



**PRIVATE SECTOR DEVELOPMENT
THE CASE OF PRIVATE HEALTH FACILITIES**

BY

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
AMOs	-	Assistant Medical Officers
AMREF	-	African Medical Research Foundation
APHTA	-	Association of Private Hospitals in Tanzania
BAKWATA	-	Baraza Kuu la Waislamu Tanzania (Muslim Council of Tanzania)
BOT	-	Bank of Tanzania
CCM	-	Chama Cha Mapinduzi (Revolutionary Party)
DDHS	-	District Designated Hospital
DMO	-	District Medical Officer
EDF	-	European Development Fund
FHI	-	Family Health International
HB	-	Haemoglobin
HIV	-	Human Immuno-deficiency Virus
MAT	-	Medical Association of Tanzania
MCH	-	Maternal and Child Health
MD	-	Medical Doctor
MMC	-	Muhimbili Medical Centre
MO	-	Medical Officer
MOH	-	Ministry of Health
MSD	-	Medical Stores Department
NAPCO	-	National Pharmaceutical Company
NBC	-	National Bank of Commerce
NGOs	-	Non Governmental Organisations
RMO	-	Regional Medical Officers
SSS	-	Social Sector Strategy
STD	-	Sexually Transmitted Disease
TB	-	Tuberculosis
TPDF	-	Tanzania Peoples Defence Forces
UMATI	-	Uzazi na Malezi Bora Tanzania
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
URT	-	United Republic of Tanzania
USAID	-	United States Agency for International Development
USS	-	Ultra Sound Sonography
WHO	-	World Health Organisation

1.0 BACKGROUND AND METHODOLOGY

1.1 Background

1.1.1 Socio-economic Context

The socio-economic context of Tanzania can be described under two phases: the pre-economic reforms phase and the post-economic reforms phase. The pre-economic reform period, particularly after the Arusha Declaration, was characterised by state control of the economy. During this period, there was steady improvement in social indicators such as literacy and mortality rates. The Government put in place a system of social service delivery that greatly increased access to basic social services, namely primary education and health care. However, the economic crisis of the early 1980s adversely affected the growth rate of the productive sectors. In turn, this had an adverse effect on the capacity of the economy to support the delivery of basic social services.

In response to the crisis, the government introduced a series of economic reforms in the mid-1980s. The reforms aimed at, among others, reviving economic growth through re-orientation of the country from a public sector-led economy towards a liberalised economy with increased private sector participation. These reforms have involved restructuring measures at the macro level to ensure macro-economic stability. Liberalisation measures have promoted private sector participation in all sectors of the economy including social services such as health and education. This has resulted in increased private participation in the provision of education and health services. This is consistent with one of the reform objectives in the Social Sector Strategy (SSS), which seeks to relax constraints to private sector participation in the provision of social services.

1.1.2 The Health Care System

At independence, the government assumed primary responsibility for the provision of health care to its people and made progress in developing a comprehensively structured health care delivery system from the national to the village level. Government health services have, however, been supplemented by private health services. Initially, not-for-profit health care providers, particularly church-owned facilities, dominated this sub-sector. However, subsequent to the 1991 amendment of the 1977 Act that had banned for-profit practitioners from providing health care, there has been a rapid increase of for-profit health care facilities. About 46% of the private for-profit health facilities were established after 1990.

According to the 1995 Health Statistics Abstract, private hospitals and dispensaries (for-profit and not-for-profit) in Tanzania mainland constituted 48% and 23% of the 183 hospitals and 3,286 dispensaries respectively. Most of these were not-for-profit health facilities; only 9 hospitals, 1 health centre and 212 dispensaries were for-profit facilities. By 1997, private health hospitals constituted 56.2% of the 224 hospitals in the country while private dispensaries constituted 35.5% of the 4,276 dispensaries. The number of private for-profit hospitals and dispensaries had increased from 9 to 11 and from 212 to 780 respectively.

A few studies undertaken in Tanzania show that there has been a rapid growth of private health providers beginning 1991. In a survey of Dar es Salaam and Kilimanjaro regions, Munishi et al (1995) found that official statistics were grossly under-estimated. One reason for the under estimation is the rapid increase in the number of for-profit facilities since 1991, with some of the facilities escaping government count, which has made updating of the records difficult. There has been more increase at the level of dispensaries, which make up 89% of all private facilities in Dar es Salaam. According to the Dar es Salaam City Council Survey, for-profit providers owned 42% of all private health facilities in Dar es Salaam as of 1993. These included 15 (83%) of 18 private hospitals; 30% of facilities belonged to non-profit organisations, and 28% were employer-based facilities.

1.2 The Study and its Methodology

1.2.1 The Problem

As the private health care sub-sector continues to grow, questions are being raised regarding its capacity to effectively complement the public sector in attaining the health sector goals, and on whether the government is providing an effective regulatory framework and a facilitating environment for effective delivery of quality and equitable private health care services. This study, therefore, attempts to examine the development and performance of the private health care sub-sector with particular attention to promoting and regulating private health care provision, including assessment of existing linkages among health care providers, and between health care providers and other key actors in the health care system.

1.2.2 Objectives of the Study

The main objective is to study private sector development, using the case of private health facilities, with a view to examining the experience in promoting and regulating private investment. The study also seeks to examine broad-based linkages in the health sector, and to demonstrate what could be desirable forms of public-private sector partnerships in the provision of quality and equitable health care, which is of high priority in the socio-economic development of the country. Specifically, the study aims at:

- (i) Providing a solid understanding of the nature and performance of private health facilities.

- (ii) Assessing the extent of government involvement in the promotion and regulation of private health care.
- (iii) Exploring areas where collaboration between government and the private sector could increase volume and quality of health services.

1.2.3 Methodology

This study utilises mostly primary data collected by interviewing both private health care providers and officials in the Ministry of Health and other private health care supporting institutions in Dar es Salaam Region.

A sample of 300 health facilities was randomly selected from the Ministry of Health (MOH) Register of non- - governmental health facilities. Out of these, about 52% were either closed or could not be located in the area specified in the register. About 3% of the owners/medical officers in charge refused to be interviewed. The sample was randomly drawn from all three districts of Dar es Salaam Region, i.e. Ilala, Kinondoni and Temeke.

1.2.4 The Sample

In total, 136 health care providers were interviewed as detailed in Table 1. The distribution of these facilities by district and by type of health facility is presented in Table 1 below. A total of 12 hospitals were visited, out of which 50% were located in Kinondoni District, 33% in Ilala District and 17% in Temeke District. Ten (10) facilities in the sample were registered as health centres, of which 70% were located in Kinondoni District while 20% and 10% were located in Ilala and Temeke districts respectively. Dispensaries constituted the largest proportion of health facilities accounting for 75.7% of the total number of facilities visited. Of the 103 dispensaries in the sample, 36.9% were in Kinondoni District, 40.8% in Ilala District and 22.3% in Temeke District. Eleven (11) health facilities registered as clinics were also visited - 73% of them were in Kinondoni District, 18% in Ilala District and 9% in Temeke District.

Table 1: Distribution of Sampled Private Health Facilities by District

District	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Temeke	2	17.00	1	10.00	23	22.30	1	9.10	27	20.00
Ilala	4	33.00	2	20.00	42	40.80	2	18.00	50	37.00
Kinondoni	6	50.00	7	70.00	38	36.90	8	73.00	59	43.00
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Field survey data

Figures 2 and 4 show how representative the sample is, compared to the distribution of private health facilities in Dar es Salaam districts (Figures 1 and 3) as per the 1997 Health Statistics Abstract. Figure 2 shows over-representation of hospitals in Kinondoni District. However, the high rate of turnover of private health facilities makes it difficult to conclude with certainty that there was over-representation.

Figure 1

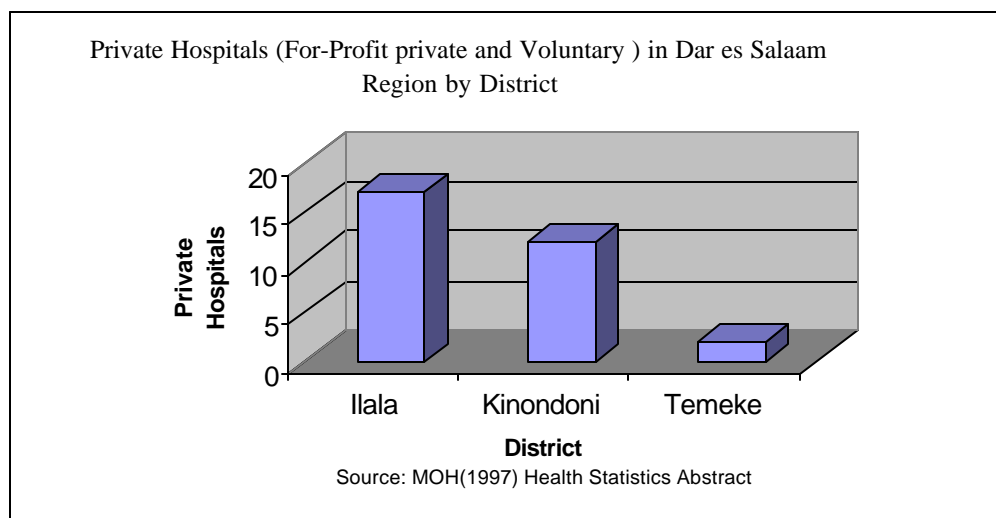


Figure 2

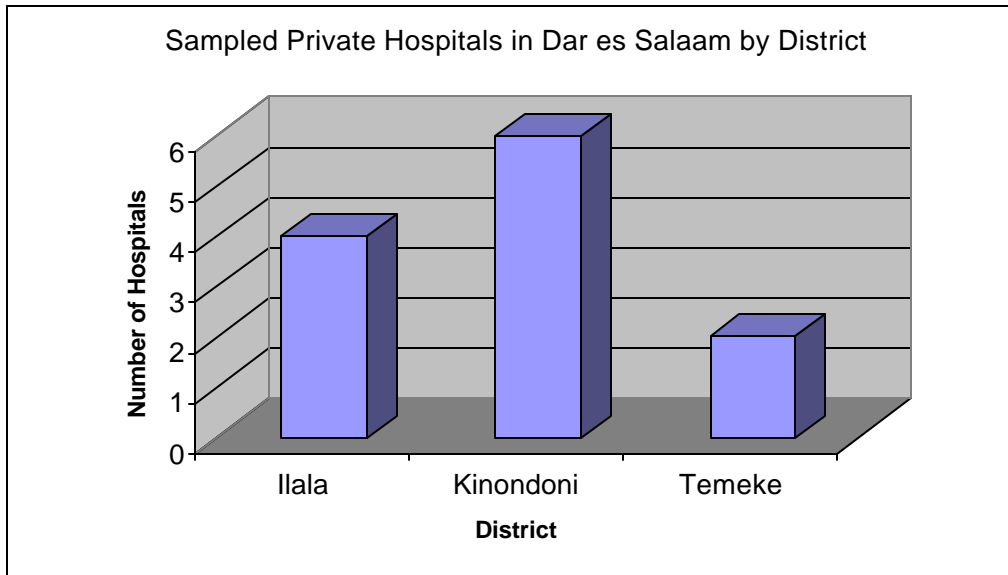


Figure 3

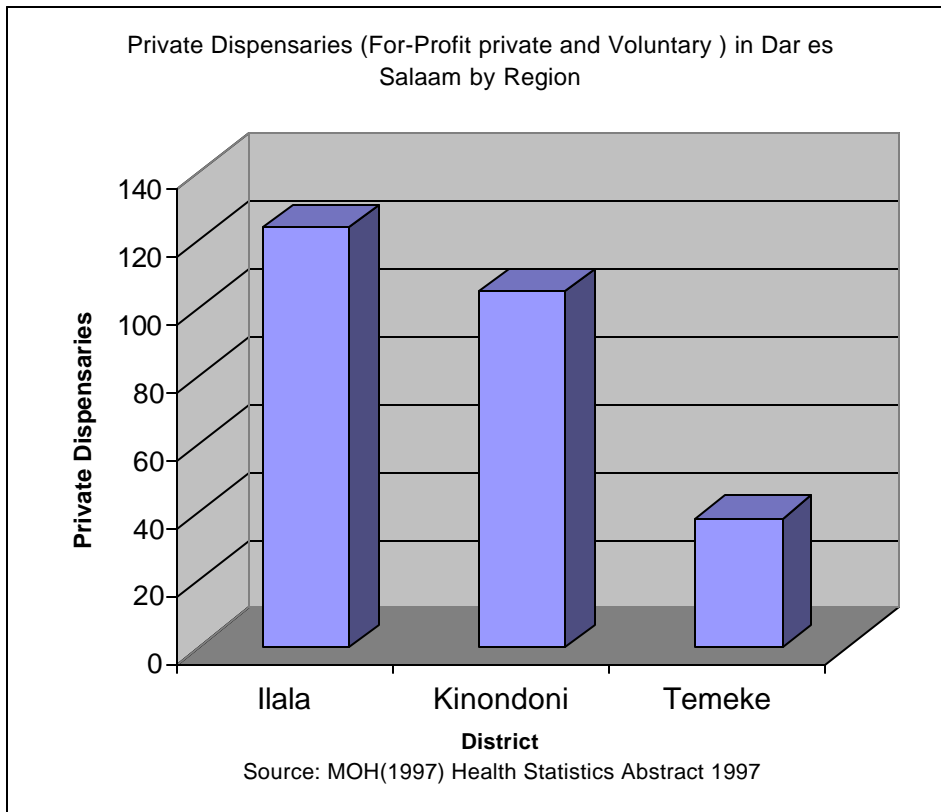
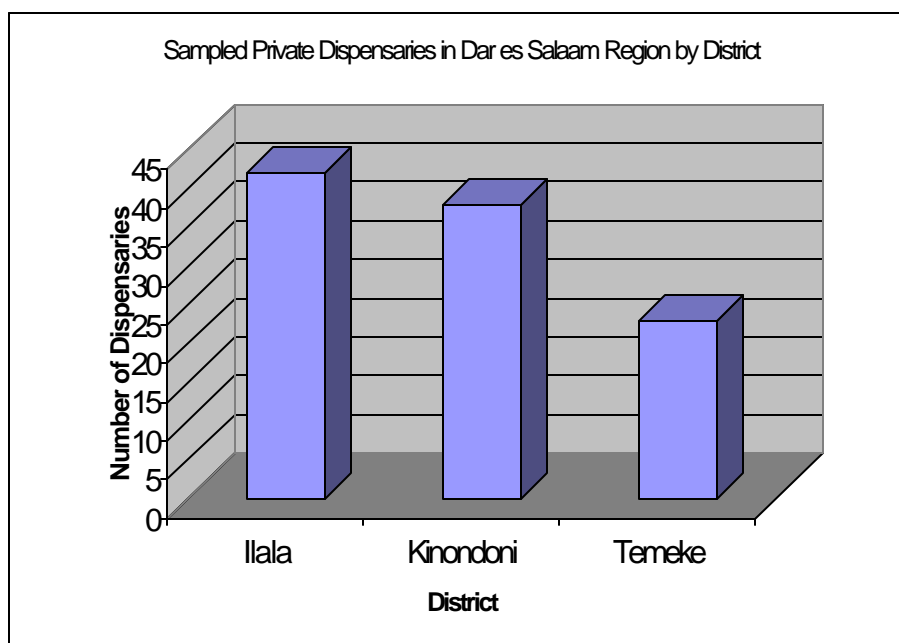


Figure 4



Apart from private health care providers, 30 officials employed in the Ministry of Health and other health care related institutions in Dar es Salaam Region were interviewed. Most of the officials from the Ministry of Health were heads of sections and units in the departments of hospital services, preventive services, training, health planning and primary health care. Others included District Medical Officers for Ilala, Kinondoni and Temeke districts and senior officials in other key health care related institutions. Sixty percent (18 out of 30) interviewees were Medical Officers/Assistant Medical Officers (MO/AMOs) 10% (3 out of 30) Nurses, 20% (6 out of 30) other medical personnel and 10% (3 out of 30) non-medical professionals (please refer to Table 2). All officials interviewed were undertaking either only administrative or both administrative and medical duties in their work places.

Table 2: Distribution of Interviewed Government and Other Health Care Related Institutions Officials by Profession

Profession	Total	%
MO/AMOs	18	60.00
Nurses	3	10.00
Other: Medical*	6	20.00
Other: Non-medical**	3	10.00
Total	30	100.00

Note:

- * Other medical personnel include laboratory technicians, pharmacists, and radiographers.

** Other non-medical personnel include Economists and Administrators.

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter provides a review of literature on trends in the development of the private health sector, its performance and the role of government in private health care provision.

2.1 Development of the Private Health Sector

Literature on the development and growth of the private health sector in developing countries, Tanzania included, show that private health care is already a common phenomenon. In countries like India, Papua New Guinea, Sri Lanka and the Philippines the private health care sector is already an important part of the health care delivery system. Studies undertaken in these countries indicate the importance of this sector in the provision of health services. Reviews by Ramesh (1993) on the studies by Duggal and Amin (1989) and Yesudian (1990) on the utilisation patterns in India indicate that there is a high dependence on private health care by health care seekers. Reviews of other studies (Vishwanathan and Rohde, 1990) further indicate that the private health sector in India plays just as important a role as that played by the public sector in controlling disease patterns, and that the private health sector provides a larger proportion of health services than provided by the public facilities. As of January 1988, for example, the private health sector in India owned 50% of the total number of hospitals, 30% of hospital beds and 49% of the dispensaries. In Tanzania, as already mentioned, the number of private health facilities has been increasing in recent years.

2.2 Private Health Care Provision and the Role of Government

The health care market in many ways diverts from the assumptions of perfect competition in a free market where transactions of goods and services are made by sellers and buyers of the same, with the forces of demand and supply determining the price. Whereas conditions of imperfect competition characterise many different types of markets where transactions of goods and services takes place, market failure is even more pronounced in the health care market because of its unusual characteristics. These include the following:

Derived demand for health care: Because one does not know when one will fall sick, it is usually difficult to plan ahead for health care demands. This increases an uncertain environment and a higher risk of incurring high costs for health care. Thus, for example, while provision of insurance to risk groups is

not common in other types of markets, insurance is provided to even such groups in the health care market. However, insurance schemes are still lacking in many developing countries, and Bennett (1997) points out that this provide financial incentives to providers to over-provide care because health care seekers have to pay out of pocket on a fee-for-service basis. (Arrow, 1989; McGuire, 1991).

Asymmetric information: Although patients are able to describe symptoms, they do not usually know the kind of treatment that is needed for their ailments. On the other hand, the doctor does both the diagnosis and prescription, often making decisions on behalf of the patient, decisions that may not necessarily reflect interests of the patient's welfare only. Such a situation requires government intervention not only in terms of instituting laws and regulations to curb misappropriate behaviour by health care providers, but also in establishing a system of incentives to encourage providers to act in the patients' best interest.

Positive externalities: Positive externalities occur when a third party receives benefit from a transaction that he/she was not part of. In health care, some services have positive externalities on other people's welfare. It has been argued that consumption of goods and services that have positive externalities, in particular if they are public goods whereby others cannot be excluded, is less than socially optimal unless they are subsidised.

Merit good: Some services are perceived by society as essential to ensure equity and social justice, hence the argument that such goods and services should be provided to everybody. The idea is that such goods should be provided even if they are not demanded by the people because they are good in themselves (Rosen, 1991). Health care is one of the services that are perceived as something good for everybody.

The government must, therefore, influence private health care providers' behaviour to avoid market failure in the health sector. Health care providers have excessive power in terms of prescribing and providing treatment. Most patients are not able to assess the validity or usefulness of a provider's prescription and treatment. The government's role is necessary particularly because in the private market those who are not willing or able to engage in market transactions will not do so. For this reason, Muschell (1995) argues that if prices for health services are not monitored and if competition between providers fails to keep prices down, the poor and vulnerable will be denied access to appropriate care. It is thus important to ensure that during the period of change in public and private roles in health care, social objectives e.g. equality, are not compromised.

Bennet and Ngalande-Banda (1994) point out that governments have to regulate provision of private health care because of concern over several issues. For example, governments are often concerned that

for-profit-providers do not give consumers a fair deal (they may provide low quality care, supply unnecessary services or over-charge). Also, governments may be concerned about the equity implications of a substantial private sector, which may be benefiting a relatively small section of the population, often located in urban areas. In Zimbabwe, the private sector accounts for 37% of health sector expenditure but benefits no more than 10% of the total population, with 75% of private practitioners located in Harare or Bulawayo. Bennet and Ngalande-Banda (1994) thus acknowledge the necessity of regulating private health care provision. There is need, for example, to ensure that for-profit providers offer quality and equitable health care. In this regard one could, for example, assess the extent to which the government has set:

- (i) Minimum structural standards
- (ii) Minimum education qualification of health providers
- (iii) Minimum years of experience before which practitioners cannot be allowed to operate privately.
- (iv) Provisions for controlling the number of private health care providers.
- (v) The price of care: for example, are there mechanisms to ensure that private health care providers do not over-charge?

However, the characteristics of private health care markets described above imply that the role of government should be interpreted in a broader sense. That is, government should not only regulate, but should also be concerned with ensuring that proper incentives exist for private health care providers to offer, in an efficient manner, quality and equitable health services. It is in this context that Bennet and Ngalande-Banda (1994) also emphasise the need for provision of incentives to facilitate private health care providers. While some regulation by the government is essential to protect both the consumers and providers, the government must also ensure that incentives are in place to facilitate effective and efficient private health care services. An enabling environment is the main concern of private health care providers. Muschell (1995) identified both non-monetary and monetary incentives such as:

- (i) Allowing private sector activity to take place within public sector facilities. In Mozambique for example, medical staffs are allowed to run special private clinics in government facilities outside normal working hours.
- (ii) Providing incentives to private practitioners who provide less-profitable services. For example, in some countries such as Nigeria and Zimbabwe, the government has encouraged private practitioners to offer preventive services by providing them free supplies such as vaccines and condoms. The danger here, however, is abuse of this incentive by the private sector as found

out in countries where it was offered. In Zimbabwe, supply of free vaccines to private practitioners was stopped when it was discovered that they were charging for these services.

- (iii) Giving private health care providers financial breaks such as:
 - (a) Allowing duty free importation of specific medical supplies.
 - (b) Bonus incentives such as tax exemptions on certain medical supplies to encourage physicians locate in under-served areas.
 - (c) Allowing private providers to purchase drugs and other medical supplies from government sources as it is done in Ethiopia. This is an implicit subsidy as government stores prices are usually lower than those of private suppliers are.

2.3 Private Provision and Accessibility Trends

It is often argued that provision of private health care frees up government resources to provide services for the poor, thus ensuring equitable distribution of care. Such argument, however, has been countered. For example, Muschell (1995) points out that too much reliance on private health care could lead to inequality in access to care.

The distribution of private health care facilities in most of the developing countries seems to be highly urban-biased. With a bigger proportion of the poor more likely to be in rural areas than in urban areas, the implication is that private health care is biased in favour of the well-to-do. Survey findings in India (Ramesh 1993) indicate that most of the private health facilities are concentrated in urban areas. In a survey of Papua New Guinea Private Medical Practitioners, Aitken et al (1989) found that private medical services were still provided for the urban minority, and stressed the need for developing both the public and private health services in harmony so that private health sector does not grow to the detriment of public medical services for the rural majority. Studies in Thailand (Nittayaramphong et al 1992) too show that private health facilities are extremely concentrated in urban areas particularly in the capital city, Bangkok, where 37% of the hospitals and over half of total hospital beds are concentrated.

In Tanzania, the findings of the study by Munishi et al (1995) indicate that the majority of the newly-established private health care facilities are located in urban areas, especially in Dar es Salaam. Out of 1128 private health care facilities as of February 1995, 70% were located in urban areas, and only 30% in rural areas.

The location of private health care facilities in urban areas has a high correlation with the income level of the would-be users (Munishi et al, 1995). Findings indicate that only voluntary health facilities seem to be more physically accessible to the majority of the population since they are also located in the rural areas. Such a pattern could thus increase regional and urban/rural inequalities in access to medical care, if deliberate efforts are not made to change it.

Other studies have come up with different findings on private health care utilisation patterns. Findings from studies on the utilisation pattern of health care services and its determinants, and the analysis of household expenditure data obtained through surveys carried out in India indicate that people generally prefer private health care facilities, and that their spending on health care is quite significant. Studies by Duggal and Amin (1989) on the socio-economic demographic determinants of utilisation of health care facilities indicate that differences in income do not have much influence on the propensity to use different types of facilities. The findings also indicate that the pattern did not change much between rural and urban settings. Even in the slums of Bombay, communities were found to be using more private health facilities than the public facilities, at least for outpatient cases, which did not involve considerable cost.

The perception that private medical utilisation is exclusively for the rich also seems to be discounted by the fact that the majority of patients attending private health facilities in Papua New Guinea, Thailand, Sri Lanka and India, had a modest income. This is an indication that the low-income earner places a very high value on an expected successful health outcome from private health care. People will thus choose to pay for services they perceive to be of higher quality despite the availability of free public services. Household utilisation surveys in Thailand show private clinics to be extremely popular sources of outpatient care because they are considered convenient in terms of both opening hours and location (Muluo et al 1989)

In other places however, income and socio-economic characteristics have been found to significantly affect access to health care. For example, survey data on private health sector utilisation in Thailand (Nittayaramphong 1992) indicate that those in better paid occupations (e.g. professional and administrative staff) tend to use private hospital and clinic services more often than the poorly paid groups e.g. farmers, miners and the unemployed. Findings similar to those of Thailand were recorded by a survey on characteristics of patients attending private clinics in Papua New Guinea. Muluo et al (1989) found that most patients attending such clinics were employed in professional jobs although a sizeable proportion of the patients were from low and modest income categories. However, 40% of those interviewed revealed that they had to borrow money to meet the cost of the services provided. Mulou et al (1989) also found that the level of education was positively associated with both attending a private health facility as a first choice of treatment and joining a medical insurance scheme, and that

medically insured health care seekers were likely to choose private health care as their first treatment choice.

According to Abel-Smith and Rawal (1992), choice and use of private health providers increases with increase in incomes. As income increases, the use of government health facilities gradually declines, with more people seeking health care services in private health care facilities. This is an indication that people are willing to pay for better health care services and private-for-profit facilities are perceived as providing high quality services.

In Tanzania, results of the 1993/94 Human Resources Development Survey indicate that wealthier people are more likely to seek medical care in private hospitals than poorer people are. For example, 55 percent of sick individuals in the poorest 20 percent of the households sought care in government health centres or dispensaries compared to 26 percent of those in the richest 20 percent of the households. On the other hand, only 6 percent of sick individuals in the poorest 20 percent of households sought care in private health centres and dispensaries compared to 24 percent of those in the richest 20 percent of households.

The above findings indicate problems of access to private health care services for certain groups of the population such as the poor and/or those living in rural areas. Such problems imply the need for government intervention not only in terms of regulation to ensure easy physical access to different providers of health services, but also in terms of facilitating private health care providers to offer services which are affordable to the majority of the population.

2.4 Private Provision and Trends in Quality

It has also been argued that the infusion of market forces of competition will lead to improvements in service quality. This has also been counter-argued on the basis that although there is evidence, particularly in the non-health sector, that competition and private ownership can lead to provision of better goods and services, quality is not assured. This is because of the competing objectives of equity, efficiency and resource (income generation). Often, in an effort to control costs and/or ensure profitability, quality of service is compromised.

The quality of health facilities can be reflected, among other things, in the quality of personnel working in these facilities. In a review of studies done in other developing countries, Kiwara (1994) showed that in India many health care providers do not have formal medical qualifications. Experiences in countries such as Sri Lanka, Thailand and Papua New Guinea have shown that the private health sector is expanding at the expense and detriment of public health care services, whereby government health care

facilities are deprived of specialists whose training has been through public resources. Rapid private growth and income differential between the public and private sectors serve to pull both doctors and nurses into the private sector (Nittayaramphong et al 1993).

In a survey of Papua New Guinea Private Medical Practitioners, Aitken et al (1989) found that almost all the private medical practitioners interviewed gave financial reasons as the main cause for leaving the public service, comparing long years of study required to acquire a lowly remunerated medical qualification and the heavy work load. Fifty percent of them gave poor working conditions as another reason for leaving the public service. On the introduction of private health care in Tanzania, Kiwara (1994), noted that this would cause a scramble for available human resource in health care and emphasised that the country should, at any cost, preserve and sustain past achievements in the health sector.

The quantity and efficiency of health care can also be determined by the type and level of services provided, as well as by the location of dispensing facilities. In a study of General Practitioners in Sri Lank, Sivagnanasundram 1977) found that 31.8% of General Practitioners had their practices in their own homes while 51.1% practised both at home and elsewhere. There is all the likelihood that home premises used for provision of health care services do not meet the approved standards set by health authorities.

The above review shows how quality is not necessarily assured in the provision of private health care. This is quality in a broad sense in terms of aspects such as physical facilities, qualifications of medical personnel, availability of necessary equipment, patient handling and process quality. Again here the need for government intervention is seen in terms of establishing a regulatory frame work to ensure provision of quality private health care.

2.5 Key Research Questions

In view of the objectives of the study and experiences in private health care provision reviewed in the preceding sections, the study attempts to address the following questions:

- (i) How well are private health care providers performing?
- (ii) Is there a regulatory framework in place to monitor and regulate private health care provision?
- (iii) If so, to what extent is the regulatory framework effective?
- (iv) To what extent does the government provide incentives to promote private health care

provision?

- (v) To what extent are linkages among health care providers, and between health care providers and other key institutions in the health sector developed and functioning?
- (vi) What are the best forms of collaboration between government and private health care providers to develop and promote private health care?

In the following chapters, we attempt to analyse and discuss issues directed at addressing the above questions.

3.0 INCOME, EXPENDITURE AND PRICE COMPETITION

Financial sustainability is very important for the survival of any organisation. This study, therefore, sought to examine the pattern of expenditure and income in private health facilities so as to assess financial sustainability and challenges facing investors in the private health care market. Prices charged for selected services and drugs were also examined with a view to assessing the extent to which there is a competitive environment in the private health care market. Following are the main findings:

3.1 Business Turnover

Business turnover may be defined as the total sales of services rendered to consumers in a certain period of time. In this case, consumers are patients attended to in private health facilities. When the business turnover is higher than the total cost, then the firm is generating profit and vice versa. Therefore, the concept of business turnover is very important in understanding the financial performance of the health facilities and, hence, prospects for financial sustainability.

While business turnover is an important concept in understanding business performance and viability, it is also sensitive information for many businessmen to reveal. Often, people do not like to reveal how much a business earns for fear of tax implications. Such unwillingness was also apparent in this study. Some of the private health care providers were reluctant to give information on their business/sales turnover. About 40% (55 out of 136) providers did not respond to the question at all. It is also apparent from a comparison of the data on income and expenditure that some of the private health care providers did not give exact turnover figures. For example, a hospital that indicated its income as over Tsh. 750 million indicated expenditures amounting to over Tsh. 1 billion. Another facility indicated an income of Tsh. 3.6 million and expenditure amounting to Tsh. 12.4 million, which is more than three times as much as income is. A dispensary that had the lowest income of Tsh. 0.6 million, had a total expenditure of about Tsh. 2 million, which is also more than three times as much. It is important, therefore, that data on income be interpreted with caution.

Data on turnover (Table 3) shows a huge variation within both same level facilities and across facilities of different levels. Hospitals have higher turnover figures compared to lower level facilities such as health centres and dispensaries. The highest turnover in the private hospitals sampled was over Tsh 750 million per year and the lowest turnover was Tsh. 3.6 million per year. In the case of health centres, the highest business turnover was Tsh 290 million per year and the lowest was about Tsh 7 million per year. The highest business turnover in dispensaries was Tsh 48 million per year and the lowest was Tsh 0.6 million

per year. In the case of clinics, the highest turnover was Tsh 25.8 million per year and the lowest was about Tsh 2.17 million per year.

Table 3: Descriptive Statistics of Annual Income by Level of Facility (Tsh. Million)

Statistic	Type of Health Facility			
	Hospital	Health Centre	Dispensary	Clinic
N	8	8	58	7
Maximum	750.0	290.0	48.0	25.8
Minimum	3.6	7.0	0.6	2.1
Mean	150.5	72.5	12.9	13.1
Median	39.4	17.4	10.9	6.0

Source: ESRF (1997) Private health facilities field survey data

Using turnover as an indicator of the size of business, there seem to be substantial variation even among same level facilities as already noted. Most of the facilities, however, have income below the mean. At hospital level the mean is Tsh. 150.5 million. The median is much lower at Tsh. 39.4 million. Essentially therefore, only one or two hospitals seem to be earning much higher income than the others. A similar pattern is depicted at the level of health centres where the mean is Tsh. 72.5 million and the median is Tsh. 17.4 million. At dispensary level, the mean and median are much closer at Tsh. 12.9 million and Tsh. 10.9 million respectively. Most of the dispensaries, therefore, appear to be of the same size, which implies more competition within this level. As already mentioned, accuracy of income data is an issue of concern, hence its interpretation is made with caution.

3.2 Expenditure

Private health care providers incur costs in running their health facilities. Like in any other business, expenditures have a direct bearing on the profitability of private health care facilities. Respondents reported to incur costs on several items that are essential for operation of their facilities. These include rent, wages, pharmaceutical products, payment of shared services such as X ray, non-routine laboratory test and Ultra Sound, catering for in-patients, transport, water, electricity and other costs.

Analysis of expenditure data by level of facility shows a similar pattern as that for income, with hospitals incurring much higher costs than lower level facilities. Also, the variation in expenditure is much more pronounced in the hospital category. The mean for hospitals is Tsh. 142.3 million and the median is much lower at Tsh 44.6 million. The mean and median for health centres are Tsh. 36.3 million and Tsh. 11.4 million respectively. Figures for the same values at the dispensary level are Tsh. 11.9 million and Tsh. 10.7 million respectively.

Table 4: Descriptive Statistics of Annual Expenditures by Level of Facility (Tsh. Million)

Statistic	Type of Health Facility			
	Hospital	Health Centre	Dispensary	Clinic
N	12	10	101	10
Maximum	1,014.0	235.9	56.0	52.4
Minimum	6.4	5.8	0.6	1.3
Mean	142.3	36.3	11.9	13.6
Median	33.6	11.4	10.7	4.4

Source: ESRF (1997) Field survey data

Out of the listed expenditure items, the most expensive at all facility levels are the wage bill, pharmaceuticals and rent. Examination of the means presented in Table 5 show that pharmaceuticals are the most expensive item in hospitals, dispensaries and clinics. The second most expensive item in these facilities is the wage bill, whose figures in hospitals and dispensaries do not differ much from those on pharmaceuticals. In the case of health centres, the order is reversed, with the wage bill being the most expensive item, followed by pharmaceuticals.

Table 5: Descriptive Statistics of Selected Expenditure Items by Type of Facility (Tsh. Million)

Expenditure item	Statistic	Type of health facility			
		Hospital	Health Centre	Dispensary	Clinic
Pharmaceuticals	N	12	10	97	7
	Maximum	240.0	108.0	30.0	30.8
	Minimum	1.0	1.0	0.004	1.2
	Mean	40.8	15.5	5.2	8.1
	Median	10.2	4.7	4.2	6.0
Wage Bill	N	12	10	97	9
	Maximum	240.0	102.0	23.0	12.0
	Minimum	2.2	2.4	0.4	0.5
	Mean	38.4	16.2	4.3	3.8
	Median	23.7	4.8	3.7	1.4
Rent	N	10	9	86	9
	Maximum	60.0	1.4	28.8	2.4
	Minimum	0.7	0.5	0.1	0.1

	Mean	11.4	0.9	1.5	1.0
	Median	4.2	1.2	0.8	0.9

Source: ESRF (1997) Field survey data

Further analysis of maximum expenditures shows that, at the hospital level, the maximum amount spent on pharmaceuticals is about the same as that spent on wages (about Tsh. 240 million in each case). The minimum wage bill is more than twice as much the minimum value for pharmaceuticals, indicating higher variation in expenditures on pharmaceuticals. At the level of health centres, the maximum expenditure on pharmaceuticals is slightly higher than that on wages (Tsh. 109 million compared to Tsh. 102 million). The minimum expenditure on the wage bill in this category is also twice as much as that for pharmaceuticals. This, and the higher mean for the wage bill, also indicate higher variation in expenditures on pharmaceuticals. Although maximum figures are rather high, much lower means in both cases indicate that most of the health centres' expenditures on the two items are at the lower end of the distribution. At the dispensary and clinic level, expenditures on pharmaceuticals and wages are also the most expensive items with a similar pattern of a tail of relatively higher expenditures and the majority concentrated at the lower end. Figures 5 and 6 show mean and median values for pharmaceuticals and wages by level of facility.

Figure 5

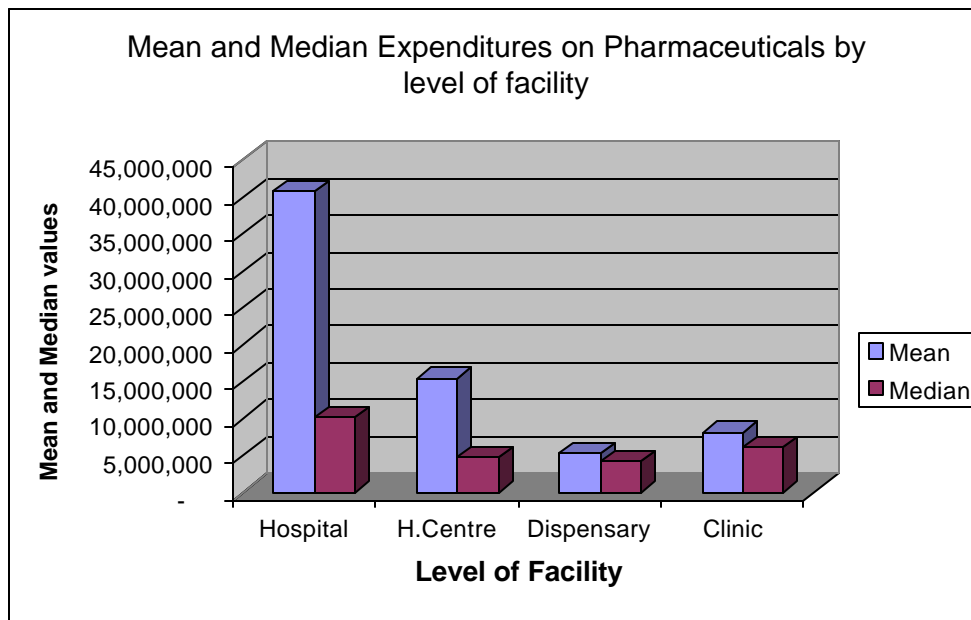
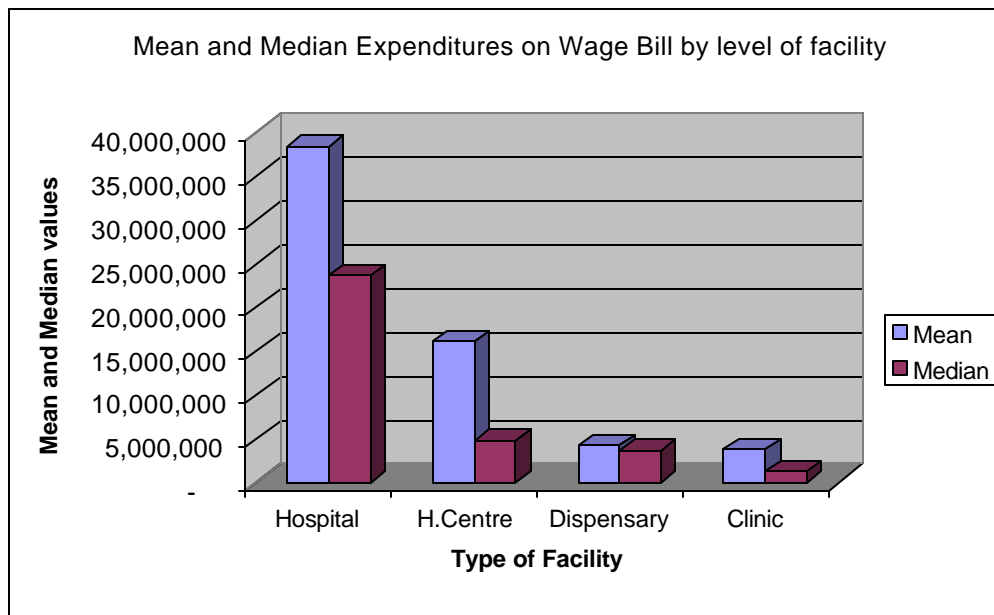
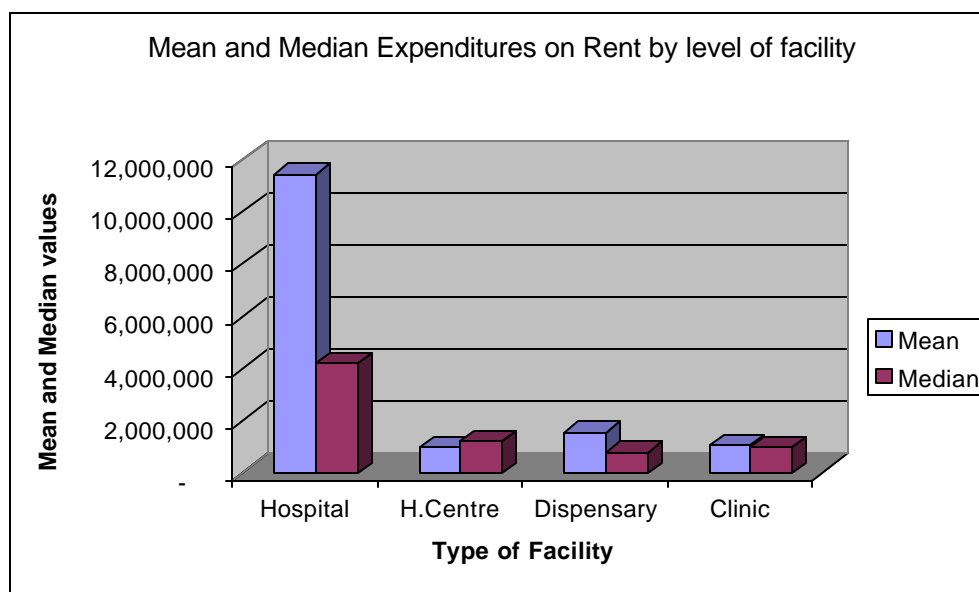


Figure 6



The third most expensive item at all levels of private health facilities was rent. As in the case of the first two items, expenditures on rent are also characterised by a small number of facilities paying very high rent and the majority paying much lower rates. For example, at the level of hospitals, the maximum amount spent on rent was Tsh. 60 million per annum but the mean was low at Tsh. 11.4 million and the median even much lower at Tsh. 4.2 million. This pattern repeats itself at lower levels as well. For example, at the dispensary level, while the maximum rent was Tsh. 28.8 million, the mean and median were much lower at Tsh. 1.5 million and Tsh. 0.78 million respectively. Health centres seem to spend less on rent than other facilities. The maximum amount indicated was Tsh. 1.4 million. Figure 7 shows mean and median values for expenditures on rent by level of health facility.

Figure 7



Very low expenditures on rent could imply that some of the private health care providers are operating in sub-standard buildings. Actually, this was observed during field survey whereby some of the providers, especially in lower level facilities, were operating in former residential or still residential houses that did not meet the standards specified in the Guidelines. A few were operating in buildings that had neither tap water nor electricity.

3.3 Pricing and Competition

One of the characteristics of private provision of goods and services is competition among providers. Holding constant other factors that influence market transactions, prices of goods and services provided can act as an indicator of the extent of competitiveness in the market. The study therefore attempted to examine prices for selected services by private health providers, with a view to assessing the extent of competition in the provision of health care services. Prices examined include those for consultation, normal child delivery and selected drugs such as those for the treatment of malaria and antibiotics.

3.3.1 Consultation Fees

Data in Table 6 shows that consultation fees in private health facilities differ substantially, ranging between Tsh. 100 to Tsh. 5,000. The mean for the whole sample is Tsh. 603, indicating that most of the facilities charge a much lower consultation fee than the maximum fee indicated. The mode and median value, which is Tsh. 300 in both cases, also lend support to this conclusion. Moreover, the mean of Tsh. 300 would imply that most of the facilities charging more than Tsh. 300 are clustered around the mean,

with a skewed tail of higher fees.

Table 6: Descriptive Statistics for Consultation Fees and Fees for Normal Child Delivery (the whole sample)

Service charged	Valid N	Mean	Median	Mode	Minimum	Maximum
Consultation fee	115	603	300	300	100	5000
Normal child delivery	43	16901	10000	10000	1500	62750

Source: ESRF (1997) Field survey data

3.3.2 Charges for Normal Child Delivery

Analysis of charges for normal child delivery also shows a similar pattern, with a maximum fee of Tsh. 62750 and a relatively much lower mean of Tsh. 16,901. The mode and median have equal value of Tsh. 10,000, implying that very few facilities were charging above the mean value. Descriptive statistics for consultation fees and fees for normal child delivery for the whole sample are presented in Table 6.

Table 7: Descriptive Statistics for Consultation Fees by Level of Facility

Statistic	Hospitals	Health Centres	Dispensaries	Clinics
Valid N	11	9	85	10
Maximum	5000	2000	3000	3000
Minimum	100	200	100	200
Mean	1836	522	401	1020
Median	1500	300	300	750
Mode	300	200	300	1500

Source: Field survey data, 1997

Analysis presented in Table 7 shows that hospitals charge much higher fees than lower level facilities. For consultation, the maximum fee was Tsh. 5,000 compared to Tsh. 2,000 and Tsh. 3,000 for dispensaries and clinics respectively. However, some of the hospitals charge consultation fees similar to those charged in dispensaries and health centres. For example, the most common fees was Tsh. 300, which is the same as the most common fees at dispensaries and slightly higher than the most common fee of Tsh. 200 at health centres. Clinics have a much higher median and mode values (Tsh. 750 and 1500 respectively) than health centres and dispensaries. This is not surprising, as these are supposed to be specialised units.

Table 8: Descriptive Statistics of Charges for Normal Childbirth by Level of Facility

Statistic	Hospitals	Health Centres	Dispensaries	Clinics
Valid N	12	4	24	3
Maximum	62750	10000	30000	10000
Minimum	10000	5000	2500	1500
Mean	34562	8750	10854	5500
Median	535000	10000	10000	5000
Mode	50000	10000	10000	1500

Source: ESRF (1997) Field survey data

Although the small number of observations in the health centre and clinic categories make comparison of charges for normal child birth across facility levels difficult, it is still possible to make some meaningful comparison. As in the case of consultation fees, data on charges for normal childbirth show that hospitals charge much higher rates than lower level facilities do. According to the data in Table 8, the minimum charge in hospitals is Tsh. 10,000 while the minimum in the health centre and dispensaries is Tsh. 5,000 and 2,500 respectively. Health centres and dispensaries have the same mean and mode of Tsh. 10,000. Their means are also close at Tsh. 8,750 for health centres and Tsh. 10,854 for dispensaries. Thus, with the exception of a few outliers in the dispensary category, health centres and dispensaries seem to charge more or less similar rates for normal childbirth.

3.3.3 Charges for Chloroquine Tablets

Another item that could be easily compared within and across facility levels is Chloroquine tablets. According to data on the price of Chloroquine tablets, most of the facilities in the sample that indicated charges for Chloroquine tablets charged between Tsh. 100 and Tsh. 200 per dose. The variation in the price of Chloroquine tablets across different levels appears to be small. Hospitals and dispensaries have the same mode of Tsh. 100. However, hospitals have a slightly higher mean of Tsh. 194 compared to Tsh. 179 for dispensaries and health centres (Table 9). Although there are outliers as indicated by maximum prices of Tsh. 600 and Tsh. 900 for hospitals and dispensaries respectively, these appear to be an exception as indicated by the relatively much lower mean, median and mode values. The concentration of prices suggest competition and a price sensitive market. However, a tail of higher prices suggests that some patients are not sensitive to prices and are willing to pay more for other reasons such as quality of service. This is consistent with findings in other countries as noted in the literature review in Chapter Two. People may choose to pay rather than go for free treatment or to pay more for services they believe to be of higher quality.

Table 9: Descriptive Statistics of Prices of Chloroquine Tablets by Level of Facility

Statistic	Hospitals	Health Centres	Dispensaries
Valid N	8	7	63
Maximum	600	250	900
Minimum	100	100	70
Mean	193.8	178.6	178,9
Median	100	200	150
Mode	100	200	100

Source: ESRF (1997) Field survey data

3.3.4 Charges for Ampicillin Capsules

The antibiotic cited by most respondents was Ampicillin. Data show more or less a standard charge across most of the facilities. About 90 percent of the facilities (83 out of 92 respondents) charge between Tsh. 1,00 and Tsh. 1,500. The mean is Tsh. 1,182, with the median and mode having the same value of Tsh. 1,200. There are few facilities that charge more than Tsh. 1,500; these could be higher level facilities such as hospitals, which are expected to have relatively higher overhead costs that are reflected in the prices they charge for services and pharmaceuticals.

3.3.5 A Comparison of Charges between Private-for-Profit and Private not-for-Profit Facilities

When the sample is split into two categories - private for-profit and private not-for-profit facilities - it is apparent that generally the former charge more than the latter. The following few examples attest to this. In the case of consultation fees, while the maximum consultation fee in the not-for-profit category was Tsh. 500, about 16 percent of the private-for-profit facilities charged Tsh. 1,000 and above. Although one may assume the relationship to be spurious if the facilities charging higher consultation fees are also higher level facilities, this does not seem to be the case because data shows that there are lower level facilities charging up to Tsh. 3,000 for consultation.

Table 10: Frequency Distribution of Prices for a Dose of Ampicillin Capsules by Type of Health Facility

Price	Frequency	
	Private for-profit	Private-not-for-profit
100	0	0
200	0	2
300	1	0
400	0	0
500	0	0
1000	25	15
1500	33	9
2000	2	0
5000	4	1

Source: ESRF (1997) Field survey data

A similar analysis in the case of charges for a dose of Ampicillin capsules also shows that more for-profit facilities charge higher compared to not-for-profit facilities (Table 10). For example, while the single most common price in the for-profit private facilities is Tsh. 1,500, the most common price in the not-for-profit facilities is Tsh. 1,000. Also, only one facility in the latter category charges above Tsh. 1,500 for a dose of Ampicillin capsules compared to 6 facilities in the former category.

3.3.6 Conclusion

Overall, unreliability of income and expenditure data makes it difficult to make totally valid conclusions. A substantial number of respondents indicated to spend more than they earn. This is difficult to believe, especially if it is a repeating pattern and given the indicated difficulty in securing credit, as analysis in Chapter Six indicates. Unfortunately, the survey was cross section and did not capture trends. If over-expenditure is real in most of the facilities and if this is the trend, then this could explain the high turnover rate of private health facilities. We noted in Chapter One that a substantial number of facilities that were picked in the sample using the MOH register were no longer in operation. The private health sector thus still needs support for further development and sustainability. So far, it appears to be dominated by very few big providers with the majority competing for scarce resources at low levels. Pharmaceuticals and wages are key items without which private health care provision is not possible. Yet these are the most costly items in all types of facilities. There is need to explore ways that can reduce costs incurred by health care providers on these items.

Regarding prices of services and drugs in general, analysis has shown that to a large extent there is little variation in prices, particularly within same level facilities. Even for items that seem to cost relatively more, for example Ampicillin capsules, there seems to be a small range of selling price for most of the facilities. Analysis of the price data, therefore, suggests existence of a fair degree of price competition in the private health care market. It also appears that, to a large extent, providers are aware of each other's charges. The observed variation in prices could be due to, among other things, differences in overhead costs, transportation costs and location. A tail of higher prices for some of the services imply that there could be factors, other than price considerations, which determine clients' choice of health care services/treatment. Such factors include quality in terms of, for example, staff qualifications, availability of medical equipment and good patient handling. Future studies should therefore take into account these and other factors that are possible determinants of prices. This could help in making a more reliable assessment of the differences in charges for similar services across facilities.

4.0 LINKAGES

4.1 Introduction

In this section we analyse health sector linkages so as to explore areas in which collaboration among health care providers and between them and other key actors in the health care system exist, and to explore how such linkages could be strengthened with a view to increasing the volume and quality of health services. It is perceived that such linkages can contribute to sustainable development of private health facilities in Tanzania. This may be in terms of, for example, delivery of quality services, increased accessibility and efficiency gains, which health units cannot easily attain otherwise.

The environment, from the perspective of a single health facility, may be viewed in terms of its network, which is basically other providers of health services (both public and private) and organisations with which the single unit is interacting. These institutions include the financial sector, the Ministry of Health, public medical training centres and medical associations. Health units also build up relationships with each other to gain access to or exchange resources such as medical equipment, personnel, consulting services, medicine and information. Such relationships are perceived to contribute to the provision of sustainable quality health services.

Table 11: Institutions that Private Health Care Providers Indicated to have Linkages with

Institutions	Number of Providers Indicating Linkage
Muhimbili Medical Centre	58
Public - District Hospitals	2
Private Hospitals	45
NGOs	9
Other Institutions	7

Source: ESRF (1997) Private Health Facilities Survey Data

Table 11 shows the type of institutions in the health care system that sampled private providers indicated to have linkages with. The most-mentioned institutions that respondents indicated to have linkages with were Muhimbili Medical Centre (MMC), public district hospitals and other private facilities. Very few facilities indicated to have linkages with NGOs or other institutions.

4.2 Linkages with Financial Institutions

Increased private sector participation in the provision of health services necessarily triggers the demand for financial services, e.g., demand for short, medium and long-term loans and other credit facilities by health units. Financial institutions that could meet such demand include banks, provident funds, capital markets and others. The linkage between financial institutions and these health units is considered vital for private enterprise development in health care provision.

Providers of private health care and others interested in starting health services need to raise enough starting capital or working capital as health care provision is costly in terms of both equipment needed and the cost of drugs, which are mainly imported. This means that even those entrepreneurs who have started operations need a large starting and working capital, which could be provided by financial institutions. Private health care providers need access to credit to meet the shortfall between expected revenue and expenditure. For those wishing to start a new business or expand capacities of existing ones, financial institutions have to provide or supplement investment capital.

The survey conducted in 136 private health facilities showed that only a few owners / managers of private health facilities had some sort of financial arrangements with formal financial institutions. Data in Table 12 shows that only 11% (15 out of 136 facilities) of the private health care providers had formal financial arrangements with financial institutions. About 87.5% did not have any financial arrangements with formal financial institutions. Analysis by level of facility shows that more hospitals had financial arrangements with financial institutions than lower level facilities. For example, out of the 12 hospitals surveyed, 33% had some financial arrangements compared to 20%, 8% and 9% of the surveyed health centres, dispensaries and clinics respectively.

Facilities that did not have any financial arrangements with financial institutions indicated a need for them, pointing out factors hindering such arrangements, which include credit squeeze by the Bank of Tanzania (BOT) and lack of adequate capital base or security/collateral of some health institutions. It is evident that lack of financial arrangement was skewed against small private health institutions like dispensaries and clinics.

The ongoing credit squeeze by BOT and corporate reforms in the financial sector have forced public financial institutions to reduce the amount of short-term credit facilities, i.e., bank overdrafts to potential customers. Lack of or inadequate domestic savings and inflation are among the factors that have led to high interest rates and limited demand for bank credit. Only a few projects with high returns can afford to take bank credit. Many of the private health care providers resorted to alternative sources of finance. These sources include their own funds, borrowing from family and friends and religious and non-governmental organisations.

Table 12: Existence of Financial Arrangements between Health Facilities and Other Organisations

Status	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	4	33.30		20.00	8	7.77	1	9.09	15	11.03
No	8	66.70	8	80.00	93	90.29	10	90.91	119	87.50
No Responses	0	0.00	0	0.00	2	1.94	0	0.00	2	1.47
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities survey data

4.3 Financial Linkages with Other Institutions

Analysis further shows that very few facilities were getting financial support from other sources. Some of the NGO-owned health facilities depended on non-banking financial institutions. These are mostly religious oriented institutions such as Associations in Saudi Arabia and Catholic Relief Services. Few have indicated to have received financial (including in-kind) assistance from international aid / donor agencies such as USAID, UNFPA and EDF.

It is thus apparent that there are very few sources of finance to support the development of the private health sub-sector. Most of the potential indigenous investors in this sector are qualified and long-term experience medical personnel. However, these have little savings from their low wages/salaries, and lack collateral demanded by formal financial system.¹ It has been observed that banks and non-banking financial institutions preferred giving credit to well-established commercial enterprises that have high rates of return on investment, low capital and political risk of government interference.

4.4 Linkages with Other Health Care Providers

Study findings have shown existence of both vertical and horizontal linkages among private health care providers on one hand, and between private health care facilities and public health care facilities on the other. Vertical linkages involve multiple level interactions within a system. Such vertical linkages are more out of lack of necessary skills or equipment at a particular level rather than a tool for mutual benefit. Horizontal linkages are those forms of collaboration that are established among same level

¹Munishi Gasper K, (1992), An analysis of The Private Health Sector Growth in the Post Liberalisation Era in Tanzania: Some Policy Considerations. A research report prepared for the International Health Policy Programme, University of Dar es Salaam.

providers who are pursuing provision of more or less the same health services. Usually, such linkages are willingly established for mutual benefit. In the context of health care provision, vertical linkages are those related to the referral system, either as formally instituted according to levels of provision or as referrals which could not have been made if required skills and/or equipment were available at the referring facility. The latter type of referral can be either between different levels or within then the same level providers differing in capacity in terms of human resources and equipment. Types of linkages with other providers as mentioned by respondents were referrals, and sharing of medical personnel and medical equipment.

4.4.1 Referrals

Two types of referrals were identified: the first one is the formally instituted referral system whereby lower level facilities are expected to refer cases they cannot handle to upper level facilities. Respondents indicated to have such referral links with government district hospitals, MMC and private hospitals such as Hindu Mandal and Aga Khan.

Private health care providers also refer patients to other health facilities for diagnostic tests for which they lack the necessary equipment. These patients have to be re-registered and re-examined by another specialist doctor in the referral hospital. This process is time consuming and costly to the patients. Table 13 shows health facilities where respondents indicated they refer their patients for diagnostic tests/services and the type of tests they send them to undergo. These include CT Scan, blood bank, autoclave, x-ray, microbiology tests and Ultra Sound. Data in Table 13 also show that there is referral for diagnostic services even at hospital level, indicating that some of the private hospitals are not self sufficient in equipment. It is also noted that some of the shared equipment, for example CT Scan, autoclave and blood bank, are too expensive for some facilities to afford.

Table 13: Health Facilities Where Private Health Care Providers Send Patients for Indicated Diagnostic Tests

Type of Health Facility	Type of Equipment	Name of Institution
Hospital	Diagnostic facilities (Hormones)	MMC, Hindu Mandal, Oysterbay
	CT. Scan, Blood Bank, Autoclave	MMC
Health Centre	X- ray facilities, Microbiology tests	Hindu Mandal, MMC
Dispensary	X-ray	MMC
	Microbiology, Radiology, Ultra sound	MMC, Lugalo - TPDF
	X-ray laboratory services	Modern Hospitals, MMC
Clinic	CT. Scan, Special X-ray services, Physiotherapy Department	MMC

Source: ESRF (1997) Private health facilities survey data

4.4.2 *Use of Medical Personnel From Other Health Facilities*

Study findings show that private health care providers use medical personnel of varied professions and levels from the public health sector. These include specialists such as gynaecologists, paediatricians, cardiologists and other experienced medical personnel e.g. nurse midwives and nurses. Many work on part-time basis while others have completely moved from the public service to start their own private practice or be employed by private health facilities. This indicates that the private health sector is not fully developed and is not self sufficient in human resource. Most of the staff have been trained and worked in the public sector before moving to the private sector.

Table 14 shows that private hospitals use more Medical Officers and Assistant Medical Officers from other institutions than other type of medical personnel. Institutions cited most as suppliers of Medical Officers who work part time in private hospitals are Muhimbili Medical Centre (MMC), Aga Khan Hospital and Hindu Mandal Hospital. It was pointed out that MMC has many specialists in various categories who are not well paid, so they tend to work part-time in private health facilities to supplement their incomes.

Because of its infancy, the private health sector has to rely on the availability of medical personnel from the public sector. It is unfortunate, however, that some of the private health facilities use low-level medical personnel who are not approved to operate/own private practice. A study by Munishi (1995) on the analysis of the private health sector growth in the post liberalisation era in Tanzania indicated that by regulation, only qualified medical personnel at the level of Assistant Medical Officer or Medical Officers can be entrusted and/or licensed to open up a prescribing and treating health care facility. As of 1994, the MOH records showed that there were only 1134 Medical Doctors (MDs) in Tanzania. The market at the moment can hardly supply such qualified personnel, and this is another limitation to the growth of the sector.

Few clinics, i.e. 18% of the total clinics, use medical personnel from other institutions. This may be due to the fact that most of the clinics are small and are run by specialists who are also owners. It is within the rules of the Ministry of Health that clinics should be managed only by the specialist in that field, e.g a dental clinic has to be run by a dental surgeon.

Table 14: Medical Personnel from other Medical Institution Working in Private Health Facilities

Source of personnel	Type of Health Facility																
	Hospitals					Health Centre				Dispensaries						Clinic	Total
	M	C	A	N	T	M	N	O	T	M	C	A	N	O	T	M	
MOH	-	-	-	-	0	-	-	-	0	0	-	-	-	-	0	1	1
City council	-	1	-	2	3	-	-	-	0	7	3	4	1	1	16	-	19
MMC	18	-	-	-	18	5	4	-	9	29	-	-	11	5	45	-	72
Other Govt. Medical ins.	-	-	-	-	0	-	-	3	3	12	2	1	1	-	16	-	19
Other private Health Ins.	4	-	-	2	6	1	-	-	1	4	-	2	4	2	12	3	22
Total	22	1	0	4	27	6	4	3	13	52	5	7	17	8	89	4	133

Key: M = Medical/Officer/Assistant Medical Officers
C = Clinical officers (Medical Assistants)
A = Assistant Clinical Officers (RNAs)
N = Nurses
O = Other Medical staff
T = Total

Source: ESRF (1997) Private health facilities survey data

A study by Kiwara (1995) found out that most of the private health facilities surveyed were manned by about two to four workers. The nurses performed different duties at different times depending on the number of patients. Some health personnel move from a registration window to an injection room and vice versa. At times, the “doctor” does the registration simultaneously with clinical consultations. This suggests that some private health care facilities are operating without enough staff. While the findings indicate that there is need for purposeful policy measure to ensure access and employment of skilled medical personnel in both the public and private health facilities, it is possible that under-staffing in some of the private health facilities is deliberate so as to minimise personnel costs.

4.4.3 Use of Medical Equipment in Other Health Facilities

The use of modern and specialised medical equipment is crucial in the provision of quality health services. Many health facilities indicated a desire to own such medical equipment given the nature and demand for health services. Most of the providers, however, also pointed out that they could not afford the equipment, which is mostly imported from abroad and is very expensive. Some medical equipment

needs skilled personnel to operate and manage them. Those who lack specialised medical equipment pay to use equipment of other health facilities.

In this study, only about 5% of the whole sample indicated use of medical equipment from other health facilities (Table 15). This is rather surprising, and does not necessarily imply that most private health facilities are self sufficient in terms of medical equipment. As already mentioned, very few facilities can afford to purchase expensive medical equipment. During the survey, it was observed that many health facilities, especially dispensaries, are under-equipped. A study by Munishi (1996) revealed that high prices of medical equipment and drugs affect the growth of the private health sector in Tanzania, e.g., an examination bed was selling for as much as Tsh. 600,000 in some shops. This is as much as some qualified doctor's gross income for more than a year. A study by Kiwara (1995) also found that most private health facilities are deficient in medical equipment. Some health facilities lack equipment for sterilisation. In a large number of private dispensaries, sterilisation was still being done by using kerosene stoves or heaters, and laundry was done by hand. Their laboratories cannot perform culture and sensitivity tests or any serum-related tests.

Table 15: Use of other Health Facilities' Medical Equipment

Response	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	2	16.7	1	10.00	3	2.91	1	9.09	7	5.15
No	10	83.3	9	90.00	100	97.09	10	90.91	129	94.85
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities survey data

4.5 Linkages with Other Institutions in the Health Care System

Apart from linkages among health facilities, the study also sought to identify types of linkages that exist between private health care providers and other institutions in the health care system. The new institutional economics literature points to some very important features of institutional facilities and capacities that facilitate private enterprise development. This refers to rules, conventions and other forms of structural framework of the system. Such institutional linkages play a key role in reducing the uncertainty of professional interaction, minimising transaction costs and allowing the collective efficiency and equity gains. These institutions include legal,² regulatory and organisational institutions. Currently,

²Effectively enforced property rights, formal business contracts and guarantees, trademarks, limited liability, bankruptcy laws and other known corporate laws.

the government is reviewing laws and regulations so as to facilitate development of the private sector and enable it to provide quality and affordable services in all socio-economic activities.

Private health facilities have three main types of institutions with which they have linkages:

Statutory institutions

A service provider has to be a statutory member, i.e. a private health facility has to be registered, regulated and supervised by the Ministry of Health.

Membership institution

Actors who provide similar services tend to form associations for mutual benefit. To access such benefits, one has to be a member of e.g. Association of Private Hospitals in Tanzania (APHTA), Medical Association of Tanzania (MAT), Tanzania Public Health Association, and Tanzania Nursing and Midwifery Association.

Beneficiary institutions

These are institutions offering services/assistance to private health care providers and include NGOs and other health institutions.

Institutions with which private health care providers have linkages include:

(i) Ministry of Health (MOH)

The Ministry of Health has the major responsibility to supervise private health care practice. The major roles of Ministry of Health in relation to private health care provision include:

- setting and administering all registration procedures;
- setting laws and regulations that govern private health care provision;
- monitoring and regulating effectively private health care provision in terms of quality of services rendered;
- reviewing the price structure of medical treatment rendered by private health care providers;
- providing health education through seminars and workshops (i.e. communication and co-ordination linkage).

The above roles provide major linkages between the government and private health facilities. The survey suggests that all private health care providers have a formal relationship with the Ministry of Health in one form or another. There are views that laws and regulations are not adequately enforced and there are gaps in their application. The conditions of legal and regulatory environment have hindered the

growth of the private health care sector (Munishi, 1992).

(ii) City Commission Health Department

Private health care providers have a strong relationship with the City Council Health Department. The City Council oversees health facilities in all three districts of Dar es Salaam, including the district hospitals. The City Commission Health Department plays an important role in the registration of private health facilities. All registration application forms have to pass through the City Commission Health Department before being submitted to the Ministry of Health. The City Commission Health Department also sends its officials to inspect private health facilities.

Inspectors have to be sure that private health facilities are following regulations and standards set by the government. Most of the private health care providers indicated that they were being inspected at least twice a year. There are a few who complained that after the first inspection (for the registration purposes), further inspections have not been possible due lack of personnel, financial and transport facilities.

The City Commission Health Department also collaborates with private health care facilities in controlling epidemic outbreaks such as cholera and typhoid. All reports from private health care providers have to go to District Medical Officers (DMOs) in respective districts. Also, monthly reports on patients' attendance and diagnosis are sent to the City Commission Health Department. Patients with complicated cases from private health facilities are at first referred to the district hospitals before being referred to Muhimbili Medical Centre, which is a referral hospital in the country.

The City Commission Health Department, through its district hospitals, also conducts seminars in family planning and MCH services. The department provides immunisation drugs, vaccines and family planning devices. Private health care facilities also collaborate with the City Commission Health Department in polio immunisation campaign. Further, as already mentioned, complicated cases from private health facilities are referred to district hospitals, which are under the City Commission.

(iii) Muhimbili Medical Centre

Muhimbili Medical Centre (MMC) is the biggest referral hospital in the country. The main linkage with MMC, as already pointed out, is referrals. Private health facilities have both direct and indirect links with the MMC. Private health providers refer their patients with complicated case either directly (if hospital) or indirectly through the district hospitals, which then refer the cases to MMC, if they are also unable to handle them.

Direct referrals to MMC are also allowed for cases that need immediate attention e.g. heart diseases, fractures and blood transfusion. The present system of referring all patients through a district hospital is not efficient, and patients sometimes by-pass the system. Corruption, caused by poor salaries and wages, complicates the official channels and encourage more bypassing.

Muhimbili Medical Centre also runs clinics for Diabetic and TB patients, and provides consultations for people with HIV/AIDS. Patients from private health care facilities also attend these clinics. MMC also offers several training programmes including postgraduate and undergraduate degree courses, nursing, pharmacy and paramedical college. Private health care providers have access to train their personnel if they sponsor them. Apart from the fact that many health workers in the private sector were trained at MMC, this link is still weak because most of the respondents indicated that they had not sent their employees for training. Another link, which has already been mentioned, is that of MMC specialists working part time in private health facilities.

(iv) Medical Associations

Linkages can also be institutionalised in the form of medical associations. These associations may seek to improve the collective position of the providers, for example, by lobbying the government on behalf of the members' interests or by enhancing capacity of the members through a range of support services.

Twenty-nine percent (29%) of private health care providers in the sample indicated to be members of different medical associations. Fifty percent (50%) of the hospitals are members of medical associations such as the Association of Private Hospitals in Tanzania (APHTA) and the Medical Association of Tanzania (MAT). Private health facilities that are owned by religious bodies are members of religious health organisations. Private health facilities that are owned by Christian organisation are members of Tanzania Christian Medical Board and Diocese Medical Board (Catholic), while those owned by Muslim organisations are members of BAKWATA. Association members meet and discuss all problems facing them and make suggestions on how to improve their services. They also hold workshops and seminars to exchange professional knowledge and improve their working skills.

(v) Medical Stores Department (MSD)

Only a few private health care providers have links with MSD. Most of the respondents in the sample indicated that they were not allowed to purchase drugs from MSD. Although there are MSD branches in selected regions that serve as zone distribution points, in most cases these sell their goods to government-owned health care facilities. Most private health care providers interviewed indicated that they would like to buy drugs direct from MSD because buying drugs and other medical supplies from MSD would also

provide assurance to private health care providers that supplies provided are well preserved and have not expired.

(vi) Non-Governmental Organisations (NGOs) and International Organisations

Few private health facilities have established formal relations with NGOs. These include religious organisations, e.g. BAKWATA, Catholic Medical Board, and international organisation, e.g. AMREF. These NGOs provide medical information and knowledge, financial assistance and consultation on projects organised by some private health care providers. Family Health International (FHI) is a non-governmental US organisation financing and co-ordinating HIV/AIDS-related projects through its HIV/AIDS Campaign Programme (AIDSCAP).

Few private health care providers work under the umbrella of religious health institutions. Examples include Aga Khan (Ismailia), Hindu Mandal (Hindu), Mission Mikocheni (Christian - Lutheran) and TMJ (Bohora) hospitals. Private health care providers also co-operate with private pharmacies for purchase of drugs and/or prescribed drugs that are not available in their health facilities.

Some of the private health facilities have good working relations with international organisations or institutions. These institutions collaborate with private health care providers so as improve provision of quality health services to the population. For example, the Tanzania Red Cross Society provides training for health workers. A few international organisations provide material support in the form of drugs in cases of epidemic outbreaks while others provide funds for training workshops and seminars, e.g. WHO and USAID.

4.6 Conclusion

Overall, findings have shown that linkages, particularly those between health care providers and other key actors in the health care system that could enable development and promotion of effective and efficient private health care, are still weak and need to be strengthened.

Regarding linkages with financial institutions, it was found that only a few (11%) of the facilities in the study had such a relationship. Notable also, was the fact that a relatively larger proportion of hospitals had such linkages (33%), compared to lower level facilities (20%, 6% and 9% for health centres, dispensaries and clinics respectively). This is a common trend whereby financial institutions are more likely to give credit to well-established enterprises that have high rate of return on investment and low capital risk. In addition, very few facilities indicated to have received financial support from other non-financial institutions and/or international organisations.

Although vertical and horizontal linkages were found to exist within the private health care sub-sector and between this sub-sector and public health facilities, the relationships mentioned most were those of referrals and use of medical personnel from other facilities, particularly MMC where 72 out of 136 facilities indicated to get part time medical personnel, of whom 52 were doctors. This indicates the infancy of the private health care sub-sector, which reinforces the need for such linkages. This was, however, not the case in terms of use of medical equipment in other facilities where only about 5% of the facilities in the sample indicated to use equipment of other health care providers.

Linkages with other key players also indicated that most of the mentioned relationships were those of a regulatory nature, with the MOH and the City Commission Department of Health playing a key role. Very few links existed, for example, in terms of forming associations to pursue common goals for mutual benefit or in terms of relationships with institutions that provide some form of assistance.

5.0 REGULATORY FRAMEWORK AND REGULATORY PROCESS

5.1 Regulatory Environment Context

Health care providers exist and function within the context of a regulatory environment that consists of basic legal framework, which governs activities in the health sector, and a regulatory apparatus that administers relevant rules, and social, economic and administrative factors influencing the implementation of the rules. The main objectives of the regulations are based on, firstly, the market entry and structure that includes accreditation and licensing, minimum and maximum prices, levels and types of services to be delivered and guidelines for geographical distribution of providers for equity objectives. Secondly, regulation aims at improving and maintaining the quality of services to be provided, which entails inspection, minimum standards of cleanliness, training of staff and equipment as well as liability and malpractice laws as instruments to regulate quality of health services. Thirdly, regulation aims at improving efficiency in health services provision. In Tanzania, private practice is governed by the Private Hospitals (Regulation) Act of 1977, which was amended in 1991 and Guidelines of Standards for Health Facilities issued in November 1996 by the Ministry of Health (MOH).

The Private Hospitals (Regulation) Act No. 6 of 1977 stipulated that qualified and experienced medical practitioners could not manage or own health facilities unless employed by an organisation. This Act was amended in 1991 to allow and approve individuals and approved organisations to manage private health facilities through the Private Hospitals Advisory Board under MOH. The Board has limited powers; it only advises the Minister on applicants who have fulfilled conditions for registration. The Minister may approve or refuse to approve of any application without further consultation. The Board has neither monitoring nor supervisory powers like those vested in the Registrar under Section 6A (3) of the Private Hospitals Regulation (Amendment) Act of 1991. It is anticipated that the Board will be granted powers to hold an inquiry before it can order deletion from the Register of any applicant, and that an applicant would be granted the right to appeal before the Court of Law. However, day-to-day oversight is also supposed to be exercised by the professional statutory bodies of the Ministry of Health.

In November 1996, the Ministry of Health, through the Board, prepared a document titled "Guideline Standards for Health Facilities". It also decided that all registered private health facilities should be re-registered within six months (January - June 1997). The units were re-registered following the new guidelines. By July 1997, about 87% (523 private-for-profit health facilities out of 604) applications had been accepted (unpublished data). Previously, a total of 1,531 private for-profit health facilities were registered. This indicates that many facilities did not meet the set standards and that committed

supervision by the government can be effective in monitoring and regulating health care provision.

However, analysis of facility ownership indicates that regulations/guidelines are not followed. Some of the facilities were owned by non-approved personnel. Data in Table 16 shows that while most of the health facilities were owned by Medical Officers (MOs) or Assistant Medical Officers (AMOs), 90% of the hospitals (11 out of 12) were owned by either Medical Officers or Assistant Medical Officers. For health centres, dispensaries and clinics, the proportion of owners who were either MOs or AMOs was 60%, 73% and 87% respectively. Other owners included Clinical Officers, Clinical Assistants, Nurses, other medical professionals and non-medical professionals. Ownership of private health facilities by personnel who are not registered/licensed medical/dental practitioners is against the guideline standards, which stipulate that "...Clinical Officers (Medical Assistants), Clinical Assistants (Rural Medical Aides) and other non-registered or non-licensed health cadres are not allowed to own dispensaries, clinics, health centres or hospitals"³. Data showing the distribution of health facilities by ownership is presented in Table 2.

Table 16: Distribution of Health Facilities by Profession of Owners

Profession of Owners	Type of Health Facility									
	Hospital		Health centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
MO/AMO	11	92	6	60.00	62	60.78	8	73.00	87	64.00
Clinical Officer	0	0.00	0	0.00	7	6.90	0	0.00	7	5.00
As. Clinical Officer	0	0.00	0	0.00	1	1.00	0	0.00	1	1.00
Nurse	0	0.00	0	0.00	4	3.90	2	18.00	6	4.00
Other Medical	0	0.00	0	0.00	1	1.00	0	0.00	1	1.00
Other non- Medical	1	8.00	4	40.00	28	27.00	1	9.00	34	25.00
Total	12	100.00	10	100.00	102	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

5.2 Knowledge of Laws and Regulations

Respondents in this study were asked if they were aware of any laws and regulations that govern private health care provision. About 100%, 90%, 88% and 19% of the respondents in hospitals, health centres, dispensaries and clinics respectively (Table 17) reported to be aware of such laws and regulations in Tanzania. In total, about 83% of all the respondents reported that they are aware of the existence of the said laws and regulations. Surprisingly, when they were asked to mention them, only a few mentioned

³URT (1996) "Guideline Standards for Health Facilities" MOH, PP3

the right laws and regulations while many of them mentioned wrong laws/regulations.

Table 17: Respondents' Awareness of Laws that Govern Private Health Care Provision

Response	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	12	100.00	9	90.00	91	88.35	2	18.18	114	83.82
No	0	0.00	1	10.00	8	7.77	8	72.73	17	12.50
No Responses	0	0.00	0	0.00	4	3.88	1	9.09	5	3.68
Total	12	100.00	10	100.00	103.00	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

These results indicate that the bigger the health facility (in terms of types and levels of health services provided by a health facility) the higher the probability of respondents reporting awareness of laws and regulations. Among the implications of such results are that hospitals and health centres are more likely to be operated by strictly adhering to the known laws and regulations, and probably operated by more qualified staff compared to dispensaries and clinics.

Most of the respondents were able to mention the Private Hospital Regulation Amendment Act of 1991 and the Standard Guidelines issued by MOH in November 1996 as well as other requirements by the City Council (payment of tax, issuing of receipts etc). However, a good number of respondents had either a wrong idea or never knew what laws and regulations govern private practice. In such a situation, maintenance of quality of health care and adherence to required standards becomes a far-fetched goal to attain. This suggests that private providers should not only be obliged to have/buy these regulations/laws documents, but also to be educated on what these documents mean.

Such responses are also a reflection of how regulations and laws governing private health care provision are poorly enforced, and thus it is not surprising that they do not have the desired effect. Providers need to be furnished with information on regulations not only in a booklet form, but also by seminars, workshops and other learn-by-doing methods. Health care service provision patterns are likely to change and attain a higher quality, and probably become more efficient with the knowledge of regulations and laws than without it. Information need to be provided not only to owners but also to all other staff in health facilities.

On the part of officials from the government and supporting institutes, 80% (24 out of 30) respondents were aware of the laws and regulations that govern private health care provision as compared to only

20% (6 out of 30) who were not aware. However, only 20% (3 out of 30) of providers with knowledge of these laws and regulations cited them correctly. Laws and regulators mentioned include:

- Private Hospitals - Regulations Act No. 6 of 1977 and Amendment No. 26 of 1991,
- Private Health Laboratory (Regulations) Act 1997
- Private Hospitals - Regulation Act No. 6 of 1977 and Amendment No. 26 of 1991
- Tanganyika Medical and Dental Practitioners Ordinance Cap 409.

5.3 Government Capacity to Monitor and Regulate Private Health Facilities

The question of whether the government has the capacity to monitor and regulate effectively private health care provision is one of the core issues in ensuring quality. Respondents were thus asked to give their opinions on the capacity of the government to monitor and regulate private health facilities effectively. About 69% of private providers reported that the government has that capacity, while 31% said it does not have that capacity (Table 18).

Table 18: Respondents' Perception on whether the Government Has the Capacity to Monitor and Regulate Effectively Private Health Care Provision

Response	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	5	41.70	8	80.00	72	69.90	9	81.82	94	69.12
No	7	58.30	2	20.00	31	30.10	2	18.18	42	30.88
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

As to why they think the government has the capacity to regulate private health care provision, respondents gave the following reasons:

- MOH has enough trained and qualified personnel, so it only needs to give them incentives;
- MOH has enough financial resources;
- The MOH has a regulatory organ, therefore it only needs to give more impetus enforcing existing rules, standards and regulations;
- MOH has legal power to register and to freeze registration;
- MOH has health personnel down to the district level; it just has to use DMOs and RMOs effectively by decentralising authority;

- MOH needs to collaborate with private practice boards/associations e.g. Association of Private Hospitals;
- MOH needs only to insist on getting regular reports from private health facilities.

Most of these reasons imply that the government has the capacity to effectively enforce regulations but that it does not do it. Furthermore, most of them are more of suggestions than reasons on how the government could enhance its capacity to monitor and regulate more effectively. Apart from the need for the ministry to collaborate with private health providers, most of the reasons mentioned remain within the jurisdiction of MOH. For the Ministry to be an effective regulator, it has to have a better appreciation of the forces driving the private sector and the relative market power of different providers, as well as their capacity to enforce regulations. It is only by involving private providers that MOH can be an effective and powerful regulator.

Thirty-one percent of the respondents reported that the government had no capacity to regulate effectively, and gave the following reasons:

- MOH has inadequate funds, manpower and means of transport;
- there are too many private health facilities, and are widely scattered;
- some private health facilities are located in unreachable places;
- MOH employees are too busy to have time for effective regulation;
- inspectors and regulators are not given any incentives;
- MOH has failed to monitor even government-owned health facilities, therefore adding private health facilities would make the Ministry more ineffective in monitoring and regulating
- no specified credible and proper regulatory system/organ;
- the regulatory system is not decentralised to district and regional health authorities;
- the surfacing of corruption;
- owners of private health facilities are not transparent;
- the registration system is weak - it allows unqualified medical people to own health facilities;
- Government is too bureaucratic.

Responding to the same question, 56.67% (17 out of 30) of government and supporting institute officials agreed that the government has the capacity to effectively regulate/monitor private health care provision.

Some of the reasons to support this response were:

- it has enough motivated supervisors;
- it enforces respective laws and regulations;
- the organisational structure from national to district level is in place;
- there is capacity if Registrar, RMOs and DMOs perform their duties. These are representatives at regional and district levels who are empowered to reinforce regulations;

- the government has powers to enforce laws and regulations through set procedures, which should be followed and adhered to by private health care providers;
- the government has resources, powers and skills;
- the government has enough supervisors, though they are not well motivated to do the job.

Although most of these responses indicate that the government has the capacity to regulate, (thus implying that the problem is capacity utilisation), most of the following responses indicate absence of capacity. The inconsistency in the respondents' responses could be explained by differences in perception of what capacity means. Most of those indicating existence of capacity were referring to adequate personnel.

On the other hand, 43.3% (13 out of 30) of the government and supporting institutes officials interviewed thought the government lacks capacity to effectively monitor and regulate private health care provision. Reasons given include:

- the government has scarce human and financial resources;
- the government has limited capacity to monitor and regulate even its own institutions;
- because the government also owns health care facilities, it is difficult for it to spare required experts to carry out the monitoring and regulatory function effectively as existing experts are engaged in government facilities.

Apart from lack of funds, transport and human resource as reasons for the incapacity of the government to monitor and regulate effectively, most of the reasons given are administrative, which could probably be rectified and/or implemented within the MOH human and financial resources means. Furthermore, to implement effective regulatory policies requires information on those who are being regulated. This has been a major weakness in Zambia where there has been no attempt to systematically collect information on private providers. (Berman et al 1995).

5.4 Government Involvement and Effectiveness in Regulating Private Health Care Provision

Respondents were also asked to rate the degree of government involvement in regulating private health care providers.

Table 19: Providers' Perception on the Degree of Government Involvement in Regulating Private Health Care Providers

Degree of involvement	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Very High	1	8.33	0	0.00	10	9.71	0	0.00	11	8.09
High	3	25.00	4	40.00	33	32.04	4	36.36	44	32.35
Low	4	33.30	5	50.00	43	41.75	4	36.36	56	41.18
Very Low	4	33.30	1	10.00	14	13.59	2	18.18	21	15.44
Zero	0	0.00	0	0.00	3	2.91	1	9.09	4	2.94
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

About 67%, 60%, 58% and 64% of the respondents from hospitals, health centres, dispensaries and clinics respectively, rated the degree of government involvement as low or very low (Table 19). The reasons given for that low involvement were:

- irregular/lack of inspection and inspectors;
- monitoring is done only as a response to complaints;
- no communication/interaction between private providers and the government;
- no enough staff, funds and reliable transport;
- the government does not know all private health facilities;
- the government is not serious or neglects regulation;
- the government does not motivate health workers;
- the government is allowing unqualified people to work in private health facilities;
- the government has not instituted a good and specific regulatory system;
- Government does not assist private health facilities;
- weak legal and regulatory framework;
- some private providers are involved in malpractice but the government takes no appropriate action against the culprits;
- there are private health facilities that are registered although they do not meet the required standards;
- there is no follow up on standards (after registration), and sometimes registration is done without inspection of premises.

Seventy-three percent (22 out of 30) of government and supporting institutes officials interviewed thought government involvement in regulating private health care was low, while 20% (6 out of 30) rated it high. Only 7% (2 out of 30) rated it very high but none rated it very low. Poor regulatory capacity of the

government institutions to carry out the law has also been found in Zambia, (Berman et al 1995). This has been attributed partly to lack of interests and/or commitment, worsened by lack of human and financial resources.

Those who reported a very high/high involvement mentioned the following reasons for rating:

- the government has issued guidelines (1996);
- private health facilities that do not meet required standards are closed;
- the Government gives licences to private providers;
- health facilities are visited for regulation.

Apart from the degree of involvement, respondents were also asked to assess the effectiveness of that involvement. For example, if inspections are carried out, are appropriate measures taken against those who are found not to meet the set standards?

Table 20: Providers' Perception on the Degree of Effectiveness of Government Involvement in Regulating Private Health Care Providers

Degree of effectiveness	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Very High	0	0.00	0	0.00	9	8.74	0	0.00	9	7.00
High	6	50.00	3	30.00	33	32.04	3	27.27	45	33.00
Low	3	25.00	4	40.00	34	33.01	4	36.36	45	33.00
Very Low	3	25.00	3	30.00	22	21.36	2	18.18	30	22.00
Zero	0	0.00	0	0.00	5	4.85	2	18.18	7	5.00
Total	12	00.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

In the case of providers, only about 40% of all the respondents reported that government effectiveness in regulating private providers was either very high or high. About 60% said it was either low or very low (Table 20).

For government and supporting institutions officials, 57% (17 out of 30) indicated that, effectiveness was low while 33% (10 out of 30) thought that the degree of government effectiveness was high. Seven percent (2 out of 30) of the respondents rated the degree of effectiveness very high and only 3% (1 out of 30) rated it very low. The reasons given for low or very low effectiveness were:

- poor quality of premises and care provided by most private health facilities;
- registration of non-qualified personnel to run health facilities;
- the absence of control on prescription, laboratory and drugs given by private providers;

- lack of feedback on reports sent to MOH from private providers;
- visits are done only when problems arise;
- corruption;
- there is a lot of bureaucracy in licensing;
- the government is issuing many instructions but only a few are implemented; no serious action is taken against those who fail to comply with or implement regulations.

The above reasons were given by the majority of the respondents, implying that the government involvement in enforcing laws and regulations is not effective. Licensing of private health care providers began only about six years ago, following the Amended Act as a response to the global market oriented economy. This was probably done without serious consideration on how the market structure, quality and efficiency of the private health services would be regulated.

Those who reported that the government degree of effectiveness was either high or very high supported their response with the following reasons:

- the government has now started to issue guidelines/directives to private providers;
- the government carries out regular inspections of private providers, and those found guilty have been punished;
- the government re-registers previously de-registered private health facilities after they attain/establish required standards;
- the response from private providers in following the new government standard guidelines shows that government regulation is effective;

Most of these reasons reflect the most recent exercise of re-registration of private health facilities, which has resulted in the withdrawal of many private health facilities that did not meet the set standards.

5.5 Inspection

To corroborate the information reported on regulation and monitoring, respondents were asked to report if they were aware of any inspection which has been carried out in private health facilities by relevant authorities to ensure that services meet the set standards. About 88% of providers reported that they were aware of such inspection. Among those, 92%, 90%, 88% and 73% were from hospitals, health centres, dispensaries and clinics respectively (Table 21). However, most of them said the inspection was not very regular because of scarcity of personnel, funds, and transport.

Table 21: Providers' Awareness on Inspection of Private Health Facilities by Relevant Authorities

Response	Type of Health Facility									
	Hospital		H/ centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	11	91.70	9	90.00	91	88.35	8	72.73	119	87.50
No	1	8.30	1	10.00	10	9.71	3	27.27	15	11.03
No Responses	0	0.00	0	0.00	2	1.94	0	0.00	2	1.47
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

For government and supporting institutes officials, only 53% (16 out of 30) respondents said they were aware of such inspection, whereas 47% (14 out of 30) said they did not know. An earlier discussion with District Medical Officers from various districts of Tanzania Mainland indicated that on average each health facility is visited only once per year unless a particular unit has specific problems such as an outbreak of disease or disease surveillance. (Based on discussion held between the Registrar of non-government health facilities and DMOs from several districts of Tanzania Mainland).

About 88% of the providers who reported to be aware of inspection of private facilities by relevant authorities were asked to mention when and what type of inspection was done. The following were the responses on what the inspectors came to observe and/or check:

- sanitation, sewage and cleanliness;
- building standards and premise environment;
- general inspection;
- type of services provided;
- inspection for re-registration.

Most of these inspections were reported to be done by health officers (95%) - building, sewage and sanitary inspection - and rarely did DMOs or any clinical expert accompany them. Nobody reported anything on inspection of the quality of service. The inspection seemed to be irregularly done and dominated by sanitary check up and rarely on services delivered. Furthermore, apart from inspection for re-registration, several respondents reported to have seen inspectors after the introduction of the new guidelines. Most of the providers (80%) who said to have seen an inspector recently (three months before the interview), mentioned that the inspection was done for the purpose of re-registration as per newly-issued guidelines.

5.6 Registration

Respondents were asked to describe conditions that they were required to fulfil before they could register their health facilities. Respondents mentioned the following:

- the facility must have qualified staff, accepted premises and necessary equipment;
- the facility must have adequate staff, enough rooms (laboratory, consultation, observation, store, pharmacy, injection, toilet and dressing rooms);
- inspection and evaluation to be done and certified by DMOs and City Medical Officer, with a condition that there should be a qualified medical practitioner;
- the facility premises must be clean,
- the facility has to be under a registered and approved organisation or person;
- premises must have a conducive environment for a health unit (enough water supply and a good sanitary system and refuse disposal).
- payment of taxes and license fees has to be done.

Most of the respondents mentioned the right conditions that are stipulated in the guidelines for registration of private hospitals (MOH 1996). Contrary to this, observation during data collection shows that most of the surveyed health facilities did not comply with the conditions that were mentioned. Some of them did not have qualified staff and some had very poor sanitary facilities and refuse disposal. Some dispensaries were located in residential houses. This discrepancy could be explained by the fact that most of the facilities surveyed had not been re-registered by the time this survey was being undertaken; so while they mentioned the right conditions required they had not complied with them.

Respondents described different procedures they went through to register their respective health facilities. Most of the respondents explained different starting points as follows:

- Local Authority (ward executive)
- District Medical Officer
- CCM local office
- Ten-cell Leader

The same end point of registration was mentioned by all respondents but where to start the process to obtain the registration differed amongst them. About 30% said they had to channel their applications through the local leaders while the rest contacted the DMO's office directly for inspection and approval of the premises before getting a licence.

5.7 Ensuring Quality of Care

Respondents were asked to suggest a way of ensuring quality of private health services. In summary, providers suggested the following:

- Ensuring that health facilities have qualified staff, good premise and required equipment;
- having regular strict monitoring and inspection;
- educating private providers regularly through workshops and seminars;
- licences should be given to medical professionals only;
- limiting the number of facilities to be registered in a certain area;
- having a recommended price list by MOH;
- involving private health associations in inspection;
- strict regulations and laws on quality of service and drugs, which providers have to adhere to;
- frequent interaction between the government and owners of private health facilities; through seminars, workshops, newsletters etc;
- ensuring that the regulatory framework is known to all private practitioners;
- the government providing soft loans and lower taxes to private providers to enable them improve the quality of services;
- putting in place standardised quality guidelines;
- taking to task health facilities in case of misconduct/malpractice.

Recommendations by government and supporting institutes officials were more or less similar to those made by providers, and included the following:

- defining standards and enforcing them;
- allowing only those who meet the standards to operate;
- undertaking regular inspection of medical/dental facilities to ensure quality of services provided in terms of equipment, supplies and staff abiding by the regulations and guidelines as set by MOH;
- setting up a multi-disciplinary body to advise the Registrar of private health care providers.
- recruiting sufficient and competent staff for monitoring and supervising private health care providers;
- educating/training private health care workers to improve their working skills.
- granting tax exemptions on some medical equipment, drugs and laboratory reagents;
- providing soft loans to private health care providers in order to enhance quality, confidence and trust of private health facilities. There should be a better system for provision of loans to support those willing to invest in the sector. Loans can also be provided for joint ventures between doctors and other medical personnel;
- introducing Bills of Rights of a patient;
- all private health care providers must display a price list of the services offered.

In general, most of the respondents (over 85%) suggested regular supervision and strict monitoring as the most effective way to monitor quality of health services provided by private health care facilities. This implies that there has been no strict regulation and control on the quality of health care services provided by private providers. Most of them also suggested interaction of MOH and private providers and owners by using seminars, workshops and newsletters to educate and inform private providers on the required new medical practice standards. Health information has an important role in maintaining the technical quality of private providers. On the providers' side, the information is more likely to enhance quality and efficiency in creating a more competitive environment since private providers would be informed of actions in the market and what type of technologies are currently in use. On the consumers' side, if consumers know what appropriate and inappropriate treatment is for common conditions, they are more likely to receive the right treatment from private providers.

Some of the respondents suggested that health facilities should be operated only by qualified medical personnel. The Private Hospital Guidelines of 1996 and the Private Hospital Amendment Act 1991 do not restrict ownership of private health facilities to medical professionals. Approved organisations are also allowed to own private health facilities in Tanzania (Act 1991). This study found that some facilities were owned by non-approved personnel, which is contrary to the stipulated guidelines.

5.8 Regulation of Prices

The government could regulate private providers by issuing fees structures to safeguard the poor, and hence foster equity. In other countries governments have regulated the charging of fees by private providers (see Berman et al 1995). In Tanzania, the Private Hospital Amended Act of 1991 states that the Minister for Health has the power to check and regulate the prices charged and remuneration paid by private providers. The Minister can fix the maximum price to charge and the price lists are supposed to be posted on conspicuous places so they can be easily seen.

Respondents were asked if they were aware of reviews of fees structures of medical services rendered by private health care providers in the last three years.

Table 22: Respondents' Awareness of Reviews of Fee Structure of Medical Services Rendered by Health Care Providers in the Last Three Years

Response	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	0	0.00	0	0.00	4	3.89	0	0.00	4	2.90
No	12	100.00	10	100.00	95	92.23	9	81.82	26	92.70
No Responses	0	0.00	0	0.00	4	3.89	2	18.18	6	4.40
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

Data in Table 22 shows that only about 3% (4) of surveyed providers (all from the dispensaries) said they were aware of any, while 93% said no review of fees structures had been done in the last three years. About 93% (28 out of 30) of the government and supporting institutes officials interviewed said they were not aware of such reviews while only 7% (2 out of 30) said they were aware.

The government had never released any fees structure guidelines for private providers. Some countries issue fees structures to deter private providers from hiking fees that could impede most of the people from obtaining the much-needed primary health care. In the absence of fee structures, private health care providers are likely to maximise profits by charging high fees.

Table 23: Respondents' Awareness of Medical Treatment with Price Ceilings in Private Health Facilities

Response	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	1	8.33	2	20.00	7	6.80	0	0.00	10	7.40
No	11	91.70	8	80.00	95	92.23	10	90.91	124	91.20
No Responses	0	0.00	0	0.00	1	0.97	1	9.10	2	1.50
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

About 91% of the providers reported not to know any medical treatment in private health facilities for which a maximum fees has ever been set. This was reported by 92%, 80%, 92% and 91% of respondents from hospitals, health centres, dispensaries and clinics respectively (Table 23). Eighty-three percent (25 out of 30) of government and supporting institutes officials were not aware of any medical treatment in private health facilities for which maximum fees has been set. Only 17%(5 out of 30) respondents were aware.

Those who said they were aware of medical treatment with a price ceiling gave examples of laboratory investigation charges, CT scan, delivery charges and surgical treatment. Since no standard fees have been set for the private sector, it is possible that such perception emanates from price competition among providers, who tend to charge more or less the same fees for certain services. Evidence of price competition among private providers was discussed in Chapter Four.

When private health care providers were asked to suggest a way to control pricing of health services in their facilities, they responded that the government should devise means of reducing running costs, such as tax reduction on drugs and/or subsidising and/or controlling prices of drugs and other medical supplies by:

- fair control of fees structures for different treatment regimens;
- improving public health facilities to attract patients from private health facilities;
- grading private health facilities and treatment options charged according to facility grade;
- MOH setting treatment fees structures in collaboration with private health providers associations;
- displaying fees conspicuously on health facilities notice boards so that patients can choose facilities within their financial means;
- allowing private practitioners to purchase drugs from the Medical Stores Department (MSD).

Government and supporting institutes suggested the following:

- standardising fees for common treatment in private health facilities and making them known to the public;
- reviewing and scaling down sales tax and income tax, and granting tax exemptions on essential drugs.
- allowing private health practitioners to purchase drugs from the Medical Stores Department or other government institution.

Most of the respondents suggested that the government should find a way of reducing prices of drugs and other medical supplies, which would enable private providers reduce their running costs. They suggested lowering of taxes on drugs and other medical supplies, subsidising drugs, tax exemptions on imported drugs and medical supplies. Such measures could eventually translate into low fees to patients.

5.9 Equity

In principle, there should be equity in consuming health care as a "merit good". Respondents were asked to make suggestions on how to ensure equity in access to private health care. Providers suggested the following:

- controlling the prices of drugs;

- making sure that the poor are given the needed care in public facilities;
- having a standard price list for various services/treatments;
- establishing a health insurance system;
- lowering taxes on drugs and other medical supplies;
- licensing and registration of private health facilities should take into consideration geographical disparities;
- encouraging providers to put up health facilities in rural areas (for example, by giving them subsidy);
- improving government-owned health facilities (which are relatively cheaper) so as to attract more patients;
- the government meet the cost of poor patients in private health facilities; or subsidising private health facilities;
- building a strong national economy.

Government and supporting institutes officials suggestions on ensuring equity in access to private health care include:

- establishing a health insurance scheme to cover the majority of the population;
- enforcing laws governing private health practice;
- encouraging private providers to invest in areas that are less favoured. MOH should give priority to applicants from areas without health facilities e.g. semi-urban and rural areas, and, if possible, provide subsidies to private providers and NGOs to serve the poor. Incentives should be provided to those who will opt to operate in deprived areas.

The majority of the respondents suggested that the government should take action on reduction of prices of drugs and medical supplies by either giving subsidy or lowering different taxes on drugs. Others suggested that there should be a standard accepted list of prices and criteria for who should be exempted. On distribution of private health facilities, most of the respondents suggested that licensing should be pre-determined by geographical disparity in location of health facilities and population density. As far as rural areas are concerned, respondents suggested that the government should subsidise private providers to enable them to settle and operate in such areas. Regulations for geographical distribution are needed to reduce inaccessibility while exemption mechanisms are needed to reduce fee barriers for the poor.

Equity of accessibility to health care services by the poor is a subject of major concern in privatisation and health financing reforms. While most private providers (with the exception of church organisations) would operate to generate profit, the government has the obligation to make sure that the poor are not denied essential health care. A good number of respondents suggested that medical insurance scheme be introduced as a way of reducing health care costs to consumers and inequity in health care

consumption. In any way, the poor should be protected to improve the health status of the population. This is an important policy requirement in health care provision.

5.10 Conclusion

Overall, respondents' views on the regulatory framework and process show that there are inadequacies in the existing regulations and inadequate capacity in the enforcement of the regulations. Capacity is taken in its broader sense to include not only human resources but also other necessary inputs such as finances and infrastructure support. Findings have further shown that existing capacity is not well utilised and is ineffective. Barriers to effective regulations are not only limited to resource constraints but also to the process of formulating and enforcing implementation of set regulations. Involvement of both regulators and the regulated appears to be an important aspect in ensuring effective regulation. A well-facilitated regulatory body with a decentralised support system is also critical if effective regulation is to be ensured.

6.0 INCENTIVES

6.1 Introduction

The issue of incentives was examined with a view to determining the extent to which private health care facilities are provided with an enabling environment for provision of quality and equitable health care. Existing literature (Bennet and Ngalande-Banda, 1994. Muschell, 1995) acknowledge the importance of incentives in facilitating effective and efficient private health care delivery. Both monetary and non-monetary incentives have been identified (Muschell, 1995); and those which have been introduced in other developing countries include:

- allowing private sector activity to take place within public sector facilities. In Mozambique, for example, medical staff are allowed to run special private clinics in government facilities outside normal working hours;
- providing incentives to private practitioners who provide less profitable services. For example, in some countries such as Nigeria and Zimbabwe, the government has encouraged private practitioners to offer preventive services by providing them with free supplies such as vaccines and condoms. The danger here, however, is that the private sector might abuse this incentive as has happened in countries where it was introduced. In Zimbabwe, supply of free vaccines to private practitioners was stopped when it was discovered that they were charging fees for these services;
- giving private health care providers financial breaks such as (a) allowing the importation of specific medical supplies duty free; (b) bonus incentives such as tax exemptions on certain medical supplies to encourage physicians to locate in under-served areas; and (c) allowing private providers to purchase drugs and other medical supplies from government sources as it is being done in Ethiopia. This is an implicit subsidy as government warehouse prices are usually lower than those of private suppliers are.

This chapter attempts to examine the extent to which incentives exist in Tanzania to facilitate and enable private health care facilities provide quality and equitable health care. Questions were asked on whether private health care providers receive financial and other types of assistance, whether they are entitled to any kind of tax/duty exemption, have access to government sources for purchase of pharmaceuticals and other medical supplies, and whether the government assists in the training of their medical personnel. The study also sought to determine whether private health care providers have ever applied for and received credit, and whether the government sought providers views on what they thought the government should do to promote private health care provision. Responses to these issues are

presented in the following sub-sections.

6.2 Financial and Other Forms of Assistance from the Government

A question was asked on whether respective private health care providers get financial assistance from the government. All providers in the sample indicated that they don't get financial assistance from the government. On whether providers were entitled to some form of tax/duty exemption, 16.7%, 1%, and 5.8% of the hospitals, health centres and dispensaries respectively responded in the affirmative. None of the clinics in the sample received any exemption (Table 24). Listed items for which providers got exemption include pharmaceuticals, theatre, x-ray and laboratory equipment and stamp duty. Health facilities that indicated to have received tax/duty exemption were either owned by religious organisations or operated under the umbrella of a religious organisation, although in practice they appeared to be for-profit.

Table 24: Whether a Health Facility is Granted Duty/Tax Exemption

Duty/Tax Exemption	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	2.00	16.70	1.00	10.00	6.00	5.83	0.00	0.00	9.00	6.62
No	10.00	83.30	9.00	90.00	95.00	92.23	11.00	100.00	125.00	91.91
No Responses	0.00	0.00	0.00	0.00	2.00	1.94	0.00	0.00	2.00	1.47
Total	12.00	100.00	10.00	100.00	103.00	100.00	11.00	100.00	136.00	100.00

Source: ESRF (1997) Private health facilities field survey data

Allowing private health care providers to purchase drugs from government sources has also been identified (Muschell, 1995) as one way of facilitating them to provide affordable health care. A question was therefore asked on whether providers are allowed to purchase pharmaceuticals and other medical supplies from government sources. Results showed that 75%, 40%, 23% and 18% of the hospitals, health centres, dispensaries and clinics respectively are allowed to purchase pharmaceuticals and other medical supplies from government sources. Response on the question seeking additional comments, however, indicate that government sources could have implied only the National Pharmaceutical Company (NAPCO) for some of the health facilities, particularly those which do not belong to religious organisation. Many health facilities indicated that they should be allowed to purchase drugs from MSD, implying that they were not purchasing any pharmaceutical products from MSD at the time of the interview. The type of pharmaceuticals and medical supplies purchased from government sources include anti-malaria drugs, antibiotics, analgesics, surgical instruments, dressing materials, laboratory equipment, intravenous infusion, laboratory reagents, disinfectants and other assorted medical items.

On the same question, 54% (16 out of 30) of the government and institutions officials interviewed said

that government did not provide financial assistance to private health care providers. Only 23% (7 out of 30) said that private health care providers get financial assistance from the government while 23% (7 out of 30) did not know whether the government provides financial assistance or not. Those who said the government provides financial assistance cited private not-for-profit health care providers, especially the church-owned health facilities. The type of financial assistance provided by the government as mentioned by respondents include:

- Funds given to some church-owned hospitals as a subsidy. These include all District Designated Hospitals (DDHs);
- funds given to supervising NGOs health facilities;
- tax exemptions on pharmaceutical products;
- Payment of salaries for employees in DDHs.

Regarding provision of duty/tax exemptions, 43% (13 out of 30) of the officials were not sure as to whether the government provides duty/tax exemption on pharmaceuticals and medical supplies purchased by private health care providers, 40% (12 out of 30) indicated that the government does not provide tax/duty exemption while 17% (5 out of 30) indicated that the government does provide tax exemptions.

When asked to elaborate, those who said the government provides tax/duty exemptions cited voluntary health facilities as an example of non-government health care providers that are tax exempted. Specifically, the following examples, which all refer to not-for-profit private health facilities, were given:

- the so-called charitable non-government hospitals;
- private not-for-profit institutions, e.g. religious bodies, are allowed to purchase tax free supplies;
- pharmaceutical products are exempted for NGOs and voluntary agencies, but for-profit private hospitals it is difficult;
- voluntary agencies and missionary hospitals.

On provision to purchase pharmaceuticals and other medical supplies from MSD, 50% (15 out of 30) of the government and supporting institutes officials said that private health care providers do purchase pharmaceuticals and other medical supplies from MSD, which is a government agency. Thirty percent (9 out of 30) were not sure whether or not such a provision exists, whereas 20% (6 out of 30) indicated that private providers are not allowed to purchase pharmaceuticals from MSD.

Again here, as in the case of responses by those providers who indicated that private health facilities purchase pharmaceuticals from MSD, could have been referring to the not-for-profit private providers or to a recent move by the government allowing registered private for-profit health providers also to purchase pharmaceuticals and other medical supplies from MSD on cash terms.

6.3 Provision of Sponsorship to Staff of Private Health Facilities

Enhancement of human resources skills and individual motivation is essential for efficient and effective delivery of quality services. A question was therefore asked whether respondents knew of any member of their staff that has ever been sponsored by the government for further training. Only 9% of the providers interviewed indicated a member of their staff to have received such support, while 90.4% said no member of their staff has ever been sponsored by government for further training. The question had a 'don't know' category but none of the respondents indicated lack of knowledge as to whether members of their staff had been sponsored by government for training. Table 25 shows the distribution of responses by type of health facility.

Table 25: Government Provision of Sponsorship for Further Training to Staff of Private Health Facilities (Providers' response)

Provision of sponsorship	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	1	.33	3	30.00	8	7.77	1	9.09	13	9.60
No	11	91.70	7	70.00	95	92.23	10	90.91	123	90.40
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

A follow up question sought to know posts held by members of staff who had been sponsored for training, the type of training attended and the sponsoring institution/government. Members of staff who had undergone further training through government assistance included nurses, clinical officers, laboratory assistants, and doctors. The type of training listed include counselling, nursing, laboratory training, health education, STD/HIV control and post-graduate training. Sponsoring institutions listed include the Ministry of Health (MOH) and district hospitals. Other sponsors were the British Government and the United States Agency for International Development (USAID).

Government and supporting institutes officials interviewed were also asked whether they knew of any government sponsored/trained staff working in private health care facilities. Sixty percent (18 out of 30) of the officials did not know of any staff in private health facilities that had been sponsored by the government. Twenty percent (6 out of 30) were not sure that such assistance exists. Only 17% (5 out of 30) said the government does provide sponsorship to private health care staff and 3% (1 out of 30) didn't respond.

Cited examples of training opportunities provided include:

- participation in various workshops conducted by the Preventive Department in MOH, HMTS. The respondent who gave the example cautioned that it is not easy for private providers to allocate time for staff training;
- most of the health workers in private health care facilities have been trained by the government before being recruited into or moving to the private sector;
- staff from the private sector are involved in family planning through attending seminars and workshops.

The examples cited above indicate that basic training has been provided by the government. Kiwara (1995) found that virtually 98% of all workers found in private practice units were working in government institutions and that some of the staff receive continuing education in terms of seminars and workshops.

On the question of whether providers received other government assistance, only 11.7% of the respondents in all types of health facilities indicated to have received other forms of government assistance apart from that already mentioned above. More than eighty-eight percent (88.2%) indicated not to have received other government assistance. Responses on a follow up question regarding specific assistance provided include supply of contraceptives through FP and MCH services, vaccines and medical equipment.

Responding to a question regarding what other assistance private health care providers would like the government to provide them with, so as to facilitate provision of quality and affordable health care, respondents mentioned:

- tax exemptions;
- upgrading staff through training;
- establishing a medical insurance scheme for all people;
- providing credit facilities;
- improving infrastructure such as roads and water supply;
- allowing providers to purchase drugs from MSD;
- reducing income tax rates;
- providing loans with fair conditions, and subsidising expensive equipment such as X-ray machines.

Responding to the same question, officials from government and supporting institutions mentioned the following:

- financial assistance through provision of loans;
- sponsoring private health care staff on contract;
- undertaking joint formulation of policy, law, regulations and provision of an autonomous regulatory body;
- involving private health care providers in continuing education, seminars, educational workshops etc
- ensuring regular supportive supervision;
- establishing good communication system in which new information and changes in technology should be easily accessible to all professionals in the health setting;
- granting tax exemptions on pharmaceuticals and other medical supplies;
- providing drugs and medical supplies to private health care facilities at competitive prices via its agency (i.e. MSD);
- providing transparent standard guidelines for both public and private health facilities;
- Conducting regular inspection by professional boards.

6.4 Measures to Promote Private Health Care Provision

Respondents were asked what they thought the government should do to promote private health care provision. Measures that were mentioned by most of the providers were:

- providing training and regular seminars to staff of private health facilities;
- granting tax exemption on pharmaceutical products and other medical supplies;
- reducing price of drugs and medical equipment;
- removing (unnecessary) regulations that limit rather than promote private health care provision;
- educating and encouraging the public to use private health facilities;
- establishing health insurance schemes that will enable many people to afford private health care;
- providing loans/credit;
- allocating land to private health care providers on which they can construct health facilities;
- controlling quality through regular inspection;
- seconding qualified staff to private health facilities;
- subsidising the poor so that they also could afford private health care;
- treating both private and public health care providers equally, maintaining the same level of trust;
- removing bureaucratic registration procedures;
- regarding private providers as partners in service provision, and networking and linking activities with them;
- allowing private providers to buy pharmaceuticals from the Medical Stores Department;
- establishing a firm supervisory board;
- involving private health care providers in national health policy formulation and planning.

- encouraging opening of more private health facilities in rural areas by subsidising them;
- incorporating APHTA members in law-making bodies;
- allowing doctors working in government hospitals to also work in private hospitals on part-time basis.

Out of the many suggestions summarised above, the most frequently mentioned were granting of tax/duty exemption on pharmaceuticals and other medical supplies, provision of loans/credit, training of medical personnel and enforcement of regulations to control quality. The latter response is an indication that private providers are also concerned about the quality of health care. A facilitating rather than an inhibiting environment is however critical if private facilities are to effectively provide quality health care. Responses reported ad verbatim in box 1 below indicate private health care providers' concern and commitment to ensure quality control in health care provision.

Box 1: Providers' Comments Indicating Commitment to Provision of Quality Health Services

"The government should give permits to operate private health facilities to only those who meet the conditions and requirements as stipulated by relevant authorities."

"Form a medical/dental quality control audit team comprising of medical/dental private practitioners who, in collaboration with members appointed by the MOH, should convene meetings of private practitioners to set guidelines for private health care."

"The government should be very strict on private facilities so as to limit the rapid increase of such facilities, thus making it easy to monitor the existing facilities more effectively."

"The laws governing private health facilities are there, the government should enforce them."

"Monitoring and evaluation should be regular to make sure that regulations are followed."

"Government should make regular follow-up of all facilities and close those which do not comply with existing laws and regulations."

Government officials' responses to the same question were similar to those given by private health care providers. To promote private health care provision, they recommended that the government do the following:

- make sure that all private facilities are run by qualified medical officers and other qualified medical cadre, and allowing doctors to work freely in the private sectors;
- encourage more qualified people to open private health care facilities in under-served areas where services are needed and assisting in seconding properly qualified staff;
- provide clear guidelines and laws regarding private health care;
- institute supportive policies, for example provision of soft loans;

- conduct regular inspection to make sure health facilities maintain standards to encourage competition.

6.5 Collaboration between the Government and Private Health Care Providers

Providers were asked whether they thought there was collaboration between the government and private health care providers. Sixty-one percent (61%) said yes, 36% said there was no collaboration and 3% did not respond (Table 26). Those who thought there was collaboration mentioned the following indicators: private providers being able to refer patients to government hospitals at different levels; regulation by the government, which some of the respondents thought was the only form of collaboration so far, recommending that collaboration should go beyond this and that the government should regard private providers as partners in service provision; government providing vaccines and equipment such as refrigerators, weighing scales and sterilisation equipment for running MCH clinics; MTUHA (HMIS) seminars, which at least show government concern; having an APHTA member on the board of private health facilities regulatory body of the government and APHTA liaising with MOH.

Table 26: Providers' Perception on whether There is Collaboration Between the Government and the Private Health Care Providers

Provision of sponsorship	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	9	75.00	7	70.00	62	60.19	5	45.45	83	61.03
No	3	25.00	3	30.00	39	37.86	4	36.36	49	36.03
No Response	0	0.00	0	0.00	2	1.94	2	18.18	4	2.94
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

Respondents who thought there was no collaboration between the government and private health care providers mentioned the following reasons, among others: withdrawal of financial support to voluntary health facilities; absence of a forum for meetings between the government and private providers for exchange of ideas and discussion; absence of effective private health care authority to represent private health care providers in such collaboration, and absence of financial or material support. Elaborating on why they thought there was no collaboration, four of the respondents said:

"The only link is through registration and inspection."

"There is very little collaboration. Most of the time the government makes things difficult, I am a specialist doctor but it took me two years to get registered."

"For the three years that I have worked in the private sector, no government official has suggested ways to improve my health unit."

"I have never seen government officials at my premises since my registration years back."

On the same question, government officials indicated that there is generally good interaction between the government and private health care providers. Seventy-seven percent (23 out of 30) said there is collaboration, while 23% (7 out of 30) thought there was no collaboration between the two parties. Following are the examples cited to indicate existence of collaboration between the two parties:

- regular meetings conducted by MOH, to which members of associations of private practitioners are sometimes invited;
- MOH has a desk officer in charge of operations of private health sector and the Registrar of private health facilities;
- MOH formulates policies and regulations, and provides professional support;
- Government medical personnel work part-time in private health care units.

6.6 Loan/Credit Facilities

Investors in the private sector have often expressed concern on tough requirements for approval of loan/credit for business development, citing this as a major obstacle in efforts to develop the private sector. A question was therefore asked on whether respondents have ever applied for a loan/credit. Only 15% said yes, with the majority (84%) saying no, while 1% did not respond. The distribution of responses is presented in Table 27. An explanation as to why more than 80% of the respondents have never applied for credit could be their scepticism at the chances of getting a loan.

Table 27: Application for Credits by Private Health Care Providers

Provision of sponsorship	Type of Health Facility									
	Hospital		Health Centre		Dispensary		Clinic		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	3	25.00	1	10.00	17	16.51	0	0.00	21	15.00
No	9	75.00	9	90.00	86	83.50	10	90.91	114	84.00
No Responses	0	0.00	0	0.00	0	0.00	1	9.09	1	1.00
Total	12	100.00	10	100.00	103	100.00	11	100.00	136	100.00

Source: ESRF (1997) Private health facilities field survey data

Of those who applied, only 24% (5 out of 21) said the loan/credit was approved. Those who did not get loan/credit cited two main reasons: lack of collateral and corruption. For example, one respondent said he was unable to get credit because he was not willing to pay bribery amounting to 10% of a Tsh. 500,000 loan he had applied for.

6.7 Conclusion

Data in this chapter has shown that there are very few incentives, if any at all, for private health care providers. Credit/loan facilities to start or expand health care facilities are very limited, and a system of tax exemptions and provision of subsidies almost non-existent. There also seems to be limited government support in developing human resources in the private health care sector. As in other sectors of the economy, the environment is thus still not facilitative to the development of this private sub-sector.

Private health care provision plays a key role in complementing public health care, which is still inadequate. The government should therefore recognise the private sector as a partner not only in the rhetoric but also by taking practical steps to encourage private health care providers and facilitate them to offer quality and affordable services.

7.0 SUMMARY OF MAIN FINDINGS AND RECOMMENDATIONS

This chapter summarises findings on key issues analysed in the study and makes suggestions/recommendations to promote the development of a quality and affordable private health care sub-sector.

7.1 On Income, Expenditure and Price Competition

Analysis has shown that most of the surveyed private health facilities realise very little profit or operate at a loss. This finding, however, should be observed with caution because, as noted in Chapter Three, it is possible that some of the providers under-reported their incomes because of the sensitive nature of this information. Further, data collected was cross sectional thus it is difficult to determine whether the findings represent the general trend or not. There is need, therefore, to undertake another study of providers willing to give financial information covering several years that could be analysed so as to determine financial performance.

On expenditures, wages and pharmaceuticals were found to constitute the bulk of expenditures in all types of facilities, followed by rent. Private health care providers indicated that government measures to help them reduce costs, especially on pharmaceuticals, can help to cut down their expenses and consequently attract more customers.

Data on fees for various services and price of drugs indicated a fair degree of competition among private health care providers. However, a few facilities were found to charge substantially higher fees and prices than others, particularly hospitals. Also, some charges, for example for Chloroquine injection and antibiotics, while competitive, appeared to be on the high side. Charges for special services and tests, e.g. X-ray and CT Scan that patients are often referred to undergo, were also rather high. Several factors could have contributed to the variation in fees, including the price at which providers procure drugs, equipment, and other medical supplies, the magnitude of overhead costs, quality of services provided and, of course, profit margins. These factors were however not looked into.

The limitations noted above notwithstanding, one may conclude from the indicated features in terms of, for example, shortage of funds for investment and a relatively high level of price competition that although a service sector, in terms of basic business and economic dynamics the private health sector parallels, in many ways, what is happening in the productive private enterprises sector. In view of the above, the following is recommended:

- Creating a stable and conducive environment for sustainable private health care provision. This could be done, for example, through government granting of tax/duty exemptions and/or provision of subsidies on pharmaceuticals and other essential medical supplies so as to facilitate them offer affordable services. Private health care providers should also be assisted to having access to credit facilities, which may help them not only to develop their facilities but also to keep them in the market during financial crises.
- Allowing a public/private mix where the government could contract private providers to offer services that they do not have a comparative advantage in offering;
- Even though there is price competition, relatively high prices for some of the services imply a need for instituting measures to ensure that those who cannot afford, have access to such health services. One such measure is the introduction of health insurance schemes and other funding mechanisms. This will not only ensure that the poor have access to needed health care but it will also create a more stable environment for providers;
- Due to unreliable income data, there is need to undertake another study of those providers willing to give financial information covering several years, which could be analysed in order to determine financial performance.
- To enhance understanding of fees/prices and competition in the private health sub-sector, analysis of future studies should include factors that determine fees and prices.

7.2 On Linkages

Both horizontal and vertical linkages among providers, particularly in terms sharing medical personnel from the government health facilities and referrals, were found to be common. Strong statutory linkages were also found to exist between private health care providers and key institutions in the health care system such as the Ministry of Health, the City Commission Health Department and the government district hospitals. On the other hand, private providers had very limited linkages with other stakeholders such as NGOs and international organisations. Further, Linkages with financial institutions were almost non-existent. Very few of the private health care providers (11%) had formal financial arrangements with financial institutions.

Overall, one can therefore see that linkages between private health care providers and other stakeholders that are stronger are only those which are more or less mandatory, based on set procedures and regulatory framework, for example links with the MOH and City Commission Health

Department, and the referral system. Links for mutual benefit, for example in terms of sharing equipment and joint meetings to discuss common problems and strategies for development, are rather weak. Even weaker are links with key actors such as financial institutions, NGOs and international organisations, which can play a very important role in the development of the private sector. To strengthen linkages, the following is recommended:

- private health care providers should encourage linkages that will enable them avoid unnecessary costs to providers and consumers. These should involve formation of associations to address issues of mutual benefit such as strategies to strengthen links with other key institutions, and providers holding regular meetings to discuss issues related to the development of the sector;
- links with the government should include establishing links that facilitate private health care providers in the development of the sub-sector and in provision of quality and affordable services rather than regulatory links only. There has to be a strong public - private mix in provision and financing of health services’
- links between government and private health care providers could also be strengthened by exchanging views in joint workshops and seminars. Frequent dialogue between the two parties through such fora is likely to have a positive bearing on the development and delivery of private health care services;
- strengthening links with financial institutions. This could be done by, among other things, creating an environment in which banks will have better incentives to lend more to private health care providers. Particular efforts could be directed towards introducing health sector trust funds and credit schemes. Putting in place financial policies that would bolster efficient mobilisation of domestic savings and their channelling into the private sector, which includes private health care, could also strengthen such links.

7.3 On Regulatory Framework and Regulatory Process

Many respondents were aware of the regulations governing private health care provision and many felt the degree of government involvement and effectiveness in the regulation of private health care facilities was rather low. A substantial number of respondents also felt that not only was the capacity to regulate inadequate, but the little that was available was also not well utilised. These views were consistent with the actual situation observed in the field. Some of the facilities were sub-standard, some were operated by non-approved medical personnel, while others were rarely inspected. In a few cases where inspection was done at least once, there was no follow-up to ensure compliance where discrepancies

were found. To strengthen the regulatory process, the following is recommended:

- ensuring that all private health care providers have the necessary documents on guidelines and regulations governing private health care provision. For enhanced effectiveness, the government should work hand in hand with private providers associations in emphasising the importance of adhering to set regulations and guidelines;
- government involving professional bodies in the inspection and regulation of health facilities. Forming an autonomous regulatory body comprised of government and non-government members who are well trained and well motivated is likely to be more effective;
- creating regulatory bodies at the district and regional level to work together with DMOs and RMOs in inspecting and regulating health facilities; A well facilitated regulatory body with a decentralised support system is required if effective regulation is to be ensured;
- ensuring that strict deterrent measures are put in place and enforced against providers who do not adhere to set regulations and guidelines.

7.4 On Incentives

The study has also shown that very little incentives, if any, are in place to promote development of private health care. No facility indicated to have any financial support from the government, although some respondents indicated to be aware of such support to facilities owned by religious organisations. These are usually DDHs, of which none was in the sample. Data also indicates that very few private health care providers (only those owned by voluntary agencies) received some form of tax/duty exemption. Such provision could go a long way in reducing operating costs of these facilities, which would result into lower fees on services provided. Such subsidies are not provided, regardless of the fact that health care is a basic social service. Also, apart from a few seminars and workshops, there was little evidence of government support in training private sector medical personnel. Overall, respondents described the role of the government as mainly supervisory, and thought there was very limited collaboration, which is necessary for a more effective and efficient health care system. In terms of investment and business development, data has shown that there are very limited prospects for securing credit/loans in the private health care market. The following are recommendations that would provide incentives to private health care facilities:

- providing subsidies/financial assistance to private health care providers to enable them reduce costs and offer affordable health services. This could be in terms of tax exemption, allowing private

providers to purchase essential medical supplies from the MSD and/or charging low fees for use of medical equipment in public health facilities etc;

- the government should provide training opportunities to medical personnel working in the private sub-sector when such opportunities arise. This should be done in collaboration with private health care providers who should also have their own staff development programmes and plans to implement them;
- strengthening the office of the Registrar by providing more staff and funds so as to ensure effective regulation;
- ensuring more participation of private health care providers in seminars/workshops organised by public institutions such as the MOH and district health offices.
- putting in place mechanisms to facilitate private providers to have easy access to credit so as to encourage and promote private investment in the private health care sub-sector.

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