Quest Journals
Journal of Research in Business and Management
Volume 10 ~ Issue 9 (2022) pp: 242-254
ISSN(Online):2347-3002
www.questjournals.org

Research Paper

Evaluation of the Functioning of theHealthcare Management System in Tanzania

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ABSTRACT:*This paper presents the findings of the study conducted in Tanzania in 2021 to verify the contribution of Health Sector Reforms (HSR) to the improvement of healthcare services management in the country using a multisite cross-sectional case study design involving review of official documents, facility observation, and interviews with 60 respondents from 18 healthcare facilities in Tanzania. The analysis in this paper focuses on the perceived improvement in the functioning of the healthcare system, paying attention to the service delivery point aspects of health system governance. The findings revealed that more than one-half of respondents appreciated the improvement in some aspects, such as quality, transparency, accessibility, participation, and timeliness of service provision. However, the same respondents were unhappy with the outcome of the reforms on control of corruption, enhancing accountability, responsibility, fairness, governance, and moral and ethical behaviours. To date, the lack of a sense of care prevails in healthcare facilities to the extent that some health workers insult patients or deny them services. This is more prevalent in rural health facilities. Overall, the functioning of the healthcare system falls short of stakeholders' expectations. Thus, for effective reforms, the study insists on the need for bottom-up and community-engaged reform approaches, sustained monitoring, learning systems, and a "faults mending" approach in dealing with recurring gaps in health system governance and health services delivery.*
KEYWORDS: *healthcare management, systems functioning, Tanzania*

***R**eceived 12 Sep, 2022; **Revised** 25 Sep., 2022; **A**ccepted 28 Sep., 2022 © The author(s) 2022.*
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I. INTRODUCTION

The study evaluated the functioning of the current Tanzania healthcare management system as perceived by different healthcare stakeholders through primary and secondary sources. The post-reform healthcare management systems have many components, including the organization of the health system, health financing, health services delivery, health information, health governance, human resources, health infrastructure, technology, and medicine and medical supplies, among others. A well-functioning healthcare management system requires adequate human and financial resources, reliable information to enable proper healthcare decisions, well-maintained infrastructure, and good management of the mentioned resources. However, for this study, only four major components of the healthcare management system were evaluated: the organization of the healthcare management system, healthcare resourcing, service delivery, and health governance. Each is detailed in the subsequent subsections.

II. METHODOLOGY

The study employed a multisite cross-sectional case study design that involved largely qualitative data gathering. The study was conducted in 18 healthcare facilities in three regions: Dar es Salaam, Coast and Dodoma (six facilities in each region). Data for this study was collected using three key methods: interviews (both in-depth unstructured (N = 48) and semi-structured interviews (N = 60). Semi-structured interviews involved senior public servants from ministries (N = 5), and councils (N = 5), health workers (N = 17) and facility committee members (N = 8). They also included patients' representatives (N = 12), local government leaders (N = 10), District Health Secretaries (N = 5), and representatives of NGOs that work on healthcare rights advocacy (N = 3). Interviews were supplemented by facility observation and review of library and official documents from relevant organizations, including the ministries responsible for health, local government, public service management, and finance and healthcare facilities. Data analysis was mainly qualitative and involved both content and thematic analysis.

III. ORGANIZATION OF THE HEALTHCARE MANAGEMENT SYSTEM IN TANZANIA

The current healthcare management system reforms in Tanzania started in the 1990s, especially in the post-Economic and Social Action Programme (ESAP) era. The reforms sought to replace the old top-down, non-participatory healthcare management system with a participatory healthcare system such as healthcare planning, decision-making, and resource mobilization. The reform intended to ensure better healthcare services to the citizens and, consequently, national social-economic development. In these efforts, the ministry responsible for health de-concentrated terminal functions to independent departments while leaving the central and local governments to share service delivery functions at different levels. The changes and challenges are in the forthcoming subsections.

3.1. Re-concentration and other incomplete modes of decentralization.

Decentralization becomes complete, meaningful, and effective when the central-level actors agree to shift decision-making powers, resources, and authority to lower-level actors or their agencies [4]. However, in the course of implementing HSRs in Tanzania, experience has revealed the hesitance of the central government to surrender its power and authority to other actors, especially on human resource management and finance issues. This has caused limited accessibility, availability, and predictability of health services at the local level. For example, the Medical Store Department (MSD) was established to relieve the ministry responsible for the health of the procurement and delivery of medicine to healthcare facilities. It was anticipated that this change would prevent regular stock-outs of medicines, but this has not been the case. Medicine stock-outs continue because the chain of making procurement and delivery decisions remains with the central government. To date, facilities and district councils have limited control over decisions related to where they should get supplies and when the required supplies should be delivered.

Interviews with the respondents discovered that stock-outs of some essential medicines can extend for up to two months. In that regard, health staff fails to discharge their duties as required and as expected by citizens. Therefore, the creation of MSD relieved the ministry responsible for health from medicine procurement and supply management burdens but has not ensured medicine availability to healthcare facilities as anticipated. Though the establishment of MSD has somehow improved the allocation of drugs and medical supplies through the introduction of a new allocation formula as compared to the earlier "medical kit" allocation method, the medicine allocation inequities continue. In the adjusted 70-15-15, or the three-factor formula as popularly known, 70% of healthcare resources are allocated in proportion to the catchment population, 15% in proportion to poverty, or the number of people living under the basic need poverty line, and 15% in proportion to documented under-five mortality. Within the council, for instance, discretional allocations continue, especially when there are emergencies such as the outbreak of diseases or natural disasters. While MSD is blamed for stock-outs in health facilities, this research found that MSD was not alone responsible for allocation. Allocation powers and authority since 2007 have been shared between MSD and the office of the Chief Pharmacist. It is the office of the Chief Pharmacist that determines which medicine to supply where and when. Moreover, it has been revealed that through the formula, rural facilities receive fewer medicines than urban facilities because the formula gives higher weight to population density (70%) than other factors [5].

3.2. The Existence of Deadlocks in the Distribution of Functions

A properly functioning health system requires a clear distribution of functions and responsibilities. HSR intended to increase efficiency, consensus, collaboration, and fairness in service delivery. While it has been clear that local government authorities are responsible for delivering services at local levels, problems emerge when there is a need to share efforts and resources in tasks at local levels. The healthcare management system is characterized by an indefinite sharing of functions between the ministry responsible for health, the ministry responsible for local government, and LGAs, especially in primary healthcare services provision. For instance, in Temeke and Kongwa, there were shreds of evidence where the two ministries and councils had partnered in the development of infrastructure at dispensaries and health centres. According to the senior officials from the two mentioned ministries: LGAs are responsible for the development of health infrastructure in their areas of jurisdiction as provided in the Local Government (District Authorities) Act of 1982, Sections 111(1) and 111(2) (c) [6]; the ministry responsible for health is responsible for policy, regulation, quality assurance, and mobilization and allocation of resources. The ministry also supervises national, referral, and specialized hospitals, public health-related interventions, and health-related executive agencies. When additional components of the health system, such as human and financial resources are considered, the cooperation and the role interaction extend to include the ministries responsible for public services management and finance, hence increasing the complexity of relationships and responsibilities.

The majority of interviewees appeared to be aware that these overlaps affected the functioning of the healthcare management system. However, this practice continues because of the vastness of the country, which

covers 947,300 square kilometres with a population estimated at over 60 million. While this nature of role distribution aims to ensure equity in healthcare and offset disparities, it poses challenges since, in some of the facilities, there have been instances where all three actors decline healthcare infrastructure development responsibilities. Further, primary healthcare facilities, which are directly managed by LGAs, operate under the directives, regulations, and standards set by the central ministries in discharging their functions. Primary healthcare facilities are in principle assigned by the central government to provide healthcare services that do not require the presence of medical doctors' attention, such as ante-natal, post-natal, obstetric care, infant vaccination, family planning, the dispensation of disease control medicines, distribution of micro-nutrients, and others. Primary healthcare facilities rely on centrally issued guidelines with limited additional innovations. In other words, this contradicts the logic of the reforms that sought to encourage innovation and inventions to increase efficiency. In this context, it is observed in previous studies that policymakers in Tanzania should revisit the reform to ensure that LGAs have adequate resources and autonomy to be effective [7, 8].

3.3: A Fragmented and Non-Complementary Hierarchy

The other important theme that remains unaddressed despite the reforms is the disjointed nature of the hierarchy of health facilities. Ideally, each higher facility serves as a referral for the lower facility level. However, because of the financial independence of healthcare facilities, which are organized according to administrative structure, this has become less operational. The hierarchy strictly follows an administrative structure and not a facility structure. In that regard, the dispensary cannot refer a patient to a nearby health centre that belongs to another district, however close they are. Such a dispensary is obliged to refer a patient to a distant health centre if they share the same district. For example, a respondent from Dar es Salaam's Vingunguti dispensary stated that they could not refer a patient to Buza health centre because each is financially independent and belongs to a different municipality (Temeke), whereas Vingunguti dispensary is located in Ilala. Again, when the patient is referred to a higher facility, the patient must be readmitted according to the new guidelines, something that interrupts treatment continuity, and no feedback is given to the referring facility. When the patient has been referred, it is as if the patient has been dispatched forever. As also pointed out at Mkamba health centre, once a patient is referred to Mkuranga, they have to be readmitted afresh as if they do not have a reference from a lower facility. Therefore, the progression principle is missing in the new system. In this case, efficiency and effectiveness in the entire healthcare system are constrained by the fact that the system is not organic; it is somehow fragmented and disjointed.

A special arrangement was made in the new healthcare system whereby patients requiring advanced treatment would be transferred from council hospitals to tertiary hospitals depending on the type and nature of the treatment required. However, if there was another private hospital in the council that could offer the required treatment, it would be used instead of transferring the patient to a tertiary hospital far away. Although this horizontal referral system was allowed to reduce cost, and increase harmonization, coordination, and integration, its recognition in practice remains difficult. Many of the facility managers who were interviewed pointed out that the private providers were not ready to maintain that kind of cooperation due to the claim that there were no clear terms offered for that kind of partnership. A related problem comes due to the complexity of the status classification of hospitals by health system versus administrative levels of governance. Specifically, for example, a council hospital in each region's main urban centre (municipality or city) was normally classified as the regional referral hospital for that region. Such a hospital has a dual recognition that gives it special treatment in terms of resources since, in addition to functioning as a council hospital for the council in which it is established, it serves as a referral hospital for other council hospitals and provides more specialized healthcare services generally not provided in ordinary council hospitals. With this, hospitals such as Amana or Temeke receive direct budget allocations from the central government budget and get additional funds from the councils they serve as council hospitals. In turn, this undermines the referral-continuation principle that is a prerequisite for a systematic and integrated referral management system.

3.4. Complementarity in the Role of Technical Health Management Teams

Technical teams have been established at every level, from the region down to the dispensary. These teams are responsible for facilitating technical matters, including planning, budgeting, and implementation of budgets and plans, as well as policies and laws. They are mainly composed of health professionals. From the researcher's observation and respondents' view, these teams operate effectively. However, there is an overlap in their roles and responsibilities when it comes to their day-to-day operations. This affects their accountability for intended results. The functions of each technical team are analysed in the following subsections.

3.4.1. Regional health management team.

The team gives technical support and guidance to the councils in the region. The support includes the preparation of the Comprehensive Council Health Plan and interpretation of healthcare instruments such as

policies, Acts, regulations, directives, and procedures. It also links the councils with health lead ministries (health and local government) and development partners on matters regarding healthcare service delivery, control of epidemics, coordination of emergency activities, and ethical issues in the region. RHMT conducts quarterly supervision visits in each district to assess the operation of healthcare systems. The team is accountable to the Regional Administrative Secretary (RAS) and is under the social sector support services unit of the region. The unit is one of the six units under the supervision of the RAS. The other units are management support services, staff functions, economic development support services, physical planning, engineering support services, and common cadre and operational staff.

3.4.2. Council health management team

The team is responsible for the implementation of Council Comprehensive Health Plans (CCHP) and national healthcare priorities. It also monitors and supervises the performance of healthcare facilities and ensures the availability of transport, drugs, vaccines, and medical supplies. Furthermore, the team responds to epidemics and gives technical support to health centres and dispensaries in the council; conducts the analysis of quarterly health reports and forwards them to the Council Health Services Board (CHSB) and Regional Health Management Team (RHMT) for further action. The CHMT is comprised of the following: the council medical officer, council nursing officer, council health officer, council health secretary, council pharmacist, council laboratory technician, and council dental surgeon. Other professionals may be co-opted when needed. For instance, the council's maternal child health co-ordinator, TB and leprosy coordinator, HMIS coordinator, health and health-related non-governmental organizations representatives, private for-profit and private non-profit representatives, and others.

3.4.3. Council health planning team

The CHPT is a specialized technical team responsible for preparing the Comprehensive Council Health Plan (CCHP). The major role of the team is to scrutinize and identify council health priorities for planning and budgeting. The LGAs' budgets in this plan are divided into six cost centres: the office of the council medical officer; council hospital; service agreements (private hospitals); health centres; dispensaries; and community health services. The team is formed by the council planning officer, who is the chairperson; the council medical officer, who serves as a secretary; one representative from the private for-profit sector; one representative from NGOs; one representative from faith-based organizations; one representative from the community development department; and a representative from the regional secretariat for technical advice.

3.4.4. The hospital's management team

The team is responsible for ensuring the provision of quality healthcare services in line with the essential health package. It also prepares hospital plans and budgets, ensures the rational use of hospital healthcare resources, resolves conflicts among hospital staff, ensures adherence to the professional code of ethics, and supports and strengthens referral services. The team is made up of the medical officer in charge and the heads of the hospital's departments and sections.

3.4.5. Health centre and dispensary management teams

These facility management teams are responsible for the implementation of health policies, guidelines, and plans. They monitor and supervise the provision of healthcare services, prepare comprehensive facility plans, and ensure the effective provision of transport, drugs, vaccines, and medical supplies. The teams are formed by facility in-charges and department and unit heads in the facilities. At the district/municipal level, the Executive Director is overall responsible for ensuring the effective delivery of health services. The director is assisted by the medical officer as the head of the council health department. The two are accountable to the full council for approving all council health plans, budgets, and progress reports; for ensuring effective audits (financial, human resources, and assets); enacting relevant by-laws; attending to staff and citizens' appeals, complaints, and petitions; and for ensuring effective human and financial resource management. However, in most cases, the health plans and budgets are treated as small components of the council plans and sometimes given limited attention. The government introduced administrative technical committees (facility management committees) that are responsible for the implementation of approved plans. These committees, in the case of health centres and dispensaries, are led by the Assistant Medical Officer (AMO) in-charge and Clinical Officer (CO) in-charge, respectively. These managers supervise the facility's department heads to discharge the day-to-day facility management duties. However, these managers have no well-defined mechanisms that link them with government authorities at the ward and village/street level. It was revealed from interviews in Kongwa and Mkuranga and reviewed documents that facility management teams tend to be more responsive to the DMO and DED while side-lining relevant authorities at ward and village levels. Therefore, the reformed structure of the healthcare management system in this aspect appears to contradict the need for accountability, which is also an

important aspect of the HSRs. A more detailed account of the accountability relationship will be discussed under the governance aspect that follows after the two next components.

IV. HEALTH RESOURCES RESOURCING AND ALLOCATION

Three resources are critical in healthcare service delivery and have been at the centre of reforming the healthcare management system. These are financial, human resources, and pharmaceuticals. Under the Public Service Act 2002, as amended in 2007, the mandates of recruiting and distributing staff belong to the Public Service Recruitment Secretariat (PSRS) and the Ministry responsible for public service management. Thus, sometimes there is limited or no coordination of health human resource allocation. The continuation of these challenges often results in resource shortages, especially in rural and remote community facilities. However, efforts to rationalize the allocation of resources, including human resources, are still going on. There are two new computer-based systems, POA and WIN systems, being experimented with in Mwanza, Mtwara, Mara, Morogoro, Mbeya, Kigoma, Tanga, and Iringa to see if they may improve equitability in staff allocation. Also, money in health services management is as important as blood in the human body. It facilitates both the availability and quality of the services provided. Therefore, financing was one of the components considered in health sector reforms. The evaluation of the reforms needs to consider the extent to which the new financing interventions have enhanced the current functioning of the health system. The emphasis is on the shift from centralized resource mobilization and management and discretional allocation to decentralized mobilization and management and the formula-based allocation.

The discretional mode of allocation that was in practice from independence to 2004 was not based on any agreed formula. Differences in disease prevalence, catchment population, and healthcare needs were not considered as long as the facilities were of the same level. For instance, health centres would receive similar numbers of staff, standard drug kits approved for that level, and any other items. The exception was for the Health Basket Fund allocation. This frequently resulted in excess allocations for some facilities and deficits in others. In some of the interviews, the discretional model was characterized by patronage and preferential treatment. The same models also affected rural facilities due to their accessibility limitations. Some facilities would stay with medicine to the expiration date, while others experienced stock-outs. With the reforms, a new formula-based allocation model was introduced following extensive consultation with stakeholders, including LGAs, civil society organizations, and development partners. However, there is no evidence that the consultation directly involved the patients and communities. The famous 70-10-10-10 (four-factor formula) was introduced in September 2003 and its use started in 2004. In the formulae, 70 percent is a proportion of the catchment population, 10 percent is a proportion of poverty or the number of people living under the basic need poverty line, 10 percent is a proportion of documented under-five mortality, and 10 percent is a proportion to medical vehicle routes in the area. Therefore, the poorer, needy, and remote LGAs were expected to be relieved by this new allocation formula [9]. Despite being the ideal model of efficiency in resource allocation, the model had limitations in that it could not be applied automatically to some resources, such as human resources.

Also, underdeveloped infrastructure continues to limit access to both medical items and human resources in rural and remote facilities compared to urban ones. The senior official from the ministry responsible for health insisted that the mistake which remains unaddressed is the failure to create similar conditions in rural and urban facilities so that the formula is equally applicable to both contexts. The same point was also stressed by one of the facility managers in the Kongwa district council during an interview, who argued that the formula sought to ensure a fair distribution of resources in different facilities, but the experience is that the rural facilities are still in crisis since workers reject rural postings. While some facility managers thought there were recorded improvements in the allocation following the introduction of the allocation formula, others argue it has not. For instance, there are complaints in Kongwa and Mkuranga that the formula fails to account for the already existing stocks and investments when it comes to development grants. While the formula applies to Personal Emolument (PE) and Other Charges (OC), it does not take into account the fact that PE is fixed and directly paid as part of employees' payrolls and thus has nothing to do with addressing equity at the health facility level. In the case of OC, an unprecedented challenge that is currently being observed has been the failure of some of the councils to effectively spend the OCs allocated to them.

Medicines and medical supplies, on the other hand, are supposed to be allocated to councils based on medicine and medical supply formulas, except for emergencies and exceptional cases where discretional allocation methods are applied to cater to the outbreak of diseases, natural disasters, and other emergencies. The application of the formula mode has been a great achievement compared to the medical kit allocation method explained before. Though drugs and medical supplies are distributed by MSD, the actual allocation of pharmaceuticals since 2007 has been determined by the Chief Pharmacist based on the mentioned adjusted formula. As previously stated, this has been a setback in ensuring allocation equity. In all the six councils

visited, there were experiences of unspent amounts, while there are many administrative costs that need to be covered at facility and community levels. According to the interviewees from the ministries responsible for health and local government, this often forces the government to revert to discretionary allocation on a case-by-case basis. In this situation, it is perceived as favouring the rich local councils. The same applies to primary healthcare financing, where the government contributes to the facilities by topping up the funds in proportion to the amounts mobilized from community sources such as the CHF and TIKA. Therefore, the councils that mobilize less get less from the government. This significantly affects equity as one of the motives of the HSR program. In connection with this point, the allocation of healthcare staff remains rather discretional and thus centrally organized.

V. SERVICE DELIVERY ARRANGEMENTS AND STATUS

Service delivery arrangements constituted another area of focus in the evaluation of the functioning of the health system in Tanzania. In this case, some important aspects of service delivery at the council and facility level, such as quality of healthcare services, service availability and accessibility, and service timeliness and promptness, were evaluated. The analysis in the next three subsections delves into these aspects.

5.1. Quality of healthcare services

The quality of health services may be broadly defined, however, in this study focus was on how facilities and their personnel presented the available services to beneficiaries and the evaluation of the services by the beneficiaries themselves. Therefore, it is related to the sense of care and satisfaction felt by service users in the councils and communities around the facilities. Therefore, information relating to the quality of healthcare services includes both that collected by asking respondents and that observed during service provision by the researcher. These sources were also corroborated with documented information about healthcare services in the studied councils and other facilities in the country. The findings revealed that there was some slight improvement in the functioning of the health systems compared to the period before the reforms. However, some of the respondents clearly stated that the functioning of the healthcare system had not met the expectations they had when the reform started.

In most of the interviews with officials from the councils that were researched, it was pointed out that the efforts to deliver the best services had been increasing since the 1990s, but they were being affected by unforeseen challenges that continued to face healthcare facilities within the councils. For instance, a health officer from Mkuranga informed us that he had been at the council since the reforms started; hence, he could attest that the people were getting better services compared to before the reforms. However, more improved healthcare is being curtailed by the inadequacy of financial and human resources, he attested. Another official in the department responsible for health at Temeke argued that they were facing a lot of challenges in developing comprehensive healthcare plans because these plans required special planning skills and experience they didn't have. The officer added that there is a great need to expose all councillors and key council staff to the basics of planning skills.

During one of the visits, a patient was witnessed complaining about the lack of attention from health workers, and it was confirmed that to get complete treatment in some of the facilities, a patient had to sacrifice the whole day. Similarly, during one of the facility visits, a patient was observed complaining that patients are many, but some attendants are busy with their mobile phones instead of attending to patients. It was, however, noted from the facility managers' point of view that the quality of healthcare services is affected by the poor functioning of equipment and laboratories. In eight healthcare facilities visited, laboratories were closed due to a lack of reagents and laboratory technicians. When one of the laboratory technicians was interviewed, she confirmed that it is true that they have a large workload and that they do not have enough reagents.

The findings generally indicate that the respondents had mixed feelings regarding the reforms; some considered that the reforms had positive contributions, while others had the view that they changed nothing. However, the challenges that existed before the reforms, which in the researcher's view included financial and human resources, ethics, and the irresponsibility of some healthcare actors, continued. This finding is consistent with previous Tanzanian studies [10, 11], 12]. In connection with these studies, reforms were not a cure to the service delivery problems experienced.

5.2. Service availability and accessibility

Another important aspect was service availability and accessibility. The Health Policy of 2007 identified the availability and accessibility of healthcare services as critically important components and defining features of well-functioning and improved healthcare. It is also emphasized that a well-functioning healthcare system

gives access to all without excluding the vulnerable and the poor. A review of the policy confirmed that this was the ultimate goal of the 2007 policy and its revision in 2012. Although availability and accessibility are conceptually different, in connection with service delivery at the lowest level and health system functioning, they have merged boundaries. Therefore, information relating to the two was treated together during the analysis to eliminate repetitions and overlaps. The assessment from semi-structured interviews indicated that 75% of respondents considered that the reform produced high improvement in the availability and accessibility of healthcare services, 23% considered it brought average improvement, and only 2% thought that it brought low improvement. While many respondents saw that the reforms brought positive outcomes, there were outcries across the study facilities regarding the predictability, dependability, and affordability of the services. These problems were most common in rural areas that also experienced longer times of stock-outs of medical items and a shortage of health workers. As may be noted, the majority that thought the reforms had increased availability and access to the services caught the attention of the researcher, who made an effort to understand the reason behind the responses. The research revealed that the response was influenced by how the concepts of availability and accessibility had been shaped by the history of the country before and after the initiation of the reforms. Generally, before the reforms, the delivery of health services was largely dominated by the government, with very few religious hospitals playing a supplementary role in healthcare provision. The reforms included privatization and liberalization of health services, which led to the re-introduction of private healthcare practice in the sector. Therefore, according to the respondents, the view was that availability and accessibility were improved by the increase in private health service delivery. Therefore, the reforms had solved the history of unavailability and inaccessibility since whoever wanted healthcare services and had the money to procure them had 'freedom of choice, especially to choose between the private and public health service providers depending on the quality of services provided by each. This conception of availability and accessibility is indeed a special one, despite being controversial in the health services and public administration literature. This is because, as reflected in the previous research [13, 14, 15, 16], the reforms may have meant decolonizing the health services from the hands of the government as a dominating but less capable actor.

Despite the continuation of pressing challenges such as inadequate drugs and medical supplies, acute transport problems, poor quality of care, and poor accountability in public healthcare facilities, people felt happy because they were "free to access" the "available" services. Therefore, the concepts of availability and accessibility are associated with situations where the government refrains from constraining people from having alternative channels for accessing services. However, this conception challenges the previous study on youth participation in decision-making and access to healthcare services that found that healthcare services may be available, but people are denied using them because workers are unaccountable, culturally inconsiderate, or not user-friendly [17]. In this study, the conception of availability and related ideas such as accessibility, reliability, flexibility, affordability, and dependability are all intertwined and determine the usage of the service by targeting beneficiaries. These controversies surrounding the conceptions of availability and accessibility of healthcare services suggest the need to go beyond knowing whether people have access but also understand what constitutes availability and accessibility of healthcare services in the post-reform era.

5.3. Service timeliness and promptness

A properly functioning healthcare service system has the requirement of providing timely services and taking prompt response steps when there is the experience of health challenges. As in the previous subsections, our entry point was the question that required all the respondents to provide their views on the extent to which the initiation and implementation of HSRs, which is still going on, had contributed to the improvement in the functioning of the healthcare system, particularly in terms of providing timely and prompt care and services. Based on the interview responses, the majority (45%) of the respondents considered timeliness and promptness in offering healthcare services to be below expectations, 25% thought the outcome was according to expectations, and only 25% considered the reform outcome to be above expectations. The promptness in offering healthcare services needs further improvement because of its importance in ensuring effective emergency responses. Because the majority of Tanzanians, given their socioeconomic status, are expected to seek medical services from public healthcare facilities when they get sick and the services offered are not prompt, many people are automatically likely to suffer.

In the case of facility observation by the researcher, long queues were observed as a common feature in all healthcare facilities visited. In three cases, patients who appeared to be critically sick were left without being attended to for more than two hours because the responsible health workers were busy with other activities. Also, in one of the cases, the facility in charge who was supposed to attend the patient stayed in the facility management committee meeting for more than three hours without attending the patient. In another incident in Kongwa, the nurse who was supposed to attend to the patient had gone for lunch for hours during working hours. A patient who had been involved in a motorcycle accident stayed for more than three hours waiting for

the nurse to come back after her lunch to attend to her. In these cases, the health workers did not appear to care much or were at least apologetic for what they did.

In some of the facilities visited, though the average time set for getting services was two to three hours, people were waiting up to four hours and beyond to get healthcare services. In many of the facilities that the researcher visited and interviewed service users, it was revealed that to get complete treatment, one must spend more than 8 to 10 hours. These delays and lack of swiftness tend to undermine the functioning of health systems because they eliminate the culture of preparedness in cases of emergency (Fox et al., 2014). Similarly, this culture affects responsiveness to unexpected and eruptive medical conditions such as accidents, maternity, and poisoning [18]. It also affects the capacity of health systems to serve the lives of people suffering from diseases that can result in sudden deaths, such as high blood pressure, lung failure, and heart failure. Therefore, timeliness and promptness are important conditions for the proper functionality of healthcare systems.

VI. GOVERNANCE OF HEALTHCARE SERVICES

In the area of governance, the study focused on transparency in the provision of services, control of corruption and human rights, accountability, and participation of communities and patients in decision-making. However, before proceeding into these aspects, there is a need to have a cast of governance structures that have been put in place and their functioning. The governance and oversight of health services management in Tanzania is organized in the form of health facility and services governance committees and boards at different service levels. Boards and committees are attached to the government levels, while facility committees and boards are attached to the facilities by levels. The Council Hospital Governing Board (CHGB) mobilizes and solicits healthcare resources for the effective delivery of healthcare resources in the council hospital; endorses hospital plans and budgets, and approves them before submission to the CHSBS for deliberation and approval. It also oversees all healthcare functions performed by the council hospital. The board oversees service quality, scrutinizes and approves plans and budgets, and reports to the Council Social Services Standing Committee (CSSSC). The board has seven members. The Council Medical Officer (CMO) is the secretary, and it holds meetings every three months.

The Health Centre Management Committee (HCMC) ensures the general performance of the health centre, ensures users' representation, health resources availability, and quality services, and endorses health plans and budgets for forwarding to the council. Ward Development Committees (WDC) oversee the provision of healthcare services in the ward, mobilize people to join agreed-upon insurance schemes, and raise funds to improve healthcare and community plans. The Dispensary Management Team (DMT) oversees the overall performance of the facility, ensuring user representation, the availability of health resources, and the quality of services. It endorses health plans and budgets for further approval and facilitates waivers and exemptions. The Village Council Social Services Committee (VCSSC) acts as a link between the facility and the community, mobilizes, monitors, and supervises the use of local resources, identifies people's needs, and integrates them into facility plans.

The study revealed that the healthcare oversight and governance structures in Tanzania are characterized by the existence of two parallel platforms that attempt to link the healthcare system with users. These platforms (committees and boards) are used by the healthcare system as a means for inclusive healthcare governance, decision-making, supervision, and representation. They seek to ensure the effective provision of quality healthcare services, sustainable healthcare infrastructure, reliable supply of drugs and medical supplies, adequate financial and human resources, realistic facility plans and budgets, and efficient and effective facility and service management. Even though they operate with some degree of supervisory autonomy, the study found that these committees were technically supervised by or had substantial influence and control from facility managers who are heads of facility management teams, the authorities to which they belonged, and the authority they were supposed to be supervising. This reversal sometimes makes oversight difficult. These findings are similar to the previous study findings [19]. The mentioned reversed supervisory and control relationships, plus the lack of functional clarity had transformed the facility committees and boards from being oversight institutions into actors whose role was to legitimize the decisions of facility management teams as well as support facility management teams in the fulfilment of their day-to-day operational responsibilities. This also causes a lack of uniformity in the roles of committees in supporting the effective functioning of the healthcare system since the capacity to perform their supervisory roles has been personalized. In some of the visited healthcare facilities, the capacity appeared to be low because of the competencies possessed by members of these committees, especially the chairpersons. The same applies to the relationship between government-affiliated committees when it comes to their relationship with bureaucratic actors such as the village executive officer, ward executive officer, and district executive director.

6.1. Participatory decision-making

Participation of the users in healthcare and service management decisions is another prerequisite of a well-governed and well-functioning healthcare system. Improving the participation of people in decision-making at all levels has been one of the major aims of health sector reforms in Tanzania. With the introduction of facility committees, the expectation was to have people actively participating in decision-making and for the outcome of the decision-making process to reflect the voices and needs of the people. The government directed all healthcare facilities to constitute facilities committees composed of the representatives of communities and community groups around the facility. However, the question has been whether healthcare decision-making has been more participatory since the establishment of committees as part of the reforms. The assessment of interview questions solicited views on the extent to which the reforms contributed to the improved participation of the users in decision-making and showed that the majority (70%) had the view that the reform had a high contribution to improved participation in healthcare decision-making. The rest considered the improvement to be average or low. This was because of the existence of representative participatory organs, namely the committees in all health facilities that facilitated representation of community and group interests and priorities in facility plans and budgets. In theory, participation in the form of representation became a requirement of the reformed health system where each health facility was required to conduct a minimum of four committee meetings per year. This requirement under the reforms offered a default opportunity for increased participation in facility planning, priority setting, and budgeting as required under the HSR.

As mentioned in the previous subsections, some see the committees' work as something that was desired and thus became a means towards the end. However, in nearly all the facilities visited, there was evidence of weaknesses in the committees that rendered their decisions less participatory. For example, the majority of the committee chairpersons who were interviewed said that in most cases, facility managers invited them to meetings with agendas that must be discussed. Therefore, they have no decision on what agenda item to discuss. In other words, the committee meetings often bless and legitimize the agenda provided by the facility management committees. On rare occasions, committee members engage in active discussions and document their plans and priorities, but when they do so, their resolutions are rarely acted upon by councils and upper authorities. Thus, in many cases, the recommendations of these facilities' supervisory bodies are insignificant when it comes to the actual outcomes, including in the case of medicine procurement and budget proposals. Thus, the idea of creating facility committees was brilliant, but the implementation has been a challenge. The post reforms' participatory decision-making arrangements have some limitations that make community representatives passive rather than active participants. Active participation in decision-making focuses on both the process and the outcome of the decision-making process. The findings of this study agree with the findings of previous research stating that the decision-making process becomes participatory not merely by involving communities and groups in decision-making but by ensuring that such communities have a voice in the decision-making process [17]. In other words, decisions may not be participatory enough by focusing on the process while neglecting the outcomes.

6.2. Transparency in performance

Transparency is one of the most important features of a well-governed healthcare system. Achieving transparency in healthcare service management was one of the aims of health sector reforms. Therefore, it was also a concern of the study to find out the extent to which the functioning of the post-reform healthcare system met this standard. From the interviews, the majority (70%) showed that there was an average improvement in this aspect. Only 20% of the respondents had the view that the reforms produced high improvements in transparency. The remainder thought the improvement was lower than expected. On the other hand, the analysis of data from in-depth interviews and facility observation pointed out a mixed result, ranging from a substantial improvement in the management of resources, including the CHF funds, to medicine and medical item delivery. In Kongwa and Dodoma, it was pointed out that financial and medical-related information was being published on noticeboards at healthcare facilities. In most of the interviews conducted with leaders of facility committees and healthcare facility managers, the researcher noticed that the facility managers, especially those in dispensaries, were required to go to village or street assembly meetings to report on the performance of their facilities. In the study, it was verified that in most cases, financial and medicine delivery reports were displayed on the noticeboards, but the facility managers were rarely available during village or street assemblies to respond to citizens' concerns. These findings demonstrate the existing gap in the enforcement of transparency standards in the day-to-day management of healthcare both within the facilities and communities. These findings concur with previous studies [19, 20], which verified that the gaps in transparency transcend the mere process of having procedural requirements to publish information and communicating the problems that face healthcare service management to the users; it also involves urging actors to seek, find, understand, and use the available information to challenge or oversee the consumption of resources and the quality of healthcare services.

6.3. Accountability and responsibility

Accountability, which is closely related to responsibility and answerability for decisions and actions, is an important ingredient of good governance in health system management. It relates to both being properly guided by formal rules and a sense of relational positivity between the right owners (users of services) and right holders (providers of services). Therefore, it has both legal and ethical dimensions since health workers and service providers are supposed to fulfil the requirements of the laws that manage their relationship with service users and communities while at the same time upholding positive moral and ethical standards and expectations of the communities. The reforms were introduced to give the nearby community supervisory power over the functioning of such healthcare facilities and enhance their responsibility and accountability. The findings revealed that only 30% of the respondents considered the reforms to have resulted in a high improvement in accountability and responsibility in the management and delivery of healthcare services and the rest considered the contribution average (60%) or low (10%). Despite the variation in the views, the results indicated that most of the users felt that the health workers rarely acted responsibly and rarely followed the required rules and procedures in delivering the services. Answerability and the readiness to apologize for whatever wrong they did were reported to be rare in healthcare facilities visited. Despite the existence of professional codes of conduct and ethics that require healthcare staff to offer quality healthcare services to citizens, there are many cases of workers not being accountable for what is happening daily. The situation was worse for health facilities that are not regularly inspected. From both interviews with users and facility observation sessions, the researcher noted that service users, especially women, were insulted and denied the right to receive quality services as required.

Contrary to the expectations and requirements, in Kongwa and Kibaha, there were cases where four of the health workers refused to appear before the village assemblies when they were called by village authorities following cases of mistreating patients. In two of the facilities in Mkuranga and Dodoma, facility committee leaders complained that facility managers were regularly asked to account for different matters, including medicine, facility repair, and Mother-to-Child Transmission Prevention and Treatment (MCT-PT) services, but they kept silent. These cases demonstrate a lack of accountability and a disregard for the authoritative powers of accountability forums established to oversee healthcare facilities' functioning.

At the council level, the same problem of accountability was reported regarding the relationship between the councillors who form the council policy body and the council health staff, including the medical officer. Interviews with Kongwa and Mkuranga revealed that councillors had limited capacity to interpret healthcare plans and make informed decisions even if they discovered misconduct. As a result, they could not effectively hold council staff accountable. In the same case, the council health officials from Kibaha and Temeke complained against the councillors that they were attempting to prioritize issues that promoted their short-term political motives over long-term and sustainable healthcare development in the communities. It was also pointed out in an interview with a council planning team member who is a health professional from Kibaha that sometimes councillors demanded undue favours for their respective wards just to benefit during elections, as informed by one respondent. It is obvious to see that a councillor convinces the planning team to include in the plan, for instance, the construction of a healthcare facility in his or her ward just to benefit politically, without considering other equally important factors such as staff, drugs, workers' houses, and others (Council planning team member, Ilala). This implies an implication that responsibility and accountability in the healthcare sector are limited and constrained by factors that were hardly anticipated during the reforms, such as the social-cultural values of nepotism and the tendency of health workers who are not well supervised to become "gods" or "goddesses."

6.3.1. Corruption, justice, and human rights

Besides improving accountability, HSRs pledged to improve healthcare governance by addressing corruption and bribery and enhancing justice and respect for human rights in the delivery of healthcare services [20]. In connection with the reforms, the government acknowledged the prevalence of corruption and nepotism in nearly every healthcare facility in the country. Corruption has been a major problem largely complained about by citizens. Corruption is a recognized obstacle to the effective provision of quality healthcare services. The government-initiated war against corrupt behaviour, including bribery, nepotism, and embezzlement of resources allocated for healthcare. Various fronts, including the enactment of laws forbidding corrupt practices and the establishment of specific agencies to fight corruption, have been witnessed since the 1990s. As it was for other aspects, the respondents were asked, in the first place, to what extent they thought corruption had been eliminated as a result of the reforms. According to the findings, approximately 29% of those polled agreed that the reform significantly reduced the level of corruption in the healthcare sector, while the majority (65%) thought the reforms had an average impact on the issue, and the remaining 6% thought the reforms had a minor impact. This meant that the reform had a little more of a contribution than what was expected. Incidences of

corruption, especially petty corruption, continue in almost all healthcare facilities visited. Some even claim that corruption is an institutionalized aspect of the health sector that needs deliberate effort and stern measures to contain it. The complaints about corrupt practices in healthcare facilities were so obvious among almost all patients interviewed, except for healthcare staff, who claimed the situation was not as bad as patients claimed. This might be considered their self-defence against patients' accusations.

This research, just like other previous similar studies, found that the efforts to prevent corruption in the healthcare sector, just as in other social sectors, have produced average results [21, 22, 23]. Corruption is still a critical bureau pathology that affects the efforts of the government to improve access to services and ensure justice and fairness in the delivery of services. It was also revealed in the research that ethical committees that were formed to oversee ethical issues in healthcare facilities were either non-existent or not adequately functional. These situations affected the efforts to contain unethical behaviour in healthcare facilities and facilitated the continuation of an old culture where corruption was socially acceptable and whoever condemned corruption became an enemy of the people [19]. When it comes to the improvement in justice and respect for human rights, the study found a significant existence of a lacuna where laws and regulations to ensure justice and fairness are known only by health workers and not ordinary citizens. From interviews, it was clear that all people would like their rights to be observed when they get sick and attend healthcare facilities for treatment. However, an average citizen knows that it is wrong for the service provider to violate their rights, but they are not aware of the instruments in place to safeguard their rights and restrict violation of those rights, such as the Public Service Standing Orders of 2009, Public Service Regulations of 2003, Explanatory Manual on the Code of Ethics and Conduct for Public Service and other instruments [24].

The limited awareness of the proper tactic to use in addressing violations, as pointed out in the previous paragraph, has always resulted in the continuation of disrespectful and discouraging acts against human rights in public healthcare facilities. Of all the aspects investigated, this one was one of the most bitterly complained about. The study revealed that 60% believed that the reform brought little improvement in this aspect, hence being completely unhappy with the way human rights issues are adhered to in public healthcare facilities. It was only 15% of respondents had the view that reform brought high improvement in this aspect. Many patients bitterly complained about this aspect, especially the way nurses treated pregnant women. There has been a loud outcry about this issue among citizens of all classes: town and rural; old and young; men and women. As popular as it is, disrespect for human rights in health facilities and health service delivery has been topical not only in the studied facilities. It is indeed a national tragedy that received portraits from different actors, ranging from the media and politicians to scholars and human rights activists as well as artists. Someone familiar with a popular bongo Flava music song, 'Wauguzi' (meaning physicians), composed by Wagosiwa Kaya, may understand how touchy the disrespect for human rights is by health workers whose role is to save lives. In the song, the artists lament the use of abusive language by doctors and nurses, saying that in their training they were not taught to insult patients using filthy insults. The song avers and rebukes the nurses, later warning them that the public would one day turn against them. This message reflects what the study found to be prevalent in many healthcare facilities when it comes to healthcare service delivery and interaction with patients.

VII. GENERAL ASSESSMENT OF HEALTH SYSTEM FUNCTIONING

Having covered the five aspects selected for evaluating the functioning of the health system, it is now crucial to have a general assessment of the functioning of the health system. It has been noted that almost each of the selected aspects has revealed some degree of improvement and some challenges and unforeseen results that continued to affect the performance of the health system in that particular aspect or as a whole. Informed by the respondents' point of view, the study went further to ask the respondents to score the health system on the above-mentioned indicators concerning the functioning of the system. Three scoring levels were used, namely low (standing for functioning below the expectations considering the efforts invested in the reforms), average (standing for functioning that is in line with expectations considering the efforts invested in the reforms), and high (standing for functioning above the expectations considering the efforts invested in the reforms). The assessment revealed that a majority (68%) considered that the reforms' outcomes on the queried aspects were below their expectations. Only 15% considered the outcome to be above expectations. This means that despite the significant improvement as revealed in specific aspects of health system performance, the general functioning of the healthcare system remains below the expectations of the majority of the stakeholders in conjunction with the articulated goals of the reforms. In an attempt to understand the reasons behind this gap, many of the respondents who were interviewed appeared to suggest that there are unforeseen limitations that sprang out of the reform implementation process and continue to cost the health system. However, these limitations are linked with the lack of sufficient resources to meet the cost of implementing the reforms; emphasis on the development of formal tools and procedures while forgetting the transformation of the

behaviour of the key actors in the health system; and limited empowerment of the communities to oversee the implementation of the reforms at the points of service delivery.

VIII. Conclusion

This chapter attempted to evaluate the functioning of the healthcare system. The focus was on five areas of the health system, especially the organization of the health system. These were the organization of the health system, resourcing and resource allocation arrangements, service delivery arrangements and status, and governance of healthcare services. It has been revealed that there are notable improvements in each of these aspects. One remarkable change has been the initiation and establishment of decentralized healthcare services management enabling increased access to healthcare management plans and decisions. Despite these changes, the management of healthcare services is still affected by the limited institutionalization of the changes associated with the reforms. There are dominant maladministration and unethical practices persisting in a newly reformed health system. These, therefore, affect the overall functioning of the healthcare system, making it fail to meet the expectations of key healthcare stakeholders.

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