Health Sector Reforms in Tanzania

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Introduction

Health Sector Reform (HSR) is defined as a process of fundamental changes in policy and institutional arrangement that is evidence based, guided by government, designed to improve functioning and performance of the health sector and ultimately, the health status of the population. The National Health Policy of 1990 and the PHC Strategy and the Tanzania Health Sector Strategy Note 1993, form the basis of the current Health Sector Reforms.

The specific objectives of the health policy focus on reduction of infant and maternal morbidity and mortality; ensuring equitable access to health services; self sufficiency in human resources for health; community involvement for health promotion and disease prevention; multi-sectoral collaboration in addressing health issues, and the responsibility of the family and individuals on ones health.

The major problems facing Health Sector (HS) in 1990's include inadequate resources for the health sector; inadequate managerial capacity at all levels especially at the district level; poor implementation or national policies; split (dual) responsibilities of the DMO between central and local government; lack of appropriate research priority at all levels, and the overall declining economic performance in the country. On further consideration, these issues were basically defined as ideological, organizational, managerial and financial in nature.

Ideological issues relate to government policy for making health services available to all Tanzanians, with the government being the main provide and the sole source of health financing. Non-profit NGO's and GPO's supplemented government efforts but private for profit was restricted. Organisational issue are the dual responsibility of health services at district level; inappropriate utilization of human resources and improperly functioning referral system and duplication of generic functions through implementation of vertical programmes. Managerial issues include poor understanding of the concepts of decentralization, and primary health care, and lack of comprehensive health care plans. Duplicating of activities by passing of MoH and local actors through vertical programmes. Lack of non-adherence to quality standards for health care. Capacity building focus on individual and knowledge rather than team building and skills. Weak management and communication. Inadequate community participation and DMO not being effectively the main responsible officer for health service delivery at district level. Financial issues focus on the underfunding of health services at all levels; heavy dependence on government financing of health and donor dependency for vertical programmes and poor resource management (financial, human and material)

Proposed reforms in the Health Sector

Ideological reforms stipulates that every Tanzanian will take an active part in disease prevention and health promotion including paying for health services. The government role will be more of a facilitator rather than the main provider. Private for profit health sector will be encouraged to take a more active role. The government should continue to invest in health services delivery especially for the vulnerable and poor, in a cost effective and cost beneficial way. As regards organizational reforms, the district will be organized in such a way that health services delivery system fall under one authority – the local government, for day to day management. The MoH through RA will continue to play its role in policy formulation, health legislation, regulation and control. The referral system will be strengthened so that it is functional at all levels.

Managerial reforms specifies the authority, responsibility and accountability of the DMO and the DHMT for all health delivery. Health sector plan be developed in the context of a comprehensive district plan. Health units gradually be managed by the communities in which they are located through their district and facility health boards and vertical programmes be addressed through comprehensive primary health care programme in the context of district plans.

Financial reform proposes increased government funding for health to not less than 14% of the total budget. Target resources to cost effective services with a deliberate shift of resources to preventive services. Alternative financing options and improved utilization and management of available resources must be developed.

Progress in health sector reforms, 1990 – 2000

The cabinet approved the current HSR in 1996. Between 1994 to 1998, the MoH developed a number of median term programmes of work and annual plans of action which were subjected to a series of joint reviews of appraisal with development partners. The

1998 review. recommended that a Sector Wide Approach (SWAP) be used to further develop the Health Sector Programme of work (POW) 1999/2000.

The MoH and major partners supporting the health sector signed a statement of intent as a commitment to the SWAP process and a ministerial technical committee and a Joint MOH/Partners Task Force was formed to develop the POW and a POA for 1999/2000. This was an important turning point in the HSR process as it moved from planning for the reforms to implementation the reforms.

Whereas the proposals for HSR 1994. reaffirm the PHC strategy with great emphasis on district health services. reforms in the hospital services (regional and tertiary level) were not discussed in detail. Realising that an effective referral system is one of the major pillars of PHC and that hospitals form the back bone of the referral system, the MoH appointed a Special Committee on Hospital Reforms in 1998. The Committee was changed with the responsibility to make: an in depth study of MMC and develop a proposal for reforming the hospital that will form the basis for reform of all hospitals in the country. Subsequently the hospital reform programme was incorporated as one of the strategies for the Health Sector Programme of Work (HSPOW) 1999/2000.

Major achievements in major areas of reforms

Ideological reform (policy changes) have introduced user fees (cost sharing) for health services. The concept of "free" health services for all has been discarded. thus. each individual is responsible for his or her own health. Waivers and exemptions have been introduced as mechanisms for safeguarding vulnerable groups and poor people. Strengthening of private (health) sector and their regulation to ensure provision of quality services and consumer protection. Government to continue providing for essential public health services like immunization. family planning. chronic diseases (TB. leprosy. cancer) and special groups like children. pregnant woman and the aged group.

In organization reforms the following has been completed or initiated. review of the structure and functions of MoH. A new organization structure has been approved by the Presidential Implementation Committee in 1998. Establishment of DHB based on the then existing Local Government Act was tested in Igunga (CHF). Kagera (HSPS), Tanga (FHP) and Dar es Salaam (DUHP). Community ownership and managem.ent of Health Care Delivery, was tested in Igunga district where the establishment of CHF was piloted. The community owns. finances and manages the district health services through a prepayment system supervised by a DHB. CHF has rolled on to Nzega, Singida. Iramba. Hanang. Songea Rural and Urban districts. The government has passed an Act that amends the existing LG Acts to provide for establishment of "service boards" by local authorities.

On managerial reforms achievement include training of DHMT's to work as cohesive teams in planning and management. Training models have been developed and training of DHMT's in the 37 districts of the first phase started in 199/2000. Integration of generic functions of vertical programmes has started by integrating into MSD the procurement. storage and distribution of drugs. vaccines and other supplies for EPI. Family Planning and TB and Leprosy. Other achievements include development of integrated PHC supervision: Health Management Information System and integrated Transport Management System.

Drugs and Medical supply systems; Establishment of msd as an autonomous department of MoH. Drug Indent System is being tested in Morogoro Region and Capitalization of Hospital Pharmacies to establish a revolving fund.

In financial reforms the following has been achieved: introduction of performance budgeting and Median Term Expenditure framework for public expenditure. Introduction of fee for service starting with cost sharing for service provision in hospitals. Intramural private practice has been introduced at MMC. MOI and KCMC. Community health fund as rural prepayment scheme has been pre-tested in Igunga and rolled on to 10 other districts following its success and popularity and National Health Insurance Scheme has been developed and will start in 2000/2001 for civil servants under central government.

Sector Wide Approach (SWAP) 1998

The SWAP approach address all areas in the health sector, including those already identified in the HRP and ensured that both government and donor funds are used for agreed priorities and health financing is delivered in an more effective and efficient manner using common implementation arrangements. Health Sector Programme of Work (POW) 1999/2002 was designed to implement Tanzania's health policy. building in the earlier Health Reform Proposals and Plans. Each financial year. a detailed and coasted annual Plan of Action (POA) is prepared based on agreed targets for each of the priorities in the POW. Medium term objectives and strategies in the POW 1999/2002 is organized under 8 implementation strategies that are envisioned meet the challenges of providing health services in the line with immediate

objectives of HSR's. The CG, LG, Donors, NGO's, Communities and Private Practitioners will all be involved as the focus shifs from diseases specific programmes to a comprehensive sector approach.

The eight inter-linked strategies include Strategy 1 which Provides for accessible, quality, well supported cost effective district health services with clear priorities and essential clinical and public health packages which are organized at the decentralized level. Strategy 2 provides back up secondary and tertiary level referral hospitals services to support PAC. Stragegy 3 redefines the role of the central MoH as a facilitator or health services, providing policy leadership and a normative and standard setting role. Strategy 4 addressed the challenges of Human Resources development to ensure well trained and motivated staff, deployed at the appropriatc health service level. Strategy 5 ensured the equipment, physical infrastructure, transportation and communication. Strategy 6 ensured health care financing with is sustainable, involved both public and private funds as well as donor resources, and explored a broader mix of options such as health insurance, community cost sharing as ell as user fees. Strategy 7 addressed the appropriate mix of public and private health care services and Strategy 8 restructures the relationship between MoH and the donors.
It should be appreciated that of the 8 strategies; the first two are the main implementing strategies i.e. for delivery of district health services and hospital services at regional and national level the remaining six support the complement of these two strategies. The detailed specific objectives and activities for each of the above strategies are detailed in the POW and POA documents.

Reforms of level II and level III Hospital Services

Strategy 2 in the three year POW – 1999-2002 provides backup secondary and tertiary level referral hospital services to support primary health care. The main purpose is to strengthen the referral system in line with the PHC strategy. Tanzania has a pyramidal pattern of referral from primary health units (health posts, dispensaries and health centres) to national referral hospitals with three clearly defined levels.

Each level has a hospital that services as a backbone of the referral for the lower health facilities. The hospitals can be grouped into three levels.

- Level I – district hospitals
- Level 2 – regional hospitals
- Level 3 – national referral and specialized hospitals

Current status of level 2 and level 3 hospitals

Ownership of health facilities providing public health services in Tanzania includes government (central and local), parastatal organization and voluntary/religions agencies. However the majority, of level 2 and level 3 hospitals are mainly under public ownership. This includes all 17 regional hospitals, 2 referral hospital (MMC and MRH) and 4 specialised hospitals; Mental Health (Mirembe Hospital), Tuberculosis (Kibongoto Hospital), Orthopaedic and Trauma (MOI) and Cancer (ORCI). Two referral hospitals (KCMC and BMC) are owned and run by religions organizations. The Government finances all these hospitals inorder to ensure access to equitable health care for all citizens.

During the economic decline of the 1980's and early 90's, budgetary consequences were clearly seen in public funded hospitals as reflected by a decline in the quality and availability of their services, efficiency and effectiveness of their management; access of the poor and vulnerable to hospital care, availability of basic essential medical equipment, drugs and supplies; availability of well motivated personnel (shortage of specialist) and state of repair of physical infrastructure.

Decline in quality and efficiency of level 2 and level 3 hospitals was further compounded by; the commitment to strengthening PHC and district health systems; reduction of the health budget for hospital service was done without adequate analysis or systematic planning of the services; the number of hospitals and hospital beds remained the same or increased while funding decreased. The result was that funding for hospitals decreased with dire consequences on quality and quantity of services. The situation was more severe in large multifunctional hospitals like MMC.

Unfortunately even the proportion of funding for first line primary health care units did not increase substantially.

Objectives of hospital reforms

The government has embarked on comprehensive reform of all hospitals (district, regional referral and specialized) with the following objectives; improve the quality, accessibility and availability of essential hospital care, establish the equity, efficiency, affordability and financial viability of referral and regional hospitals, promote aims of PHC's and HSR, including strengthening links and contributions of level 2 and level 3 hospitals to the other levels in referral system, so that there are effective referral and regional hospitals to back up and support district health systems; keep the hospitals' share of the health budget from increasing in the medium term, and if possible in

the long term to reduce it somewhat and base future hospital development in the country on well formulated strategic plans.

Components of the hospital reform strategy

The hospital reform strategy has the following key components; reform of Muhimbili Medical Centre and other Referral Hospitals (level 3 Hospitals). Reform of Regional Hospitals (level 2 hospitals) and strengthening Ministry of Health capacity to oversee hospital services. The first two components aim at transforming level 2 and level 3 hospitals and strengthen hospital management in order to achieve; develop and decentralized management autonomy and authority; broadened hospital financing strengthened management performance, and improvements in resources and infrastructure.

Strengthening of hospital management will entail; separation of responsibilities between those paying for hospital services (MoH and other customers) and those delivering the services (hospitals). The MoH will thus exercise its influence over hospital mainly through the process of payment for service. Clarity in that each hospital will have a framework document clearly describing its role, service aims, objectives and how its performance will be measured. It will also specify the responsibility and accountability of hospital boards, executive directors and the MoH. Management self-sufficiency stipulates that reformed hospitals will still remain subject to government policies and priorities, but their boards and executive directors will have maximum control over their resources, with no interference from the government.

Modern management practice involves using strategic and business planning, commercial style financing management and independent external auditing. Hospitals will know the real costs of services and be able to manage on the basis of resources consumption rather than just cash. Customer satisfaction and quality care entails that hospitals will focus on their patients and other customer, find out what they need and check that they are being satisfied. "Customer Satisfaction" will be one of their performance measures, as regard continuous improvement each reformed hospital will have key performance targets, and achievements will be published to provide transparency and enhance accountability. Freedoms and flexibilities provides for hospitals to operate in a business like way. Hospital boards and managers need to be freed from many current rules and regulations, and be given freedom over such areas as recruitment, appointment and management of staff, posts and conditions of service; financial authority; choice of suppliers; purchasing and contracting; and acquisition and disposal of assets, especially land and buildings. Financial viability introduces more effective income-generating measures at hospitals but with safeguards to ensure equitable access for poor people to essential care and cross subsidization for them with income from private patients and other sources.

Internal devolution strengthens the management of divisions, departments and other service units within a hospital by increasing their authority over resources and their accountability for performance and outputs and establishing cost centre budgeting and accounting and creating single lines to authority.

Strengthening MoH capacity to oversee Hospital Reforms

The third component of hospital reforms aims at strengthening the MoH capacity to oversee hospital reforms inorder to strengthen the accountability of hospitals and establish its position as purchaser of services. When the reforms are complete the MoH shall cease instructing, controlling and supervising most aspects of hospital management (**"hands-off"**), and establish goals, targets and policies for quantity, quality and level hospital service that it wants provided, monitor their delivery and pay hospitals accordingly (**"eye on"**).

The future roles of the Ministry in overseeing hospitals

The future role of MoH will include formulation of national policies and plans for providing equitable hospital care which is affordable to individual Tanzanians and for the nation as a whole. Determining what level, type and quantity of services the Ministry requires from each hospital, and pay it for these services. Establishing and actively monitoring the standards and minimum requirements that hospitals are expected to meet. Holding hospitals clearly accountable for the funds they receive. Providing clear incentives to hospitals for improvements in quality and efficiency. Deciding on the assistance which will be given for capital works of hospitals (buildings, renovations; major items of equipment), based on national priorities for the development of hospital services.

Phases for Implementation of the Hospital Reform Process

Comprehensive hospital reforms are a major undertaking that must be introduced carefully and thoughtfully, if it is to have a reasonable chance of success. A phase approach and building on experience has been adopted. MoH launched the hospital process

in the financial year 2000/2001. Each year an annual plan will be prepared that included only those activities that are considered to be realistic and achievable priorities on the path towards fulfillment of the 3 year Programme of Work (POW). Each hospital shall form a Hospital Reform Task Force that will assist and advise the Hospital Management to plan, implement and monitor the restructuring process. In the first year of implementation 2000/2001 plans and activities will focus on careful analyzing the existing situation and requirement to implement the reform; consulting with stakeholders; preparation implementation strategies and plans for the reform process; starting preparation of an overall development plan for Tanzania's hospital service; testing and introducing a few reforms; reviewing the roles of specialized hospitals for TB and Mental Health and developing the MoH capacity to oversee hospital services and reform process.

Reforms of Muhimbili Medical Centre

MMC has been chosen as the first priority for reform and the reform at the other hospitals will be built on its experience, success and mistakes. Lessons from MOI and other hospitals piloting specific aspects of hospital reforms will be valuable for MMC, other hospitals and the reforms process itself. Activities in the financial year 2000/2001 will include to separate hospital functions from University College functions; prepare regulations for MNH Act 2000; establish authority and autonomy of the hospital (Board and Executive Management); Strengthen management of resources (starting with Financial Management System) and preparation of framework document and strategic 3-years plan.

Reform of other Referral and Specialised Hospitals

Reform in other referral and specialized hospitals will be introduced gradually based on lessons learnt at MMC. MRH and BMC will start comprehensive reforms 2000/2001. The future organization and functions of Kibong'oto and Mirembe will be determined before comprehensive reforms are introduced. In 2000/2001 plan for MRH and BMC; preparation for proposal document with phase and budget for 2001/2002; initiate stakeholders consultation at BMC, MRH and ORCI; review of Mirembe and Kibong'oto hospitalsl; pilot reform of financial management and human resources management at MOI; pilot improvement of emergency and critical patient care at KCMC.

Reforms of Regional Hospitals

Regional hospitals are currently financed and administered by MRALG through the Regional Administration. The role of the central government, regional administration, and local authorities in health services delivery is being redefined by on going reforms in the civil service, local government and health sector. According to these reforms, the central government at ministerial level will be responsible for formulation of health policy; guidelines standard and legislation; training of health care personnel, and health care financing. The local authorities will be responsible for local service production and delivery.

Restructuring of the Regional Administration

Restructuring of the RA provides for a small regional secretariat with a vision to be a technical resources by supporting local development opportunities and ministerial service between central and local government. The mission to support this vision is divided in two parts, a development mission and an administration mission. The development mission centres on building capacity within local authorities to enable them to deliver management development services, economic development service, physical planning and engineering services and social development services. The administration mission centres on ensuring peace and tranguility; providing and securing an enabling environment to facilitate and assist local authorities and representing the government in the region.

Local authorities (district, town and municipal councils) are responsible for manning of health centres and dispensaries. In line with health sector and local government reforms, the running of district hospitals will also be transferred to local authorities; central government administers and finances all regional hospitals through MRALG and the Regional Secretariat; regional hospitals provide level 2 referral services to all health facilities in the region (public, voluntary agency and private) and regional hospitals also provided level 1 services for the urban authority where they are located as well as the surrounding rural district.

Role of MoH in relation to regional hospitals

Ministry of Health will continue to be; responsible for formulation of health policy, guidelines, and legislation; training of health care personnel; setting norms, standards and targets for quantity and quality of health services and mobilizing resources for health from the government and external partners. Ministry of Health in liaison with the MRALG will be responsible to identify, officially appoint and post four health personnel to the Regional Secretariat (RS). These will form the Regional Health Administration (RHA). The Regional Health Management Team

(RMHT) will be formed by these four members of the RHA plus 3 other members from the Hospital Management Team (HMT). Ministry of Health will also be responsible for co-ordination of Donors to the Health Sector.

Role of Ministry of Finance and MRALG

The role of MoF will include to create a **sub vote and budget items** for the regional hospital and hospital board and establish a mechanism for providing **Block Grants** to the hospital through the Regional sub-treasury according to recommendations of the Regional Secretariat. The MRALG has the overall responsibility for formulation of policies for development, management and administration of regional administration and local authorities and to co-ordinate activities of the RS and to support institutional development strategies for regional secretariats.

Role of Regional Secretariat (RS)

The main role of RS is to support capacity building for increased expertise in local government activities related to health service delivery through; interpreting health policy, regulations and legislation and monitoring their implementation; to build capacity of local authorities in planning; implementing, monitoring and evaluating health services; monitoring sectoral trends in health targets; providing technical and administrative assistance to RHB, HMT, DHB, DHMT and local councils; identifying health development opportunities and obstacles and recommend strategies and techniques to overcome the obstacles; recommending new strategies and techniques to overcome bottlenecks to health development; enhancing institutional capacity development and co-ordination of the regional health activities carried out by different partners in the region (Government, NGO's, Private and External Partners); carrying out health functions delegated by MoH and to run the regional hospitals as a secondary referral hospital for the region.

The numbers of technical posts for the RS are limited; therefore the RS will require a RHMT to provide the interface between the MoH, MRALG and the local authorities. MoH has proposed the posting of the following officers to the social services support cluster of the Regional Secretariat; Regional Medical Officer (Team Leader); Regional Nursing Officer; Regional Health Officer and Regional Health Secretary. The 4 members will form the Regional Health Administration. RHA will be joined by 3 technical officers from the Regional Hospital to form the RHMT. The three officers proposed by the MoH and CSD include: Regional Dental Officer, Regional Laboratory Technologist; and Regional Pharmacist. The following will be co-opted as members of the RHMT; Hospital Director; Head of Human Resource Development Department; Head of Health Promotion and Preventive Department and Head of Curative and Rehabilitative Department.

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