could be used to track each contractor’s progress on meeting the objectives of the SLAs; however, none are noted in the SLA template. The SLA template noted the regular monitoring of the implementation of the SLAs, but it is unclear if these quarterly meetings and annual reviews systematically captured the data required to attach rewards or sanctions as required by performance-based contracting. The existing SLA template includes rewards and sanctions in the form of clauses that reserve the right for termination of the contract as well as payment based on output.

With regard to SLAs in Tanzania, the SLA template has clauses that reserve parties the right to renew or terminate the SLAs if the parties fail to fulfill their responsibilities in the contract. This ensures that private sector providers are protected in cases when LGAs do not pay the health facilities adequately. Likewise, LGAs are protected in cases when private sector providers are not delivering health services in the quality that is required by the LGA. The monitoring and evaluation framework of the contracts is important to informing these decisions on whether or not termination or renewal is strategic for each stakeholder.

The SLAs are paid on an output-based method. In these cases, private health care providers typically have the incentive to deliver the highest numbers of services possible, as long as the reimbursement rates per service are enough to meet the costs of delivering the service in addition to surplus. In Tanzania, it is unclear if the reimbursement rates used for SLAs are sufficient to meet the cost of delivering the services due to discrepancies in costs estimates for delivering services. If the
reimbursement rates offer a surplus in comparison to the costs incurred to deliver the service, healthcare providers have the incentive to deliver as many services as possible. However, if reimbursement rates are too low, then healthcare providers have the incentive to decrease the number of services they deliver under the SLA because they incur a cost for every service delivered. As noted earlier in this section, the MOH and their partners must first agree on the costs of delivering services in order to properly assess if the incentives of existing SLAs are designed in such a way as to encourage efficient progress. Termination clauses and output-based payment methods are fairly limited their capacity to incentivize efficient performance; the following performance-based strategies may be considered as options for strengthening SLA arrangements:

1. **Instituting performance bonuses based on output targets.** Performance bonuses are additional compensation that the MOH may deliver to healthcare providers contingent on delivering a certain number of specified services. For example, the MOH may implement a performance bonus when a healthcare provider attains 80 percent or more coverage of children with required immunizations. The strength of this approach toward performance-based financing is that outputs are easy to measure when they refer to the frequency of services delivered. The drawback to this approach is that the indicators do not measure any change in health outcomes in a population.

   a. **Instituting performance bonuses on output targets with specified quality specifications.** This approach is the same as the first approach, with the addition of quality specification. A quality specification may refer to standard treatment protocols or other measures that identify if a service delivered conforms to an agreed upon standard of quality. The strength of this approach is that this allows purchasers like the MOH to control incentives around the quantity (e.g. number of caesarian sections delivered) as well as the quality (e.g. number of caesarian sections delivered that complied with standard treatment protocols for anesthetics and antibiotics). The drawback to this approach is that the protocols for quality of each service delivered is difficult to report and measure for each service.

2. **Instituting performance bonuses based on outcome targets.** In contrast to outputs (which refer to the number of services delivered), outcomes refer to the results of delivering those outputs in a population. For example, an output indicator measuring the progress of a MCH intervention may refer to the number of women attending the full recommended four antenatal visits. In contrast, an outcome indicator for the MCH intervention may refer to the number of complications at birth. As another example for a malaria treatment intervention, output indicators may refer to the number of children under five years old receiving a regimen of malaria treatments. Outcome indicators for malaria treatment interventions may refer to number of children with complicated in-patient cases of malaria (the rationale being that children who get proper treatment at out-patient level are less likely to require hospitalization for malaria). In this performance-based payment approach, the bonus is paid after the contractor reaches the target outcome metric. The strength of this approach is that bonuses are paid for fulfilling their intended effect on the health outcomes of a population. The drawback to this approach is that it is sometimes difficult to attribute whether the frequency of services rendered was the direct cause of changes in health outcomes.

3. **Providing public recognition or criticism based on outcome and output targets.** Instead of financial bonuses, this approach deploys various forms of public recognition or criticism to reward or sanction healthcare providers. For example, LGAs may recognize healthcare providers who meet their performance targets by posting visible signs or publishing
the successful providers in newspapers. The advantage to this approach is that it may be more cost-effective than delivering financial bonuses. The weakness to this approach is that the benefits of public recognition may not suffice to incentivize healthcare providers if they have trouble keeping financially stable or if the facilities are being over-utilized. In the cases when facilities may be over-utilized, the increased demand for their services may not be desired by the healthcare providers. Similarly, the MOH may publicly criticize healthcare providers who do not perform according to standards noted in contracts. However, in light of the strained relationship that the MOH appears to already have with its contractors, this strategy is not recommended.

4. Requiring financial penalties for poor performance. This approach requires contractors to pay the MOH (or forgo receiving a portion of their payment) an agreed upon amount of funds in instances when they do not perform according to standards in the contract. Similar to implementing public criticism, this approach is not recommended because it may further strain relationships with contractors.

While these are options that LGAs may consider when structuring SLAs with healthcare service providers, it appears that the MOH must still address the weaknesses of the SLA implementation as discussed in the previous sections. Namely, the MOH must confirm the budget available for financing SLAs and agree with healthcare service providers on the appropriate rates that will meet provider costs. Furthermore, LGAs must focus on clearly defining goals for instituting a performance-based financing program through the SLAs. This will need to be conducted by each LGA looking to sign an SLA. After these objectives have been clearly defined, the stakeholders must agree on the appropriate monitoring and evaluation framework to measure progress against meeting those goals. Several examples of output and outcome indicators were discussed in this section; however, indicators must be designed with specific attention to each contract’s objectives. Furthermore, a management information system must be in place to accurately collect the data needed to generate the indicators. The assessments of SLAs in Tanzania suggests that the implementation of SLA currently lacks the capacity to manage this data collection and reporting mechanism required for implementing a comprehensive performance-based SLAs.

Since implementing performance-based SLAs will likely require a larger amount of fiscal space to finance bonuses or activities related to public recognition, the authors recommend first strengthening SLAs to be financially sustainable in the near term. This involves implementing some of the options presented earlier in this chapter that garner more funds to dedicate toward financing SLAs. In addition to estimating and allocating the resources required for implementing performance-based SLAs, the MOH together with its partners, must design an accurate and transparent M&E system. Designing an M&E system for performance-based contract involves:

- Collecting baseline data in the areas where goals and targets are being established.
- Devising a clear schedule for data collection with regular validation.
- Benchmarking with comparison or control groups where possible.
- Assigning responsibility for the collection, analysis, reporting, and dissemination of data.
- Budgeting sufficient funds and level of effort for M&E.

After these budgeting exercises have been conducted, performance-based financing may be considered in the estimates of fiscal space required to implement SLAs.
SLAs represent the primary mechanism through which PPPs for improved health service provision in Tanzania have been attempted, and therefore provide significant experiential evidence that can improve future application of this mechanism. CSSC is the largest FBO coordinating body in Tanzania, with inter-denominational membership representing the Episcopal Conference, the Catholic Church, and the Christian Council of Tanzania, which in turn comprises 15 national churches and 14 para-church organizations and ministries. CSSC member facilities are comprised of 697 dispensaries at the village/ward level, 101 health centers at the divisional level, and 99 hospitals across Tanzania – 38 of which are in contracts with the MOH as CDH or DDH facilities. As an advocacy and umbrella organization, CSSC is involved in sensitizing their member health facilities on PPPs in general and SLA terms. CSSC members participate with the MOHSW in policy and planning initiatives at the central and regional levels. Through direct contractual partnerships with the GOT and MOH, CSSC member facilities deliver a significant portion of preventive and curative health services in Tanzania – particularly at the health system district level and above, and in rural areas lacking public facilities.

**Types of Agreements, Financing and Inclusions**

CSSC facilities have signed three types of contracts with LGAs which include: i) delivering of consultant specialists to public hospitals, ii) serving as designated district hospitals (DDHs), and iii) contracting through SLAs. While CSSC brokers relationships at the national level, each CSSC facility owner is responsible for signing the service contracts directly. Because each facility owner negotiates the terms of the SLA individually with LGAs, each SLA varies from the SLA template recommended by the central government. For example, CSSC reports that there are some SLAs with a firm 1-year time period and others with less defined terms. At the central level, CSSC receives any issues related to payments or adherence to the terms of the contracts. CSSC is then responsible for providing their member facilities with technical assistance and advocates on their behalf to the MOHSW.

As government partners, CSSC facilities are able to procure identified medicines and consumable commodities via the Tanzanian MSD. They are also able to receive financial grants from MOHSW basket funding (excluding salaries or capital development), and are provided with medical and nursing staff through ministry staff secondment inclusions. The vast majority of CSSC facilities are financed by user fees (set by the individual facilities and LGAs), as well as through international and local donors, income generation projects (such as hostels, gardening or maize processing), and/or NHIF (on average, less than 10 percent of facility financing). In keeping with CSSC’s mission to ensure the poorest and most vulnerable citizens receive care, user fees are set to ensure equity of access. FBOs also play an important role in training health professionals for both FBO and public service. Because of the long and close working relationship with the MOHSW, many view the FBOs as an extension of the government.
Challenges and Needed Reform

CSSC reports the following issues cited by their member facilities:

1. **Varying term periods of active SLAs.** CSSC reports that some of their member facilities prefer to have shorter term periods (of at most 1 year) in order to account for changes in the cost of drugs and medical supplies, or to make adjustments to their original terms. In contrast, CSSC reports that some facilities would prefer having contracts lasting for 3-5 years to allow for the flexibility to revisit outputs, service caps and inclusions on a regular basis (e.g. as part of the CCHP planning process).

2. **Late and insufficient payments.** CSSC members report operating on a loss due to late or insufficient payments from LGAs for services rendered under the SLA. This may be caused by late or insufficient budget allocations to the basket fund at the central level, but it ultimately effects the health facilities’ operations. CSSC also reports that resolving delays will be every partner’s responsibility, including CSSC facility managers reporting and invoicing on time.

3. **Lack of sufficient shared planning on the part of the LGAs and facilities.** CSSC reports that their facilities can improve regular planning for how to set capitation on service limits (if any) on the quantity of services that the LGAs can afford to cover. Some facilities report not having agreed upon limits for the number of services to provide annually, which places them at financial risk in situations where the facilities deliver more services than the LGAs can afford to cover. Given the mission base of CSSC facilities overspending in the provision of services occurs rather than refusing care.

4. **Lack of a forum or flexible meeting opportunities to settle concerns and address grievances related to the execution of SLAs.** Front-end planning on tying SLA implicated service provision to actual LGA planning processes is lacking, and CSSC reports that although SLAs are tied to consultative meetings with the CHMTs, there is need for additional opportunities for SLA partners to meet as part of SLA specific forum or as flexible planning dialogue.

5. **Lack of cost data to justify if NHIF reimbursement rates are adequate to cover cost of private provision.** CSSC reports that there is no agreement on the actual cost of services, but efforts between the private and public sector are currently underway to finalize a study on the actual cost of services in Tanzania’s various facilities. Accurate costing of public, PNFP and PFP service provision will assist in resolving deficits in adequate reimbursement.

6. **Limitations in facilities’ ability to access MSD commodities.** The reimbursement rates used for the SLA template assume that facilities will procure their drugs and other supplies at the subsidized rate at the MSD. However, when supplies are depleted at the MSD, CSSC facilities often have to purchase their supplies at private pharmaceutical supply outlets to provide care included under the SLA. These additional costs are not factored or considered in NHIF rates, which further skews accurate reimbursement.

**SLAs in the PFP Sector**

In terms of the PFP sector, partnership and dialogue have been constrained until recently and there are only one or two known SLAs with PFP providers. There is high-level GOT and PFP dialogue moving towards greater use of SLAs and other services contracting with the PFP sector, but the lack of accurate costing and persisting tensions over equity of access, quality and regulation, and effective NHIF/CHF reimbursement remain difficult areas. The same challenges that affect CSSC and other PNFP SLA facilities will affect APHFTA or other PFP facilities, and perhaps to a greater degree given the developing relationship and processes between public and PFP interaction. Since 2006, the GOT has had issues transferring money to PFP enterprises, and while it is reported that SLAs are formally allowed
to be extended to PFP facilities, standing orders at the local level, a number of temporary or ‘acting’ DMOs that are reluctant to sign such broad agreements, and confusion over SLA application in the PFP sector have prevented transfers with PFP facilities. However, in 2012, language in basket fund allocation documents was amended to also include PFP facilities. This shift has not yet been clarified or communicated throughout the health system, especially in light of a PMO circular stating that SLAs are only allowed for FBOs. The circular is in the process of being recalled to allow inclusion of PFP health facilities. Once it is recalled, the circular should significantly improve understanding of PFP allocation and allowances at the LGA level.

**Lessons Moving Forward**

The lack of clarity around the issue of SLA use with PFP facilities has led to a rise of informal agreements between LGAs and PFP health facilities. Because the agreements are informal, there is no strong incentive to adhere to the terms of the agreements. Informal agreements leave limited capacity for monitoring and effective regulation and fail to truly bring the PFP sector on as a contracted and mutual partner. For example, APHFTA reports that expenditures used for these activities are nearly impossible to track and planning, costing and making adjustments to the agreement nearly impossible.

Overall, the PNFP and PFP experience with SLAs demonstrate how lack of formality and ineffective execution of the SLA service terms, limitations on costing knowledge, and limited opportunities to resolve challenges through partner dialogue have prevented the SLA approach from filling gaps in MOHSW service delivery structures. If these issues are not resolved, then both PNFP and PFP facilities will continue to operate at a loss while participating in the SLA or might terminate existing agreements.
7. PRIVATE SECTOR INVESTMENTS IN HUMAN RESOURCES AND HEALTH INFRASTRUCTURE

Private investments (both financial and clinical capacity) for improved health service provision are discussed in this section. Firstly, section 7.1 explores the private sector’s role in the development of human resources for health in Tanzania. This section summarizes the major challenges confronting private medical training institutes (PMTIs) and presents options for making these private investments more efficient. Section 7.2 discusses the potential for public private mix and co-location of services as a way to retain health talent in the public sector, and to mitigate the negative effects of provider dual practice. Section 7.3 presents an overview of potential private sector investments into healthcare infrastructure through leasing agreements and concessions. It also defines the various options that may be pursued to improve private sector investments in health infrastructure, and outlines how those investments could expand the reach of essential services.

7.1 PRIVATE SECTOR INVESTMENTS IN HUMAN RESOURCE DEVELOPMENT

Currently there are 11 accredited PMTIs in Tanzania. PMTIs train approximately 6 percent of all medical students in Tanzania. Of the 27 universities and university colleges under the jurisdiction of the Tanzanian Commission for Universities (TCU), six offer medical programs, and four of these are private universities. Of the 57 medical training schools given at least provisional accreditation by the National Council for Technical Education (NACTE), there are nine private commercial medical training schools. PMTIs face a myriad of complex and interconnected challenges that impede their ability to graduate a higher number of health workers in Tanzania. The various challenges facing PMTIs are noted below.

Insufficient Numbers of Medical Instructors

The Tanzanian higher medical education landscape suffers from a dearth of qualified medical instructors and tutors. Many PMTIs have particular difficulties in recruiting and retaining medical instructors, compared to public institutions. The Ministry of Education indicates that public institutions, on average, have a student-instructor ratio of 1:11, while PMTIs have a higher ratio of 1:16. For some PMTIs, the shortage of training instructors has almost resulted in the loss of their accreditation. For instance, the International Medical and Technological University almost lost its TCU accreditation in 2008 due to a lack of qualified instructors. The university only survived by making major investments in faculty, facilities, and curriculum programs. A positive aspect to this major investment was a significant increase in enrollment by 2010.

At the university level, private medical universities may experience higher turnover of staff because of fewer long-term contracts with instructors. These universities may also rely on foreign instructors; for instance, up to 50 percent of the medical instructors at HKMU are non-Tanzanian. Public universities and institutions are able to provide more stable pensions and job security than their private
counterparts. While there are some exceptions at the diploma level, most PMTIs experience acute challenges in attracting and retaining a sufficient number of medical instructors.

**Limited Infrastructure**

All interviewed PMTIs experience limited and poor-quality infrastructure. There is a widespread lack of laboratory space, demonstration equipment, and student housing. These limitations reduce the number of new students PMTIs can accept and can impede accreditation, as well as posing a significant barrier to entry for new PMTIs. For instance, NACTE indicated that the Mount Ukomozi Health Sciences Training Centre must finish refurbishing its laboratory facilities for students before it can accept new students in September 2012. This infrastructure need likely affect the affordability of tuition, as PMTIs typically pass on some infrastructure development costs to students.

There are some important government and donor-funded initiatives to subsidize infrastructure development in private universities. For instance, Herbert Kairuki Memorial University was the recipient of a 1.2 billion Tsh loan from the Tanzania Education Authority to fund new student housing and a laboratory. Nevertheless, PFP mid-level institutions are particularly at risk. A new Canadian International Development Agency (CIDA)-funded initiative will help support infrastructure upgrades for mid-level training institutions in remote areas. While it primarily targets faith-based training institutions, this program could also be used to support PFP mid-level institutions.

**Financial Challenges**

All PMTIs are highly dependent on student tuition fees or Higher Education Student Loan Board payments for revenue. Most PMTIs require fully paid tuition prior to the start of each semester. All the assessed PMTIs reported some students dropping out in the second semester of an academic year, due to lack of ability to pay tuition. Many of the drop-out students eventually do graduate but are forced to take time off to work or to raise funds from family members.

Meanwhile, PMTIs maintain a number of fixed expenses, including instructor salaries and infrastructure costs. As a result, most PMTIs are experiencing significant financial difficulties. Even the well-established Herbert Kairuki Memorial University relies on an overdraft facility at 21 percent interest to pay for monthly expenses.

Revenue diversification is essential to help PMTIs stabilize financially, make necessary infrastructure improvements, and emerge in a position to enroll more students. Revenue diversification is particularly important, since public universities receive higher government financial support per student than private universities, and PFP mid-level training institutions receive no government support at all. Examples of revenue diversification options include: increased linkages with international universities for research support; offering and selling CPD courses; and increased intake of foreign medical students paying higher tuition fees.

Private medical universities have strong basic financial management practices, including audited financial statements, active boards of directors, and business plans. However, the newer mid-level PMTIs experience capacity and staffing constraints in financial management. Both accreditation agencies indicate a need for improvement in resource management, corporate governance, and strategic planning by PMTIs.

**Access to Finance Issues for PMTIs and Students**

Commercial financial institutions have limited experience lending to PMTIs or students. For the assessment, five financial institutions were interviewed to gauge market prospects for commercial lending to PMTIs and students. All five loan portfolios indicate a fair amount of consumer lending, and
three banks have lent to primary and secondary schools at low levels. With the exception of HKMU, none of the assessed PMTIs have accessed credit. However, financial institutions are open to lending to PMTIs and do not see any additional credit considerations that would make lending to a PMTI more problematic than other types of schools. With the growth of a Tanzanian middle class, demand for private education at the secondary level is expanding and the market for private education overall is likely expanding.

To date, only one bank, Banc ABC, has developed a private student loan product. Student loan products are inherently risky without government guarantees, due to the lack of salary while enrolled in school. Banc ABC’s student loan product for working students was discontinued shortly after its debut in 2011 due to the high market interest rate and loan fees, in competition with zero interest rate education loans/advances available from employers on ad hoc basis. Giving parents to access salary-based—parent loans to fund their children’s medical education may be a less risky and more appealing prospect to financial institutions.

The nationwide human resource shortage is compounded in the private sector by “brain drain” to the public sector.
Higher salaries and pensions available in the public sector are drawing health personnel out of the private health sector, exacerbating HRH shortages at both PFP and PNFP facilities, particularly in rural areas. Although this trend has helped fill staffing gaps at public facilities, it has prevented private facilities from attracting high-quality health personnel and specialists. Frequent departure of private health sector personnel to the public health sector limits incentives for private sector health managers to invest in training opportunities, and perpetuates the perception of low-quality health workers in the private sector.

PNFP and PFP employees are often unable to participate in CPD opportunities.
Multiple stakeholders from private facilities confirmed that their staff are unable to participate in public sector continuing professional development (CPD) and in-service trainings. Although these trainings are technically open to all medical professionals, public sector employees are often given preferential access. The severe shortage of human resources in the private sector also means that private facilities—especially PFP facilities without access to seconded public sector staff—often cannot afford to give their staff leave to attend CPD or other trainings. Without opportunities to advance their skills or learn about government health priorities, private sector personnel remain disconnected from the public health sector HRH strategy and are not leveraged in addressing key health challenges.

Private health sector personnel are not included or leveraged as part of LGA HRH planning.
Tanzania’s current HRH challenges are caused not only by limited supply of new health personnel but also by missed opportunities to adequately utilize available health personnel across all sectors. CSSC facilities have benefitted from the use of public health personnel seconded to CSSC facilities; in some councils, similar arrangements have allowed smaller PFP and PNFP facilities to fill short-term human resource gaps with public personnel. Formalizing such arrangements for staff sharing at the council level would allow small private facilities to send personnel for CPD and training opportunities. In addition, in rural areas public staff secondments to existing FBO or NGO facilities would make use of existing private sector health infrastructure without requiring significant investment in rural health expansion from the public sector. Incorporating private sector human resources into the larger LGA HRH strategy and planning process can promote more effective utilization of existing human resources.

There are significant barriers to entry for the growth of new PMTIs.
While PMTIs could contribute more fully to the expansion of pre-service education in Tanzania, there are significant barriers to entry for the growth of new PMTIs. Tanzania’s strong accreditation system, while commendable in its efforts to protect the quality of Tanzanian higher education, requires strong cash reserves, infrastructure development, staffing levels, and equipment needs to qualify for provisional or final accreditation. These stringent entry requirements prevent potential proprietors from completing plans to introduce new PMTIs to the market.

7.1.1 OPTIONS FOR IMPROVING PRIVATE SECTOR INVESTMENTS IN HUMAN RESOURCE DEVELOPMENT

The following options present recommendations for improving private sector investments in HRH.

1. **Develop a mechanism for joint public-private HRH planning as part of the LGA CCHP process:** The flow of private health sector medical professionals to the public sector as a result of higher salaries and pensions negatively impacts the ability of private and FBO facilities – especially those in the rural areas – to deliver key health services. Developing a mechanism for joint public-private HRH planning could help identify and address factors that contribute to competition between the sectors. At the LGA level, the CCHP process could serve as this mechanism, if it includes a more substantive role for the private sector. Potential options include increasing transparency, adding a private sector representative to discuss health sector compensation, and ensuring that regular salary benchmarking analysis occurs in both the public and private sectors to inform retention discussions.

2. **The MOHSW and LGAs should investigate expanding their program of seconding staff to include PFP facilities:** This expansion will help mitigate the severe HRH shortages at PFP facilities and will formalize the existing exchange that is already occurring at some locations. As part of this reform, the MOHSW should develop clearer guidelines for what is expected of the private facility and the seconded personnel. It should also better clarify in the contracts how the exchange will affect the seconded personnel’s benefits and tenure at their home facility.

3. **Reduce barriers to entry for new PMTIs:** Options to remedy high barriers to entry for PMTIs include phased accreditation plans, which relax requirements in the first two years of operation, or options for a new PMTI to be paired initially with a strong existing institution, for shared infrastructure and equipment. New developments in the franchising of international medical education could be investigated by the GOT, and prospective franchisees could be incentivized to open new schools in Tanzania. International franchisees are more likely to be able to conform to initial requirements for accreditation.

4. **Incorporate PMTIs in broad private health sector strengthening efforts:** PMTIs have unique needs and challenges that differ from private health facilities and practitioners. However, there are many opportunities to strengthen the ability of PMTIs to more successfully expand the health workforce in the context of broad private health sector strengthening. First, efforts to increase access to finance for private providers can be implemented in tandem with efforts to improve commercial lending to PMTIs, as well as to work with financial institutions to develop and market. Second, opportunities to expand PPPs should incorporate PMTIs for innovative solutions to health sector problems. For instance, Herbert Kairuki Memorial University partners along with public district hospitals could give students the hands-on, practical learning
experience they need, while exposing them to health care working conditions across the county. This partnership would offer some much-needed, though limited, revenue diversification for Herbert Kairuki Memorial University, while helping to expand practicum offerings for Tanzania’s medical students. Finally, efforts to strengthen private sector representation should better integrate PMTI policy needs — particularly around government-funded student loans and accreditation issues — within the agenda of APHFTA’s interactions with the GOT. APHFTA’s business and management training efforts for private providers can be augmented to include modules for PMTI proprietors around important areas, such as revenue diversification, corporate governance, and tuition-dependent cash flow management.

7.2 THE PUBLIC-PRIVATE MIX (PPM): CO-LOCATION OF SERVICES AND SPECIALIST LEASING OF PUBLIC CLINICAL SPACES

This section explores how private sector clinical capacity and patient investment in private healthcare can be retained within the public sector to mitigate dual practice and improve the quality of public services. Co-location or intramural private practice refers to the provision of private or fast-track services from a designated wing or outpatient area, in physical adjacency to a subsidized public standard of care, or during a designated time at public or PNFP facilities. The aim is to capture discretionary revenue from a subset of patients that are willing to pay for shorter consultation and surgical wait times, add-ons to care, brand name drugs and equipment, and other preferential care options. In Tanzania, these types of PPPs are financed through service contracts with the NHIF, government employers, or private companies.

In Tanzania, there is significant demand for private or fast-track services. Most facilities offering fast-track options state that existing demand could be scaled up to provide more than 50 percent of their daily patient volumes, but has typically been restricted to 10-25 percent to ensure the standard or volume of public care is not negatively affected. Human resource and physical infrastructure capacity were cited as the most prohibitive factor in scaling up the provision of private care alongside public care. Table 9 below outlines the main benefits and challenges to various actors interested in co-location and intramural practice. In summary, when incentives and considerations are successfully balanced, aligned and regulated, the advantages are clear and patients are generally satisfied with the standard of care. When handled inappropriately, such arrangements can be extremely detrimental and have wider health system impacts.

7.2.1 GLOBAL LESSONS FOR CO-LOCATION

In South Africa, three of the largest private hospital groups include Netcare, Medi-Clinic, and Life Healthcare Group and have participated in several co-location PPPs. With help from the Development Bank of South Africa and the African Development Bank, Netcare is also working to expand co-location efforts to several other African countries such as Central African Republic, Ghana, Nigeria, Zambia, Namibia, and Zimbabwe (McIntyre, 2010).

Among these, Netcare won a bid from South Africa’s government on two projects. The first was Pelonomi hospital project, which was a LRO contract to manage and renovate a 143 bed hospital for 12-
16 years. This contract will be discussed in greater depth during the following chapter on LROs. The second was the Universitas hospital project, whereby Netcare managed and provided care on two floors (or 127 bed) of the Universitas hospital. Both contracts specified that Netcare would pay for rent and upgrade facilities where they managed and controlled.

Interestingly, both projects were rolled out as a single bid. Because the Pelonomi project was extremely difficult to implement and, due to high maintenance issues, make profitable, it would not have survived as a standalone PPP. This innovative “packaging” of projects was one lesson learned by South Africa’s government. Other lessons specific to co-location were as follows:

1. Defining contracts, reimbursement policies, and risk allocation procedures were crucial to the success and effectiveness of co-location. Payment policies directly impact incentives and behaviour from private providers, which in turn can drive patients’ access to health services (equity and efficiency) as well as quality of care. Moreover, defining the role of public and private providers and how financial risk would be distributed across providers was crucial for establishing a co-location PPP that improved health system goals and was profitable. These issues have also been raised in Zimbabwe, where co-location (at Parirenyatwa Hospital, for instance) has encouraged private providers to lure patients away from the public sector facilities (Dube & Chigumira, 2010).
2. Contract negotiations between the government and Netcare for both projects take time and planning. They are also extremely costly.
3. The bidding process must be transparent and fair in order to obtain public approval, maximize efficiency and performance in the delivery of health services.

7.2.2 ASSESSING THE VALUE OF CO-LOCATION PPPS

Table 9: Benefits, incentives and considerations

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<th>Actor</th>
<th>Incentive</th>
<th>Considerations</th>
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<td>Public Sector Facilities</td>
<td>• To improve quality of subsidized public care</td>
<td>• Provision of private care should not interfere with or reduce standard of public care</td>
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<td></td>
<td>• To generate discretionary revenue for specialized resources and operation</td>
<td>• Public assets and physical resources cannot subsidize private provision without remuneration</td>
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<td>• To retain HRH and specialist care within the public system</td>
<td>• Any scale up in intramural care should accompany a commensurate increase or improved standard of public care</td>
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<td></td>
<td>• Fast track or private provisions cannot be essential services or directly related to standard or quality of care, or directly impact patient outcomes</td>
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<td>• Can provide effective dual practice retention strategy, but must not be a special privilege and “profit club”</td>
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<tr>
<td>PNFP Sector Facilities</td>
<td>• To supplement or replace donor based revenue</td>
<td>• Provision of private care should not interfere with core mission or reduce standard of free or subsidized care</td>
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<td>• To generate discretionary</td>
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<td>Actor</td>
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<td></td>
<td>• Any scale up in intramural care should accompany a commensurate increase or improved standard of care</td>
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<td></td>
<td></td>
<td>• Fast track or private provision cannot be essential services or directly related to quality of care or directly impact patient outcomes</td>
</tr>
<tr>
<td>PFP Sector Facilities</td>
<td>To provide free exempted services as per MOHSW partnerships is investment in public good</td>
<td>• Investment in the public good through exempted or subsidized services cannot interfere with sustainable operations</td>
</tr>
<tr>
<td></td>
<td>To direct a percentage of revenue to provision of free and subsidized care demonstrates commitment to public good</td>
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<tr>
<td>Providers</td>
<td>To allow for part-time private practice without illicit activity or abandonment of public post</td>
<td>• Intramural private activities must not interfere quality of care provided to public clients</td>
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<tr>
<td></td>
<td>To provide supplementary income</td>
<td>• Standard of care between public and private consultation must be equal</td>
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<tr>
<td></td>
<td>To allow for practice of specialty skills or use of expertise not often used in public care</td>
<td>• Private activities must not be resourced through public assets or infrastructure outside agreed terms</td>
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<td></td>
<td>To allow private sector specialists and health personnel to contribute to public care</td>
<td>• Additional health personnel within the team providing private care must be compensated at minimal additional cost to government</td>
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<td></td>
<td></td>
<td>• Intramural providers must not submit to the aura of special privilege and avoid on-site HRH jealousy and tension</td>
</tr>
<tr>
<td>Patients</td>
<td>To access to faster care or brand name drugs and interventions if financially able</td>
<td>• Can create a two-tiered system where the rich access higher quality care and the poor access sub-standard care</td>
</tr>
<tr>
<td></td>
<td>To access less congested public facilities with improved subsidized services</td>
<td>• Does not protect patients against nefarious practices of physician self-referral or reducing public standard of care to drive demand for private access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Works best when private add-ons to care are non-essential and have no direct impact on health outcomes</td>
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Global evidence and experiential knowledge on this practice is widely mixed and has been highly contextual.

1. **Benefits:**

Evidence in Tanzania and globally demonstrates that when structured effectively, co-location of health services can contribute significantly to broader health system performance goals. Among public and PNFP health providers, experience suggests that intramural practice can generate significant discretionary revenue to supplement constrained national and PNFP health care operating budgets. In other words, co-location increases the availability of financial, human, and technical resources that would otherwise not be present if public facilities operated independently. Studies have found that even a small percentage of services provided via PPM co-location or intramural private practice can contribute significantly to a public facility’s total operating budget. Interviewees stated that intramural contributions to daily operating expenditures ranged from 30-75 percent, depending on the type of facility, scope of services and current fee structure. These financial resources also help offset volatile funding from donors to PNFP health providers. From a workforce perspective, public facilities gain access to more diverse and higher quality health providers who might otherwise work in the private sector.

For private, for-profit providers, co-location offers a unique ability to contribute towards subsidized public services and build public-private partnerships that are often absent in health care delivery.

Co-location also allows patients to access more diverse health services than would be possible at a public facility. Specifically, it allows patients to spend greater discretionary income to receive brand name drugs, faster care, shorter wait times, or supplemental health services not offered in the public sector. Co-location has been proven to reduce the incentive for public providers to participate in dual practice. Despite it being illegal in many low income countries, dual practice frequently occurs, because regulatory capacity is not strong enough to prevent public providers from practicing in the private sector. As a result, public facilities are often unstaffed, and patients find it challenging to access needed medical care.

2. **Challenges:**

Co-location, if not implemented effectively, can actually hinder access to care, quality of care, and broader health system performance goals. For public sector providers, two challenges exist. First, providers must ensure that quality of public medical care does not decline as the provision of private care increases. Oversight is often necessary to prevent public providers from ignoring their public positions to deliver supplemental, private care – as would be done in a traditional dual practice setting. Moreover, public facilities must ensure that they are remunerated for services provided by the private sector, so as to prevent subsidizing the private sector without recouping revenue. Therefore regular monitoring of performance of the co-location benefits and risks is necessary to ensure mitigation measures are put in place to continuously improve service delivery both for the public and private provision.

For private for-profit and non-profit providers, challenges are twofold. Private for-profit providers must balance profitable, efficient medical care while also delivering subsidized services to the public. On the other hand, private non-profit providers must ensure that the delivery of supplemental, profitable medical care does not detract them from their non-profit mission.
Regulation is a key ingredient for the success of co-location, which in low income settings, has proven difficult to implement. Some opponents of co-location argue that despite its attractiveness, co-location and other such arrangements are complex and have only had “a marginal impact on improving the organization of the institution, and in many cases amount to arrangements of special privilege for senior medical staff with some level of clinical discretionary funds and/or to the hospital itself (Southon 1998).” Others go further, arguing that intramural practice is privatization of healthcare in another name, or at best the creation of two-tiered facility structures where the poor are provided with sub-standard care instead of subsidized and improved public care. This later case must be avoided in all health facilities practising co-location to ensure the poor are not made worse off due to this practice.

The implications for poorly regulated co-location on health system performance goals can be significant. Patients without disposable income to utilize private care may experience work health outcomes due to longer wait times, poorer quality, lack of provider availability, smaller breadth of health services, and other barriers to access. An incentive for providers to induce demand for private, supplemental services can also increase patients’ utilization of unnecessary medical care, thereby driving up out-of-pocket costs.

3. **Government Roles:**

To develop an effective public-private partnership through co-location of health services, the Government of Tanzania must take steps to (a) promote the benefits of co-location for public, private for-profit, and private non-profit providers as well as patients and (b) establish regulations that will provide the right incentives for providers that will lead to effective implementation. While promoting interest among public and private providers is rather straightforward, global experience from lower income countries suggests that implementing and regulating co-location can be difficult in practice. Most countries lack the human, technical and financial capacity to ensure proper oversight of the private sector, particularly in rural areas. Aligning public and private incentives is a very sincere challenge, and co-location often becomes an alternate mechanism for public providers to practice privately while ignoring public responsibilities. Infrastructure and information systems in the public sector must also be operational and accommodate the expansion of health services. Without considering these issues, co-location is likely to have a negative impact on health system performance goals. Access to care may likely decline, quality of care may worsen, and costs may escalate – particularly among vulnerable populations. While co-location offers an array of potential benefits for providers and patients, public investments to regulate and align incentives across health system actors will likely be significant.
Case Study 5: Lessons on PPM Co-location from Muhimbili National Hospital and the Muhimbili Orthopedic Institute (MOI)

Experience in the provision of private or fast-track care alongside a public option can be gained from the intramural private practice effort at Muhimbili National Hospital (MNH) and the Muhimbili Orthopaedic Institute (MOI).

MNH is Tanzania’s National Referral Hospital and University Teaching Hospital with a facility of 900 beds attending to over 1,000 outpatients and admitting 1,000-1,200 inpatients per day. The hospital has 25 departments divided into 106 units, and employs 2,700 employees including 300 physicians and specialists and 900 registered and enrolled nurses (Muhimbili National Hospital 2012). In 2011, the MOHSW advised MNH to establish of a private ward to allow for intramural private practice. This was done in an effort to relieve the hospital’s constrained daily operating budget, to respond to resource gaps in the provision of public services, and to retain HRH and mitigate the negative impacts of dual practicing physicians, surgeons and specialists who would otherwise provide private services off-site.

MOI is an autonomous institute established in 1996 under ACT no.7 that is responsible for primary, secondary and tertiary care as Tanzania’s apex orthopedic facility. Co-located on the grounds of MNH, the institute receives a large number of patients and has established intramural private practice to address the same fiscal and HRH challenges outlined above, and in order to strengthen their sustainable and discretionary revenue efforts. In addition to intramural private practice, MOI’s revenue stream includes multiple public-private arrangements including:

- An MoU with the National Health Insurance Fund (NHIF) to provide services to all members referred to MOI, to be billed to MOH on a monthly basis.
- Service contracts with insurance providers to treat all their clients referred to MOI and billed on a monthly basis. These include: AAR, Momentum, Strategies, Jubilee Insurance, and Resolution Health Insurance.

Box 5: Muhimbili and MOI intramural practice
- Located in same block as general wards but in private outpatient areas and designated impatient ward
- MNH: 64 private beds (32 male, 32 female)
- Private inclusions:
  - Shorter wait times for consultation and surgery
  - Can chose their doctor
  - Seen in prime afternoon, weekend and evening ports (at premium)
  - Can chose from name brand drugs over generic

Box 6: MOI’s public-private mix
- In 2012, the total number of MOI outpatients was 53,426, of which 21,078 were private and 8,893 were emergency cases
- 558 of MOI’s 5,183 inpatients in 2012 were private clients (10.76%)
• Service agreements with government agencies to provide services to workers referred to MOI are billed on a monthly basis. These include: TANESCO, Tanzania armed forces, JKT, Tanzania Revenue Authority, Tanzania Parliament members, President’s Office, University of Dar es Salaam and Sokoine University.
• Service agreements with private companies to provide their workers with MOI services and billed on a monthly basis. These include: Geita Gold Mine, PEPSI, Konyagi, Tanzania Railways, TAZARA.

Financing and Value for Money

Both MNH and MOI operate with government budget subventions provided by the GOT through the MOHSW. Such budget allocations cover mostly salaries of employees, but cover only a small percentage of the daily operating cost of most facilities. MOI for instance estimates that government resources are only able to sufficiently cover 25-30 percent of the cost of running MOI, while the remaining 70-75 percent is obtained through the various public-private arrangements (including private care) outlined above.

MNH also requires supplementation of government resources to meet daily operating requirements. Patient access is heavily subsidized as part of universal coverage and outpatient department, surgical and inpatient costs kept at a minimum direct cost to patients. Government budget allocations do not sufficiently make up for the costs of providing care at those prices. While a Tsh 10,000 consultation fee ensures that all Tanzanians can afford to access public care, there is a Tsh 20,000 fixed fee for inpatient care regardless of length of stay. Given the variable length of stay dependent on patient condition predicting revenue and cash flow for facility managers becomes extremely difficult. At the MOI for instance, publically referred patients pay the standard Tsh 10,000 for outpatient consultation, and Tsh 30,000 for inpatient care regardless of number of days in hospital. The average cost to MOI for an inpatient stay is Tsh 100,000-200,000, of which only a small portion is recouped through GOT budget allocation.

Table 10: Private fee structures

<table>
<thead>
<tr>
<th>MNH</th>
<th>MOI</th>
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<tr>
<td>• Patients largely self-identify for intramural care</td>
<td>• Private morning appointments are offered a low cost, but prime afternoon, evening, public holiday or weekend appointments are paid at a premium</td>
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<tr>
<td>• Tsh 20,000 for first OPD consultation; Tsh 10,000 thereafter</td>
<td>• Cost of operations depend on the severity of the illness but can range from Tsh 100,000 to Tsh 1 million, and private beds are available at single Tsh 40,000/nights and triple bed outlays at Tsh 30,000/night</td>
</tr>
<tr>
<td>• Tsh 15,000/day for private accommodation, 15,000 per day inpatient consultation</td>
<td>• MOI provides salary top-up or incentive based pay to physicians based on each service performed (usually 50% of each cost of the service/operation), which has provided strong incentives for MOHSW retention of physicians and specialists.</td>
</tr>
<tr>
<td>• Private revenue is split 30 percent to the physician and 70 percent to the hospital’s general operating budget. Forty percent of the OPD fee is provided for specialized consult.</td>
<td>• Plans are underway to include other MOI staff in the incentive structure.</td>
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<tr>
<td>• Approximately 5-10 percent of the physicians portion is provided to nurses and other staff.</td>
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MOHSW 2009
Successes and Failures

Both MNH and MOI report that private colocation has significantly relieved day to day operating budgets, and have partially made up for resource challenges such as inadequate GOT allocations, late disbursement of other charges (OE),\(^1\) and late payment from service contracts with other organizations. It has generally improved the availability of discretionary revenue from which the facility managers and department heads can fill resource gaps or acquire specialized or out of stock medicines and commodities. Key Design Features that Contributed to Success Include:

- OPD private care at a Tsh 20,000 fee remains accessible to many Tanzanians, and is not an exorbitant increase on the public fee of Tsh 10,000
- Less congestion in public OPD by redirecting approximately 15 percent of daily patient volumes to the private ward
- Public and Private care are provided from the same facilities (albeit divided wards) where quality and standard of care remain the same
- Access to brand name drugs and shorter wait times (except in emergency cases). However, it is argued that neither of these preferential options has a direct impact on patient outcome.
- Privacy and confidentiality options were enhanced, although only for patients who can afford it.
- Adequate financial incentives for physicians and specialists enabled the MOHSW to retain HRH talent within the public sector space.

Some of the colocation efforts underway at MNH, MOI and CCBRT are criticized for being privatization of healthcare in another name, creating a two-tiered health system that will inevitably lead to an uneven standard of care and a health system of special privilege for doctors and nurses.

Challenges and Ethical Considerations

- The availability of brand name drugs and shorter wait times to those who can afford it is by definition an uneven standard of public and private care. However, as long as a particular brand name drug does not have a proven higher efficacy and patients who require emergent stabilizing care are treated equally then these ethical concerns are minimized. The fundamentally different missions of the public and private wings will come in to conflict if, for example, an available brand name drug was withheld from a public client, or a public client died while awaiting surgery and a less urgent private client was attended to.

- Failure to stipulate revenue sharing among all health cadres (i.e. nurses and other staff performing or supporting private care functions) and limited guidance in intramural agreements regarding profit sharing have created tension among health personnel. While this has not greatly impacted outcomes, as intramural practice becomes more successful and profitable, a more equitable revenue sharing plan will need to be discussed among all health cadres. If a larger percentage of revenue is to be provided to HRH, then facilities will need to reassess if public care is sufficiently subsidized by colocated private activities.

- Jealousy over private revenue exists among public-only employees at both facilities. While this is somewhat inevitable, a small revenue share to public employees or equitable private care participation opportunities for all staff could mitigate this problem.

- While there are no reports of nefarious activity at MOI or MNH, global experience demonstrates that colocation attempts can result in public resources subsidizing private care, or other issues of ethical concern such as physicians ‘self-referring’ patients to private practice, or deliberately over
diagnosing or otherwise reducing the standard of public care to drive private revenue. To date strong internal resource control measures and careful budgeting at MNH and MOI have avoided these issues.

- It is not known if the intramural practice provides VfM in terms of the management time required to operate it. Such agreements (and indeed those at MNH and MOI) require moderate to significant time from public health managers to conduct the frequent and on-going discussions with providers necessary to make colocation a success.

**Lessons Moving Forward**

- Co-location has been a strong way to incentivize doctors to return to public practice after the salary related strikes of the late 90s.

- It was important that the initial momentum for colocation came from the GOT as part of their larger reform strategy, but implementation was done at the facility. This provided the MNH and MOI facility managers with sense of ownership and the ability to direct the projects for the benefit of public care.

- Colocation of practice affects all human resources at a facility, both dual practicing and public-only providers. Intramural practice works best when it is incorporated as part of a larger HRH efficiency, recruitment, retention and compensation strategy aimed at retaining private sector talent within the public health system.

- Nurses and other staff who participate in private care should be included in revenue sharing that is clearly outlined as part of the negotiated agreement between providers and management. This can reduce resentments or claims by physicians that increased funds are needed to support personnel.

- Effective dialogue between the MOH, public managers and private providers was critical to the success of this program. While areas of confusion and tension remain (i.e. with revenue sharing) the dialogue process has remained consistent and focused on achieving an effective public-private balance.

Overall, the MNH and MOI experience with colocation of public-private practice has been described as “overwhelmingly positive” and efforts to raise funds to expand intramural services are underway. MNH is continually sourcing funds for service expansion, some of which will be directed to expanding private care when new public spaces are opened. MOI is in the process of constructing a new building that will increase both inpatient and outpatient volumes of private and public care. During this process hospital management has expressed a commitment to ensuring the standard of public care is strengthened rather than weakened by collocated private provision, and that expansion of intramural practice only occurs with commiserate strengthening or growth of public care.

### 7.3 PRIVATE SECTOR INVESTMENTS IN INFRASTRUCTURE: FINANCING PPPS THROUGH LEASING AND AFFERMAGE

On site co-location of public and private services and leasing of excess on-site public infrastructure or equipment could profoundly relieve public facility operating budgets, and could attract and retain private sector medical talent within the public health system. Similarly, the leasing or affermage of existing but
idle or underutilized public infrastructure could provide a strong avenue for PPP to generate public revenue and meet the capital investment needs of private providers.

In 2007, the MOHSW initiated the Mpango wa Maendeleo ya Afya ya Msingi (MMAM) program to expand delivery of primary health care services to all Tanzanians by 2010. This policy also called for the establishment of a dispensary in every village, a health center in every ward and a district hospital in each district. In 2007, when the policy was developed, there was a shortfall of 5,162 dispensaries, 2,074 health centers and 8 district hospitals.

Further inquiry is needed to reconcile this shortfall against MOHSW’s 2012 total facility numbers,\(^8\) to update the numbers, and to confirm how many dispensaries built under MMAM would be classified as under-resourced or under-utilized, requiring further assistance.

PPP and health stakeholders in Tanzania have recently galvanized around the opportunity to use idle assets as a source of private sector financing and to scale up PPPs. Having private providers or networks lease, rehabilitate and operate health facilities where there are no other providers present could be a win-win in financing PPPs for improved service delivery in health. Ensuring that at a minimum, all Lease Rehabilitate and Operate (LRO) contracts include a clause on reporting, these contracts could ensure more structured cohesion with government services.

### 7.3.1 GLOBAL LESSONS FOR LROS

Existing country examples from South Africa, Romania and Brazil, as presented in Annex 3, demonstrate that LRO and similar contracts (as part of broader PPP agreements or not) can be modified to suit country specific needs and result in improved health system performance. In South Africa, a significant number of public health facilities were dilapidated and lacked the capacity to deliver effective medical care. The government contracted with two private companies to lease and renovate two public hospitals over a 16.5 year period. For the one of the hospitals, Netcare invested ZAR 20 million into renovating the public medical ward and ICU blocks, while the government added another ZAR 11 million into other hospital facilities. The public sector would receive a percentage of the revenue generated by the private hospital wing and retain ownership of the building after the contract period ended (Dube & Chigumira, 2010).

In 2003, Romania’s government designed a PPP contract for private providers to manage, staff, and rebuild dialysis centers (IFC, 2008). After $42 million worth of investments between 2005-2008, the project saved roughly $4.5 million over the three year period. Brazil’s government developed a similar contract whereby a private company would invest roughly $31 million to manage and equip a 300 bed public hospital.

These PPP agreements achieved several goals and offer lessons for Tanzania LROs. First, they enabled the reconstruction, equipping and staffing of public facilities without cost to the government; absent this agreement, these facilities would likely not be operational due to insufficient funds. Second, private

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\(^8\) In 2012 there were: 240 hospitals, 633 health centers and 5,469 dispensaries (according to: MoHSW (2012)).
Investment into both hospitals ultimately improved the efficiency of health care delivery and kept costs lower than they would have been in the public sector. Costs dropped significantly in Romania dialysis centers – far lower than could be achieve in the public sector – and quality of care improved. Operational capacity, an indicator of efficiency, improved in both the South African and Brazilian facilities. Third, individuals gained access to greater quantity and quality of health services – thereby achieving broader health system goals. Among lessons learned, putting in place legally binding, well regulated, and clearly defined contracts were crucial for the success of these PPPs.

7.3.2 ASSESSING THE VIABILITY OF LEASE, REHABILITATE AND OPERATE (LRO) AND CONCESSION AGREEMENTS IN TANZANIA

In general, LROs are structured so that a private entity leases a health facility, dispensary or other physical asset from the government. Ownership of the asset rests with the government, and lease payments are made to the government by the private entity on a monthly or annual basis. Unlike a standard lease or affermage agreement, in a LRO agreement, the private entity invests in the facility at their own risk to rehabilitate the physical structure, and then operate and maintain the facility for the contract period. As a rule of thumb, the longer the contract period, the greater investment the private entity will be willing to make in order to amortize their investments, attract patients and provide more efficient services that are in turn profitable. Depending on the financing available for national health insurance, services provided in the LRO facilities could be reimbursed by the government, or provided to public patients willing to pay at an additional cost (with or without PPP revenue sharing as part of an affermage contract structure). LROs should be structured so that the private entity can sufficiently finance their investments, make required lease payments to generate sufficient public revenue, and still remain sustainably profitable (World Bank 2013).

Evidence suggests that the MOHSW has made a tremendous physical investment in MMAM’s objective, but may not be able to actualize its potential alone. Many of the new dispensaries are under resourced or underutilized because of more broad HRH challenges, which have limited the public sector’s ability to staff or absorb health workers into the facilities. A recent study found that in 134 health facilities (including hospitals, health centers and dispensaries in the public and private sectors) only 20 percent met the MOHSW’s recommendations for staffing level (Manzi et al 2012). The study also cited health worker interviews suggesting many of the facilities face maintenance challenges and shortages of equipment (Manzi et al 2012). LRO contracts may provide the right opportunity for private providers to assist the government in a number ways while also meeting private sector needs for access to infrastructure and capital. If structured appropriately as part of the overall HFS, LRO contracts could significantly expand the coverage of private sector service provision and generate public sector revenue from currently underutilized physical resources.

1. Benefits

LROs are beneficial to both the public and private sector and to beneficiaries of care. For the public sector, the government can make immediate use of existing public infrastructure without having to fully staff them or invest in their physical maintenance. Since the private entity’s profitability depends on keeping costs low while meeting the quality standards specified in the PPP contract, efficiency and sustainability could be maximized by tying the contract to CHF/NHIF reimbursement. Depending on local HRH assets, facilities could jointly be staffed by MoH providers. The government can also regulate quality of care by specifying standards and reporting requirements as part of the LRO contract. LRO
contracts also enable the public sector to regulate reimbursements in the private sector. Given limited information, financial and human capacity, such regulations are often challenging if not impossible for low income country governments.

For the private entity, a LRO contract enables entry into a new market without have to make upfront investments in the physical infrastructure of a health facility, which are often significant barriers to entry for private health providers. LROs also allow for expanding provision of an essential or MBP as part of a larger LRO service contract. By contracting with public insurance agencies, such as the NHIF, private providers are able to access greater sources of funding for service provision.

For beneficiaries, new and higher quality services become available at more points of care as envisioned in MMAM. As per many low income countries, availability of medical providers, infrastructure, and medical supplies are significant barriers to medical care access. LROs, if operationalized effectively, improve broader health system performance goals by expanding access to care of the MBP. For health facilities in rural areas which are especially prone to public provider absenteeism, such contracts offer the greatest potential to expand health coverage for the Tanzanian population.

2. Challenges:

As per other PPP options, the success of LROs is driven by Tanzania’s capacity to design and implement contracts effectively. Government must design LROs so as to align incentives across the public and private sectors. Significant challenges faced by the public sector include aligning payments to private providers as well as ensuring quality and performance standards are met via contracts. In many instances, this entails a balance between earning profits and meeting public goals such as equitable access to care for the population. Government must also make certain that private providers maintain or rehabilitate health facilities.
8. OVERARCHING CHALLENGES FOR EXPANDING THE PRIVATE SECTOR’S ROLE IN HEALTH

The preceding sections have presented an overview of the primary options for increasing private sector contributions to health in Tanzania. For each source, there are overarching challenges that limit the effectiveness of each option, notably its ability to improve the overall health system through health financing or service delivery. Translating Tanzania’s health policy and regulatory environment into effective partnerships or private sector investments that improve health outcomes will require all actors to mutually address a number of barriers.

8.1 CONCERNS OVER QUALITY AND EQUITY

Longstanding walls of mistrust between the public and private health sectors have limited effective PPPs in health. Often high private sector user fees and the perceived profit-motive of private providers raise concerns over equity of access among Tanzania’s most disadvantaged. Concerns over quality and effective regulation of private care are also cited as reasons to dismiss attempts at partnerships. There is an inherent incentive for private providers to adhere to guidelines and develop a reputation for quality in order to stimulate their practice. This opens the door to more effective and mutually beneficial regulatory engagement, and an increasing cohesion with MOHSW systems. Much work has been done by the PPP Unit, the PPPTWG and their partners to promote more fruitful engagement between the sectors. Discussing these longstanding concerns openly at the local level could provide a fresh start to dialogue and partnership.

For broader private sector initiatives to invest in health delivery and financing, quality and equity challenges remain pertinent. While policies that successfully encourage the private sector to contribute towards the health system should be viewed as significant achievements, the public sector must also ensure that such investments achieve public performance goals such as equity, quality, and efficiency. Because incentives do not always overlap across sectors, government must guide the private sector to invest in ways that benefit the broader health system. For instance, in section 5 several options were presented for corporations to expand health coverage to their employees and the broader community. If corporations choose to purchase health insurance, is the share of their contribution equitable and fair to employees? Does funding cross-subsidize lower income insurance pools? If corporations instead act as a purchaser of medical care for employees, are they providing the right financial incentives for health providers to deliver high quality medical care? Are they contracting with the best health providers? If corporations opt to provide care on-site, are they offering the best health services and quality to their employees?
8.2 LIMITED GOVERNMENT CAPACITY FOR REGULATION

Even with an agreed and mutually beneficial approach to regulation and cohesion, to expect current MOHSW systems and capacity to effectively regulate the entire range of public and private health facilities in the country is unrealistic. Even now, organizations for inspection—such as the Tanzania Food and Drugs Authority (TFDA) and the CHMT and the Hospital Therapeutic Committee (HTC)—lack the capacity to effectively provide supportive supervision to the facilities within their purview. Add to this the number of individual NGO and NGO partners active in outreach, care and treatment services, and it becomes clear that effective regulation of private sector activities in health will be a joint effort. Alternatives that encourage and build incentives for self-regulation and self-reporting can minimize the cost and management effort to implement and manage PPP contracts or improve the likelihood of certain options for private spending on health coverage or service delivery. An ever increasing integration of MOHSW HMIS and District Health Management Information Systems (D-HMIS) and existing private sector reporting mechanisms will assist in this effort, and exploring the use of PPM co-location or service contracts (as discussed in Section 7) could provide additional tools to incentivize regulatory adherence and consistent quality.

With respect to broader private sector contributions to health, limited regulatory, institutional, or technical capacity can negatively impact health system performance goals such as equity and quality, as discussed above in section 8.1. While it is critical for government to collaborate with and shape evidence-based policies for the private sector, policies are ineffective without the ability to implement them. Implementation requires that the public sector have sufficient resources to regulate and incentivize the private sector to behave in ways that achieves broader performance goals. In the case of options presented in section 5, examples could include (a) mandating employer contributions to health coverage, (b) setting minimum benefit packages for corporations, or (c) setting minimum levels of quality for corporate employees through provider accreditation processes. Similarly, in section 7 private sector investments in health workforce and infrastructure may require regulations that (a) set minimum standards on health workforce education, such as quality and the distribution of new health providers or health infrastructure. A key challenge for Tanzanian policymakers is to create private sector health policies that are built on sound, empirical research and for which government has the capacity to implement effectively.

8.3 LACK OF DATA ON COST DRIVERS AND VFM

When comparing PPPs to more traditional public procurement contracts, the variables and subjective perspectives used in measuring non-monetary or relative value of the project make broad statements on VfM for PPP contracting extremely difficult. The VfM concept and calculation can be simple: compare how much it would cost the government to build and run a facility or service through the public sector to the cost of the same infrastructure or service under the PPP scheme (IFC 2010). If the cost of PPP is cheaper than traditional public provision or provision then proceed. This definition has undoubtedly excluded potentially impactful PPP projects that were more expensive that public provision, and has surely seen PPPs implemented that were less expensive but not more cost-effective. However, it is generally agreed that in health, PPPs typically feature more upfront costs in negotiation, design, implementation and maintenance of the contracts given the significant recurring costs to regulate quality and adherence to standards. In some cases, the cost of implementing a PPP would likely exceed the cost of delivering the services contained through more traditional public procurement methods.
PPPs in health may have invaluable benefits outside of cost. Some potential benefits include greater cohesion of multi-sectoral services, opportunities for early dialogue that could bear fruit as the partnership matures and greater cost-effectiveness when additional partnership inclusions, such as subsidized commodities access, are taken into account. Measuring the VfM of a PPP over other procurement options through VfM tools currently in use and under development in Tanzania should take into account the central importance of local context, existing relationships, varied benefits of ex ante and ex post project payment, and the overall value of the PPP in terms of improved health outcomes. This measurement should include the unquantifiable benefit of reduced morbidity and mortality.

Similarly, for private sector investments in health, whether to financing health insurance coverage or contribute towards improving health services delivery, efficient allocation of resource is essential given limited budgets and the need for long term sustainability. For instance, as corporations consider expanding health benefits to their employees, they must consider who should be covered, what mechanisms should be used, and how it should be applied. Such decisions require data to evaluate the cost-effectiveness of options, without which it is impossible to accurately assess the value of alternatives.

8.4 **ADDED COMPLEXITY IN CONTRACT MANAGEMENT**

The use of PPPs in the Tanzanian health sector is still evolving. As projects are implemented and mature, they will require effective management of the public private mix in health care and contract management functions will become increasingly relevant. PPPs are by nature more complex than most traditional public procurement methods: they involve a great number of partners, competing interests and partners, and technical skills in PPP contracting and regulation. The perceived complexity of PPPs has limited their application in health to infrastructure and direct management of facilities, rather than truly collaborative PPPs for service delivery (Burger and Hawkesworth 2011). Arming regional and council level PPP decision makers with knowledge on contracting mechanisms and management will be essential in enabling them to create flexible SLA and service contracts with local private sector partners.
9. MONITORING AND EVALUATION PLAN (M&E)

9.1 MONITORING AND EVALUATION (M&E) OF PPPS

Any PPP agreement should include typical performance monitoring items such as payment and penalty mechanisms related to facilities management, equipment, service provision and other nonclinical service outcomes, as well as independent certification of standard of care, and adequacy of facilities and equipment. It is expected that the MOHSW PPP coordination office will set-up an M&E framework which will cover the following major elements:

- **Risk Mitigation**: the process of identifying, monitoring and managing risk to minimize and mitigate the project or program risks.

- **Service Delivery and Performance**: ensuring that the PPP entity is achieving required service delivery outputs to the contractually defined performance standards.

- **Relationship Management**: managing the structure of authority and accountability within the PPP service delivery framework; and

- **Contract Administration**: following administrative processes required to make sure all procedural and documentation requirements issues, such as periodic reporting and service quality reviews, are being followed as laid down on the contractual agreement.

In addition to the preceding observation, MOHSW guidance on M&E should be followed. In particular, the M&E Contracting Authority should, in collaboration with the private third party, prepare an M&E framework which is comprised of:

- Project management plan
- Performance criteria
- External audit and reporting requirements
- Submission of progress reports
- Verification of project assets and value
- Stakeholders communication

The guidelines require that all PPPs be coordinated and monitored by MOHSW and LGAs. The ministry will monitor the progress of the PPP projects through quarterly progress implementation and financial reports. The PPP office at MOHSW will monitor and evaluate all PPP activities related to health and social welfare in the public and private sectors at national, regional and district levels. The National PPP Coordinating Committee and PPP TWG will also track the operationalization and implementation of PPP activities in the health sector at national, regional and district levels. Furthermore, the established
forum at regional, council and community levels will monitor and evaluate PPP activities at their respective area and submit quarterly progress reports. The proposed indicators to be tracked include the following:

**Output-Orientation**

- The number, type and location of PPP projects/services in the health sector
- The number of functioning PPP focal persons at the various levels in the health system
- The number, type and location of signed SLAs

**Process-Orientation**

- The process of formulation, appraisal, approval and negotiation PPP projects
- The financing and expenditure practices
- The valuation of VfM with particular attention to value outside cost
- The process of capacity building and supervision

9.2 **MONITORING AND EVALUATION (M&E) OF PRIVATE SECTOR INVESTMENTS IN HEALTH FINANCING AND DELIVERY**

Monitoring and evaluation of the private sector extends beyond PPPs and into the broader realm of private sector contributions to health. As the GoT develops and implements policies that encourage the private sector to invest in health – whether to financing medical care, expand health workforce, or scale up health infrastructure – it is crucial that mechanisms exist to assess the impact of such policies on the private sector. Monitoring the actions and performance of private sector participants also improves their accountability and the transparency of public initiatives.

Based on options presented in sections 5 and 7 of this report, governments may either coerce the private sector to make specific investments or provide incentives for it behave a certain way. In the case of corporate investments in health, the public sector may mandate that private organizations contribute to social insurance schemes for their employees; conversely, the public sector could encourage companies to invest in low-income insurance pools or provide services to the broader community. No matter the chosen path, data must be collected and analyzed to evaluate the success of such actions. Has the private sector improved, say, health insurance coverage and, if so, to what degree? Do alternative mechanisms exist that might be more effective? If the private sector chooses to invest in training health professionals or building health infrastructure, has it be accomplished in an effective and sustainable way that can ultimately expand access to care for individuals.
10. OVERVIEW OF OPTIONS ON PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

This document has sought to provide the ISC with a wide range of options and recommendations to consider or pursue as part of the reformed HFS. These involve options to increase private sector investments in health such as expanding fiscal space, health workforce, and infrastructure. Options also include attracting and maximizing PPP investments from the GOT, the private sector and donors, as well as contracting or other PPP modalities that could be used to operationalize PPP investments at the local level. This section provides a brief summary of the options outlined in this report. Because the evidence base on value-for-money is limited and the diversity of private sector initiatives so great, options are presented in this chapter as general guidelines for decision-making. Rather than provide concrete recommendations, this section instead lays out the tradeoffs between private sector options so that policymakers can make more informed decisions.

10.1 OPTION 1: PROMOTING PRIVATE SECTOR ACCESS TO FINANCE

The private health sector’s ability to access finance for capital investment is essential to its long-term sustainability, growth, and ability to contribute to the public good. Supporting approaches that improve private health provider access to finance as part of the HFS have the potential to increase the number of private sector providers that are able to partner with the MOHSW in joint-public health campaigns, service contracts or larger service agreements.9

Specifically, this option would entail (a) increasing private provider knowledge on access to finance and commodities and (b) promoting and investing in private sector credit mechanisms

Strengths

Business training should promote the use of financial management and administration best practices at private health facilities to help document their financial status, to demonstrate their long-term feasibility, and to identify them as viable PPP partners. Loans have helped the private sector make greater and more efficient investments in health. Moreover, the internal peer and reputational pressures created by the professional networks have led to high repayment of loans in both cases. Experience suggests that private health sector lending and rotational credit mechanisms may provide an attractive avenue to expand access to finance.

Challenges

9 Additional information can be found in Section 5.1, pages 43-46
Training and equipping private sector health providers with business administration and financial management skills will not likely be as technically challenging as other options – at least with regards to capacity. However, the public sector must still consider how it will institute and implement training programs. Global evidence also suggests that implementing successful, micro-credit schemes often requires public support. During the initial stage of development, micro-credit schemes typically lack the financial or technical capacity to establish information systems and lend sufficient resources. Moreover, the public sector must ensure that health sector policies and regulatory efforts are put in place to support rather than hinder such efforts.

10.2 OPTION 2: EXPANDING CORPORATE CONTRIBUTIONS TO HEALTH

Private corporate spending has fallen in Tanzania in recent years. Tanzania is unlikely to achieve universal health coverage of its minimum benefits package (MBP) without greater resource mobilization from the private corporate sector, which would likely free up fiscal space for the GoT. Moreover, employers and owners in the private sector have a considerable responsibility and fiscal interest to contribute to health in the workplace.\(^\text{10}\)

Such an option might include (a) employer subsidized premiums to NHIF / NSSF / PHI funds, (b) employer contributions to CHF funds, (c) contracting with health providers, (d) delivering care through on-site clinics, and (e) investing in workforce wellness programs.

Strengths

This option can increase health coverage and outcomes in multiple ways. First, it opens the door for greater insurance coverage in the private, formal sector. Second, it can increase coverage for low income households and informal sector workers. Third, it offers the possibility of increasing insurance funds’ long term stability, benefit package, and risk pool size. Fourth, if providing care locally this option allows employers the flexibility to set their own benefits, cost sharing rates, and contract with providers that offer higher quality or specific medical services. Fifth, health workforce wellness programs can improve health for formal sector employees through prevention and behavior change.

More broadly, employer contributions to health can greatly expand the fiscal space for health and reduce the burden on public sector health spending. They can also increase employee productivity, attrition, reduce absenteeism, and improve morale; in turn, this leads to greater profitability for corporations and the economy.

Challenges

Increasing employer contributions to health would likely require a mix of incentives and regulation by government as well as increased technical and organizational capacity by corporations. It can be difficult to encourage employers to contribute to employee insurance premiums and even more challenging to convince them to pay for health coverage of the community. Becoming a payer or provider of care is highly complex, costly, and requires strong capacity – i.e. information, management, and other technical systems – to effectively implement.

\(^{10}\) Additional information can be found in Section 5.2, pages 50-54
10.3 OPTION 3: CONTRACTING WITH PRIVATE HEALTH PROVIDERS VIA SLAS

SLAs are contracts signed between LGAs and private sector health facilities, where the aim is to contract and purchase services from private providers. LGAs may use SLAs to create PPPs that allow the government to expand their service delivery via a private sector proxy, and to access populations in rural regions where public healthcare infrastructure lacks capacity. While it appears that there are not enough resources to finance the growth of Tanzania’s SLAs, gaps in resources must be measured. It is important to identify greater resources to finance SLAs, but it is also important for SLAs to attain greater efficiency.\(^\text{11}\)

**Strengths**

SLAs allow the government to extend the coverage and scope of public-affiliated services through contracting providers in regions where there are no public health facilities, particularly by tying agreements to public health insurance or MBPs. Evidence suggests that contracting-out for curative, diagnostic or specialist services can have an immediate and substantial impact on access to health services, and if done as part of a public health financing scheme, can positively improve equity (Lagarde & Palmer 2009). It can also meet the broad national health system goals of strengthening decentralization and responsiveness of services, and diversification of sources and methods of health financing.

**Challenges**

1. Issues in confirming informed consent from the signatories designated to sign the SLAs
2. Weakly defined public staff secondment provisions
3. Weakly defined provisions on commodity access
4. Disagreement around service capitation:
5. Delayed and variable payments to PNFP facilities:
6. Limitations in national fiscal space to provide adequate human, material and financial resources for implementation of SLAs:
7. Weak private sector ownership of SLAs
8. Limited synergy between CCHP and SLA processes
9. Political challenges
10. Difficult to implement and operationalize

10.4 OPTION 4: PUBLIC-PRIVATE CO-LOCATION AND DUAL PRACTICE MITIGATION

Co-location or intramural private practice refers to the provision of private or fast-track services from a designated wing or outpatient area, in physical adjacency to a subsidized public standard of care, or during a designated time at public or PNFP facilities. The aim is to capture discretionary revenue from a

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\(^{11}\) Additional information can be found in Section 6, pages 58-71
subset of patients that are willing to pay for shorter consultation and surgical wait times, add-ons to care, brand name drugs and equipment, and other preferential care options.\textsuperscript{12}

**Strengths**

Evidence in Tanzania and globally demonstrates that when structured effectively, co-location of health services can contribute significantly to broader health system performance goals. Among public and PNFP health providers, experience suggests that intramural practice can generate significant discretionary revenue to supplement constrained national and PNFP health care operating budgets.

For private, for-profit providers, co-location offers a unique ability to contribute towards subsidized public services and build public-private partnerships that are often absent in health care delivery.

Co-location also allows patients to access more diverse health services than would be possible at a public facility, where they spend greater discretionary income to receive brand name drugs, faster care, or shorter wait times. Co-location has also been proven to reduce the incentive for public providers to participate in dual practice.

**Challenges**

Co-location, if not implemented effectively, can actually hinder access to care, quality of care, and broader health system performance goals. Public sector providers must ensure that quality of public medical care does not decline as the provision of private care increases, and they are remunerated for services provided by the private sector.

Private for-profit providers must balance profitable, efficient medical care while also delivering subsidized services to the public. On the other hand, private non-profit providers must ensure that the delivery of supplemental, profitable medical care does not detract them from their non-profit mission.

Patients without disposable income to utilize private care may experience worse health outcomes due to longer wait times, poorer quality, lack of provider availability, smaller breadth of health services, and other barriers to access. Provider induced demand can also increase patients' utilization of unnecessary medical care, thereby driving up out-of-pocket costs.

To develop an effective public-private partnership through co-location of health services, the Government of Tanzania must take steps to (a) promote the benefits of co-location for public, private for-profit, and private non-profit providers as well as patients and (b) establish regulations that will provide the right incentives for providers and lead to effective implementation. Implementing and regulating co-location can be difficult in practice.

10.5 **OPTION 5: ENHANCING PPPS THROUGH LEASING AND AFFERMAGE**

In general, LROs are structured so that a private entity leases a health facility, dispensary or other physical asset from the government. Ownership of the asset rests with the government, and lease payments are made to the government by the private entity on a monthly or annual basis. The private entity invests in the facility at their own risk to rehabilitate the physical structure, and then operate and

\footnote{\textsuperscript{12} Additional information can be found in Section 7.2, pages 79-83}
maintain the facility for the contract period. Services provided in the LRO facilities can be reimbursed by the government or provided to public patients willing to pay at an additional cost.\(^\text{13}\)

**Strengths**

For the public sector, the government can make immediate use of existing public infrastructure without having to fully staff them or invest in their physical maintenance.

For the private entity, a LRO contract enables entry into a new market without having to make upfront investments in the physical infrastructure of a health facility, which are often significant barriers to entry for private health providers.

For beneficiaries, new and higher quality services become available at more points of care as envisioned in MMAM. LROs, if operationalized effectively, improve broader health system performance goals by expanding access to care of the MBP.

**Challenges**

As per other PPP options, the success of LROs is driven by Tanzania’s capacity to design and implement contracts effectively. Government must design LROs so as to align incentives across the public and private sectors. Significant challenges faced by the public sector include aligning payments to private providers as well as ensuring quality and performance standards are met via contracts.

\(^{13}\) Additional information can be found in Section 7.3, pages 87-90
11. CONCLUSION

This paper has outlined a number of options, points to consider and modalities that are aimed at assisting the GOT, MOHSW and ISC in its development of the new HFS. In brief, these include:

11.1 PROMOTING PRIVATE SECTOR ACCESS TO FINANCE

To increase the private sector’s access finance for capital investment this option would entail (a) increasing private provider knowledge on access to finance and commodities and (b) promoting and investing in private sector credit mechanisms. Business training should promote the use of financial management and administration best practices, while loans have helped the private sector make greater and more efficient investments in health. Challenges include implementing and investing in microcredit or training programs by the public sector.\textsuperscript{14}

11.2 EXPANDING CORPORATE CONTRIBUTIONS TO HEALTH

To achieve universal health coverage in a sustainable and efficient way, private corporate spending on health must increase. Such an option might include (a) employer subsidized premiums to NHIF / NSSF / PHI / CHF funds, (b) contracting with health providers, (c) delivering care through on-site clinics, and (d) investing in workforce wellness programs. These would improve health coverage and outcomes for corporate employees and the broader community, expand the fiscal space for health, and reduce the burden on public sector health spending. It could also increase employee productivity, attrition, reduce absenteeism, morale, as well as corporate / economic efficiency. It would require incentives and regulation by government as well as increased technical and organizational capacity by corporations. Such policies can also be highly complex and costly to implement.\textsuperscript{15}

11.3 CONTRACTING WITH PRIVATE HEALTH PROVIDERS VIA SLAS

SLAs are contracts signed between LGAs and private sector health facilities to purchase services from private providers. It is important to identify greater resources to finance SLAs but also for SLAs to attain greater efficiency. SLAs allow the government to extend the coverage and scope of public-affiliated services through contracting providers in regions where there are no public health facilities. It can also meet the broad national health system goals of strengthening decentralization and responsiveness of services. Challenges include resistance to payment mechanisms, limited fiscal space, political challenges, and difficult implement / operationalizing SLAs.\textsuperscript{16}

\textsuperscript{14} Additional information can be found in Section 5.1, pages 43-46
\textsuperscript{15} Additional information can be found in Section 5.2, pages 50-54
\textsuperscript{16} Additional information can be found in Section 6, pages 58-71
11.4 PUBLIC-PRIVATE CO-LOCATION AND DUAL PRACTICE MITIGATION

Co-location or intramural private practice refers to the provision of private or fast-track services from a designated wing or outpatient area, in physical adjacency to a subsidized public standard of care, or during a designated time at public or PNFP facilities. Co-location can contribute significantly to broader health system performance goals by increasing access to care, quality of care, using resources more efficiently, and reducing dual practice. If not implemented or regulated effectively, co-location can increase costs, reduce access to care, drive up inequities, fragment health delivery systems, and increase dual practice.\textsuperscript{17}

11.5 ENHANCING PPPS THROUGH LEASING AND AFFERMAGE

Private health providers contract with government by renting public facilities to deliver health services, investing in the maintenance of public facilities, and being reimbursed by the public sector for providing public goods. This option can improve efficiency of existing resources, expand access to care for the population, as well as reduce costs for the private and public sector. To work effectively, contracts and payment systems must be designed well; government must have the capacity to regulate the private sector.\textsuperscript{18}

11.6 NEXT STEPS

All stakeholders share a vision to expand the availability of high quality care and support services, and to enhance the well-being of all Tanzanians. In the effort to maximize the use of private health investments, compare VfM across options, and link PPP service provision to public health insurance and other financing mechanisms, stakeholders will face challenges, regardless of the options selected from this paper. The challenges will be encountered due to the limited evidence base regionally or globally regarding which mechanisms are most effective as increasing private sector contributions to health.

As illustrates, engaging in effective PPP with Tanzania’s health sector requires a change in certain ways of thinking about partnering with the private sector, and involves taking on a new “PPP mind set” whereby common assumptions and roles are challenged as part of creating fertile ground for new partnership and joint action in health.

Table 14: Shifting to a PPP Mind Set

\textsuperscript{17} Additional information can be found in Section 7.2, pages 79-83

\textsuperscript{18} Additional information can be found in Section 7.3, pages 87-90
Adapted from IFC 2011 and Merek et al. 2005

As regional pioneers in implementing PPPs for health, Tanzania’s selection of PPPs from a variety of options comes with the acknowledgment of potential risks and rewards, and the need to adequately monitor and learn from new and ongoing application of PPP efforts in health. The options provided in this paper hold tremendous potential for Tanzania’s health system, but could also come with unforeseen or negative outcomes. Effective partnerships, multi-sectoral dialogue and the pursuit of financing PPPs for improved service delivery in health that are tied to more comprehensive multi-sectoral planning and contracting mechanisms will go a long way to ensure any options pursued enhance, rather than hinder the health system, and lead to more effective, efficient and high quality health services that benefit all Tanzanians.

This paper has also considered ways to expand private sector contributions to health more broadly, specifically mechanisms to increase health service delivery and financing of care. While PPPs have much to offer, these options allow for the private sector to act independently yet still improve broader health system performance goals. Whether investing in health through employee insurance coverage, contributing to low income risk pools, increasing health workforce through training, or building additional health infrastructure, there are many avenues by which the private sector can improve financial risk protection, access to care, and quality of care in an equitable and efficient way. Moving forward, the challenge for policymakers looking at such options will be similar to those encountered in the development of PPPs; that is, government must assess their political and economic viability – both

<table>
<thead>
<tr>
<th>The public sector can be a purchaser, not just a provider of health services</th>
<th>Current mindset: The public can and should only access health services provided in facilities operated by the government.</th>
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<tbody>
<tr>
<td>PPP Mind Set: The government cannot and should not bear the burden of public health alone. Purchasing excess supply of health resources from the private health sector to address excess public demand for quality services could be more cost-effective and impactful on health outcomes than attempting to scale up already constrained public provision. Maintaining a strong regulatory function as purchaser for some health services may allow the GOT to more effectively prioritize and allocate resources.</td>
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<tr>
<th>The private health sector is not only for the rich</th>
<th>Current mindset: The public sector provides underfinanced services to the poor majority, while the private health sector offers more costly services to the wealthy minority.</th>
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<tbody>
<tr>
<td>PPP Mind Set: People from even the poorest income quintiles access the private health sector on a routine or emergency basis. The private sector can be leveraged to deliver services to the public, increasing overall access to health services. High-user fees and access inequality can be addressed by tying efforts to public health insurance or a minimum benefits package.</td>
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<tr>
<th>Resources should follow the patient, regardless of the provider</th>
<th>Current mindset: To be eligible for public health insurance, a patient must receive services from a public provider or specified GOT facility.</th>
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<tbody>
<tr>
<td>PPP Mind Set: In a flexible and multi-sectoral health system patients will be able to obtain services where care is most convenient and of highest quality regardless of provider type, and should be covered by public health insurance to do so. This is heavily intertwined with the GOT and ISCs inclusion of options on a minimum benefits package (MBP) and reform of public health insurance in the development of the HFS.</td>
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Adapted from IFC 2011 and Merek et al. 2005
for short term implementation and long term sustainability - as well as weigh their respective benefits and costs.
REFERENCES


ANNEX 1: TERMS OF REFERENCE, OPTIONS FOR PUBLIC-PRIVATE PARTNERSHIP (PPP) HEALTH FINANCING AND SERVICE PROVISION

Specific objectives and tasks are to:

1. Review and assess a range of health PPPs, include PPPs that are judged to be both successful and not successful, analyze how they are financed, assessing to what extent has financing affected the success or failure of the PPP operations and identify what lessons can be learned.

2. Review what financing products are currently available to the private sector to fund either private sector expansion or PPP projects, e.g. project financing, investment loans, leasing, equity funds, revenue guarantees, etc. Determine how developed and accessible is these finance products in the health market in Tanzania. Explore what is needed to expand and increase the range and availability of finance products in the health market in Tanzania.

3. Analyze how far private investment:
   a. Currently fits into health sector development plans, including infrastructure (MMAM) and human resource development plans; and
   b. What incentives and regulations would be necessary to improve alignment (in case it is so far lacking)

4. Analyze investments made in the private health sector, including:
   a. What are the main factors for making investment decisions;
   b. What are current ways to finance investments in the health sector; and
   c. What challenges/bottlenecks exist for attracting investments into the health sector;

5. Assess the use of service agreements as a health financing tool, including:
   a. Establishing the total amount of public funds paid to private providers;
   b. Establishing the budget performance of Service Agreements and compare this performance with the general budget performance of Council health budgets;
   c. Assess the scope of Council health budgets to accommodate extending Service Agreements;
   d. [Assess if and in how far service agreements could be used as the main method of public spending in areas with a high density of private providers]

6. Central to the justification for PPPs is the need to demonstrate VfM of PPPs over regular public sector provision or procurement. Identify what are the major cost drivers in PPP contracts and propose/develop a system for monitoring these cost drivers to ensure VfM through PPPs over public sector.

7. Identify opportunities/challenges and ways forward in developing the regulatory and institutional framework for effective and efficient use of PPPs in the health financing context;

8. Assess the use of different options of contracting modalities, including dual practice; perform in advancing public health goals by use of a SWOT analysis.
9. Develop monitoring and evaluation (M&E) plan with clearly defined indicators and key players in the M&E framework.

10. Present between three to five reform options / scenarios for this PPP consultancy that are specific enough to bring out differences and general enough to allow for use in the Health Financing strategy document and adaptation and modification in implementation. Each of the options / scenarios is to be backed up by a SWOT analysis presenting internal strengths and weaknesses and external opportunities and threats to allow the ISC to assess the different options/scenarios and to make a choice.

11. Provide summary recommendation of three to five pages of the reform options/scenarios that can be included as part of the Health Financing Strategy document.
ANNEX 2: LEGAL AND POLICY DOCUMENTS RELATED PPP IN HEALTH AND SOCIAL WELFARE

Key legislations and regulations that pertain and relate to the implementation of PPP in the Health and Social Welfare sector include:

- National Strategy for Growth and Poverty Reduction (MKUKUTA) 2005/2010
- Vision 2025
- Local Government Reform Program Decentralization by Devolution 2009-2014 (LGRP II)
- Primary Health Services Development Program 2007-2017 (MMAM) 2007
- National Health Policy (2007)
- The Private Hospitals Act (1977), the Private Hospital Regulations (2002)
- The Private Laboratories Act (1997),
- The Pharmacy and Drug Act
- The draft Medical and Dental Practitioners Act, (2008)
- The draft National Health Services Act, (2008)
- The National Public Private Partnership Policy (2009)
- The Public Private Partnership Act (2010)
- The CHF Act (2001)
- The Child Act (2009)
- The Disabled Persons Act (2010)
- The HIV/AIDS Policy
- The Health Services Scheme (2009)
- The Health Services Act
- The Public Service Act (2002)
- Medical Council of Tanganyika – with its specific guidelines
- Nurses and Midwives Council – with its specific guidelines
# ANNEX 3: EXAMPLES OF INTERNATIONAL PPP CONTRACTS

<table>
<thead>
<tr>
<th>South Africa</th>
<th>Challenges</th>
<th>Structure of Contract</th>
<th>Results</th>
<th>Lessons Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Half of South Africa’s medical facilities suffer from lack of maintenance&lt;br&gt; • 1997 audit showed that R825 million was needed to improve infrastructure, an amount that the government could not cover</td>
<td>• Agreement established between government and consortium of two healthcare companies&lt;br&gt; • Private partner responsible to: pay and complete upgrades to two hospitals; maintain functional facilities at both hospitals; provide high quality care&lt;br&gt; • 16.5 year contract signed in 2002&lt;br&gt; • At end of contract, facilities returned to health department</td>
<td>• Private partner gained use of 500 beds, and shared access to clinical services and expensive equipment&lt;br&gt; • Two major hospitals received renovations at no cost to government&lt;br&gt; • Private entities reduced costs because did not have to build new hospital&lt;br&gt; • Insured gained access to new facilities. Uninsured and partly insured had option to use maintained and up-to-date facilities.</td>
<td>• In sharing operating space, there was a fear that patients would be poached.&lt;br&gt; • Contract included a liaison committee for dispute resolution&lt;br&gt; • Legal framework (Finance Management Act) need to be passed and fully functional before moving forward with the PPP to avoid delays.</td>
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<tr>
<th>Romania</th>
<th>Challenges</th>
<th>Structure of Contract</th>
<th>Results</th>
<th>Lessons Learned</th>
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<td></td>
<td>• Eight dialysis centers covered 25% of Romania’s dialysis patients, but the centers were run down, lacked staff and had poor quality standards</td>
<td>• Private provider received payment based on the number of patients treated&lt;br&gt; • Private provider managed facilities, staff and patient care&lt;br&gt; • Contract, signed in 2003, specified quality standards to be met by the</td>
<td>• Private provider invested US$42 million into the eight centers between 2005-08&lt;br&gt; • Romania’s National Health program estimates savings of $4.5 million while the number of treatments provided</td>
<td>• Clear and transparent pricing system helped demonstrate that services were cost effective: prior, the government used separate funding streams for different clinic operations. This was streamlined under the PPP</td>
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<tr>
<td>Challenges</td>
<td>Structure of Contract</td>
<td>Results</td>
<td>Lessons Learned</td>
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<tr>
<td>Brazil</td>
<td></td>
<td>increased</td>
<td>ROI is an important indicator to estimate program sustainability – programs that lose money during operations are not sustainable</td>
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</tbody>
</table>
| • Brazilian constitution guarantees access to health services for all citizens  
• Residents in State of Bahia did not have access to tertiary care | private provider | • Independent evaluation of the program shows that clinics provide higher quality care at a lower cost than public counterparts | |
| • Government construct new hospital  
• Private operator responsible for providing equipment and managing 298-bed hospital  
• Contract bidded out at Sao Paulo stock exchange to ensure transparency | | • Private operator invested R$31 million for all equipment  
• Increased access to health services to meet government’s goals  
• Occupancy rate of 95% with low rates of nosocomial infection. | |
| • Legal restrictions should allow for long term investment in facilities and equipment  
• Shifting operations to the private provider incrementally (ie: operate at 50% capacity for short period) ensures that systems function efficiently | |
