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Research Paper

The Contribution of Health Sector Reforms in Addressing Healthcare Services Management Problems in Tanzania

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ABSTRACT: *This paper evaluate the manner (and extent) to which health sector reforms have been able to address health services management problems in Tanzania. Different ways in which HSRs attempted to address healthcare services management problems have been documented. The most popular measures and interventions included the introduction of user fees and health insurance schemes such as the CHF and TIKA to extend the healthcare financing resources base and ensure equity and inclusivity. There were also measures to decentralize healthcare management and empower the people to have control over decisions relating to the resources. However, the actual implementation took the form of de-concentrating functions to local levels while leaving-decision making powers at the centre. Adjustments were also made in the medicine and medical supplies management chain to control stock-outs in some facilities and surplus in others. The shift from the push to the pull and formula-based approaches were popular examples. This study revealed that despite reform efforts some remaining challenges cause the persistence of healthcare services management problems such as double allegiance among healthcare personnel, duplication of planning approaches, the lack of effective monitoring mechanisms, inefficient management of referral services, shortage of qualified human and financial resources, perennial stock-outs, and what has been branded as the moral and ethical crisis in the management of health services. These challenges make the efforts to address healthcare services management problems produce and reproduce the same problems now and then.*

KEYWORDS: *Decentralization, Health insurance, Health sector reform, Services management, Tanzania.*

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I. INTRODUCTION

Health Sector Reforms in Tanzania were conducted to improve healthcare services delivery and the well-being of the people. In this endeavour, the reform, among others, strived to solve health service management problems that existed in the sector. This study was guided by the Multiple Stream Framework (MSF) developed by John Kindon in 1984 [1]. The framework insists that the existing short-term, unstable, and high-profile agenda setting is tempered by long-term continuous processes going on behind the scenes [2]. The MSF argues that there are so many policy problems that in turn are addressed by the existence of so many policy solutions [3]. Therefore, the world of policies is a world of many problem streams and many solution streams. Being a case, policy-makers make policies and develop policy change decisions in the face of ambiguity depending on how a policy problem in question can be framed, defined, or understood. Deduced from this theoretical point of view is the fact that error-free policy change decisions are rare. In connection with health sector reforms in Tanzania, since health sector problems are random and unstructured, the solutions are equally random and unpredictable. While the content of the reforms may be result-focused, the actual implementation may be determined by the combined effect of the content, context, and actors and their behaviour.

This paper provides the findings of the study conducted in Tanzania to reveal 'the Manner and Extent to which Health Sector Reforms have been able to Address Healthcare Services Management Problems in Tanzania'. To do so better, selected responses to address healthcare services management problems in Tanzania are provided, followed by the depiction of specific healthcare service management challenges ongoing despite the reforms implemented to address them and finally the conclusion.

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II. METHODOLOGY

The study employed a multisite cross-sectional case study design that involved largely qualitative data gathering methods in-depth unstructured and semi-structured interviews, facility observation, and review of official documents. The data generated using unstructured in-depth interviewees were analysed using qualitative thematic and content analysis approaches. Semi-structured interview questions were quantitative and quantified for statistical analysis. The study was conducted in three facilities in six councils in three regions in Tanzania: namely Temeke Municipal and Ilala City councils (Dar es Salaam Region), Dodoma City and Kongwa District councils (Dodoma Region), and Kibaha Town and Mkuranga District councils (Coastal Region). Interviews involved 60 respondents including 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). Data for this study were collected using three key methods: interviews (both in-depth unstructured (N=48) and semi-structured interviews (N=60). Interviews were supplemented by facility observation and review of official documents from relevant organizations including the ministries responsible for health services delivery and healthcare facilities. Data analysis was mainly qualitative and involved both content and thematic analysis

III. SELECTED RESPONSES TO ADDRESS HEALTHCARE SERVICES MANAGEMENT

Tanzania's healthcare sector has undergone significant reforms in the past three decades [4, 5]. One of the main purposes has been to improve the management of health services and hence healthcare services delivery [6, 7]. However, it is surprising to note that despite these efforts, management problems that existed before the reforms persist [4, 8, 9]. Before delving into these persisting management problems, there is a need to note some of the reform interventions carried out to address them.

3.1. Introduction of user fees in public healthcare facilities

The user fee policy, also known as the cost-sharing policy was introduced in public hospitals (district, regional, and referral hospitals) in 1993 and later rolled out to all other public healthcare facilities (dispensary and health centres) in 2004. By the late 2000s, all healthcare services in the country were for payment, mainly through the off-pocket payment system. The aim of introducing user fees was to expand the participation of the users in healthcare financing and thus reduce the financing burden on the side of the government. Another aim was to allow the government to focus more on quality regulation and other policy issues rather than direct healthcare provision. The fees were paid at the point where a patient receives services and upon receiving the services. The assumption behind this change was that it would increase the availability, quality, and choice of healthcare services for those who could pay. Also, user fees were one of the approaches for broadening the resource for financing the day-to-day delivery of healthcare services while relieving the government to finance strategic activities of the health system including human resources, innovation, and health technology.

3.2. Introduction of health insurance schemes

Various public and private health insurance schemes have been introduced to cater to the healthcare needs of Tanzanians. The government introduced the Community Health Fund (CHF) as a voluntary social health insurance scheme to cater to the health needs of rural people who work in the informal sector. This scheme was formally introduced in 2001 under the CHF Act No. 1 of 2001 to govern the operations of CHF. A similar scheme, Tiba Kwa Kadi (TIKA) was introduced for urban households in 2009. In the same vein the National Health Insurance Fund (NHIF) was established for those employed in the formal sectors and National Social Security Fund (NSSF) also introduced Social Health Insurance Benefit (SHIB) component as part of the package for its members. Informal and micro insurance and community-based health financing schemes such as Umoja wa Matibabu Sector Isiyo Rasmi Dar es Salaam (UMASIDA) and VIBINDO in Dar es Salaam and some registered private insurance companies such as Jubilee Insurance and others have also introduced health insurance cover. The idea behind the establishment of these insurance covers is to improve healthcare to the extent of attaining universal coverage.

In both the contexts of user fees and insurance, exemption and waiver systems that would allow those who could not afford to pay and the most vulnerable to get access to services in public healthcare facilities were introduced. These groups included children below five years, pregnant women, the elderly (above 60 years), the disabled, and the poor. Since the establishment of the health insurance funds, there have been several initiatives to improve both their coverage and efficiency. However, the government is still in the process of introducing compulsory health insurance coverage for all Tanzanians. When and how is yet to be determined by the government.

3.3. Decentralized management and governance of healthcare

One of the marked policy changes in connection with the reforms was the introduction of Decentralization by Devolution (D by D) to increase people's participation in decision-making and ensure accountability. Decentralization involved among other things empowering the councils to make decisions on important matters in the healthcare sector including hiring and firing, planning, and deciding on financial resources allocation. Since 1999, councils started to serve as central points for planning and managing healthcare programs that targeted their populations. Decentralization of healthcare services management and governance went side by side with the need for Medical Officers who would be responsible for managing and supervising health projects and programs within councils. As pointed out by the Policy Paper on Local Government reforms, this was indeed the essence of the need to have the Human Resources for Health (HRH) as a crucial component in the implementation of the Health Sector Reforms [10]. As one of the senior official respondents from the ministry responsible for health revealed, HRH was an automatic requirement that would serve as the engine of the decentralized healthcare system because the transfer of technical matters of the health profession to a lower level would not work without the transfer of technical personnel to those levels. However, the question that was overlooked was how this transfer was to be achieved.

Beyond the council level, decentralization reforms went as far as taking the management and governance of matters relating to healthcare facilities and communities to facility and community levels. In 1999, the management of healthcare in all facilities was similarly decentralized following the establishment of facility-level committees charged with the responsibility of facility planning, priority setting, and overseeing the use of resources and service delivery. Health Facility Committees and Boards serve as the most important decentralized platforms for ensuring the communities' and users' interests and preferences are considered in healthcare plans and decisions.

3.4. Measures to address stock out of medical supplies

The shortage of medicine and medical items was one of the problems that dominated health services management during the 1970s and 1980s. In many health facilities and especially at frontline facilities (health centres and dispensaries) patients used to die because of curable diseases such as malaria because of the scarcity of medicines. Inadequate finances and inefficiency were identified as the major causes of the above-mentioned stock-outs [6]. The economic deterioration in the country reduced the government's capacity to provide adequate amounts of medicine and medical items. The inefficiency in the distribution of the scarcely available medical supplies also exacerbated the situation. It was noted that before the reforms there was an inability to predict the spatial and seasonal pattern of infections and diseases in the country hence some facilities received more than what they needed while others were undersupplied [11].

According to the USAID report of 2010, in Lindi, Mtwara, and Tandahimba for instance, the average stock out rates of malaria medicines were 50%, 100%, and 75% respectively. On the other hand, in Masasi, Liwale, and Kilwa stock-outs were 0%, 13%, and 14% respectively [12]. The two mentioned factors made the management of the drug supply chain inefficient and ineffective [13]. As part of the reforms, the government through the Medical Stores Department Act No. 13 of 1993 established Medical Stores Department (MSD) as an independent department under the ministry responsible for health. The department was mandated to cost-effectively procure and effectively store and distribute approved medicines and medical supplies to public health facilities.

Further, as a result of these reforms, the old practice where MSD used to supply medicines to health facilities through district councils was relinquished and the new practice of delivering medicines directly to health facilities began and in times of emergency, facilities were allowed to purchase medicine from other suppliers apart from MSD. Further, effective from 2002, the former practice of supplying medicines to facilities based on requests (pull system) was abandoned and a new practice of supplying medicines based on calculated facility needs according to the burden of diseases (push system) was introduced. Based on this new practice, MSD would deliver the supplies to each facility four times a year after their requirements are approved. However, as a formality, facilities had to fill the Request and Requisition (RR) Forms and maintain their deposits with MSD.

3.4. Establishing and enhancing ethical standards

The prevalence of unethical conduct and practices was another problem that marked healthcare services management in Tanzania. Petty corruption, favouritism, nepotism, negligence, harassment, and mistreatment of patients were common in all public health facilities. These practices affected not only the quality of services delivered but also the image and trust of the public healthcare services. According to some of the interviewed respondents from Dodoma and Coast regions; measures taken to control these unethical behaviours and especially absenteeism involved the construction of health workers' houses; the introduction of performance

management tools such as OPRAS and CSC; and the enactment of laws forbidding the flaws. Further, guidelines, directives and circulars were released from time to time by the government to control these faults.

IV. CHALLENGES OF HEALTHCARE SERVICES MANAGEMENT IN TANZANIA

As part of the second study objective, the study was interested in finding out the manner and extent to which HSRs were able to address the challenges that traditionally dominated healthcare management in the country before the reforms. There were generally different viewpoints on the question of whether the introduction and implementation of the reforms had been able to address healthcare management challenges verified before the reforms. While some believed that to a large extent the reforms improved the management of healthcare, some consider the reforms failed to achieve their intended purposes. Moreover, there was also a large segment of people who viewed that healthcare problems even intensified than before the reforms. Apart from these diverging positions, there were also those whose stance was that the reform had both success and failure depending on the level of analysis and focus. To comprehend the whole picture of the outcomes; the forthcoming subsections will delve into some specific aspects of healthcare services management to identify the surviving challenges. The most important aspects in focus will be healthcare planning and supervision, financing, human resources management, private sector involvement, and ethics.

4.1. Double allegiance among healthcare staff

Double allegiance was a prevalent theme in all the gathered data analysed through thematic analysis, especially from the interviews with primary healthcare facility managers. Sometimes known as dual loyalty, double allegiance is one of the known bureau pathologies in public administration and management. It refers to a situation where the official is made to report or be simultaneously answerable to two superiors or two levels. This is indeed against the well-known principles of management and administration namely unit of command and span of control, which seek to maximize accountability and ensure a smooth flow of authority.

In many instances, respondents attributed this state of double allegiance to reforms that sought to devolve health workers' management and control to LGAs. Within a framework provided by the D-by-D policy and related changes, the government vowed to transfer most of the health human resources management functions such as hiring, supervision, payroll, disciplining, and others to LGAs under the DMOs and DEDs [14]. Astonishingly, while the devolution was promoted through the 'devolution policy paper' as an appropriate solution to some of the healthcare management shortcomings at the local level, the central government was adamant as it retained the control of the aforementioned human resource management functions. This uncertainty emerged from the introduced contradictory policies and legislations.

It was revealed for instance that the local government reform policy document and local government service regulation of 2000 granted the councils full responsibility for managing (planning, recruiting, rewarding, promoting, disciplining, developing, and terminating) healthcare staff within their jurisdictions. However, these powers were withheld by the Public Service Act 2002 and the Public Service Regulation of 2003. In this respect both the central and local governments had management powers over local government staff hence the staff had to be loyal to both of them something that undermined effective control of human resources. In this quandary, healthcare staff at the local level got confused regarding their training and career development prospects. While they had to satisfy the central government directives, they were stationed at the local level hence they had to obey LGAs directives as well. Moreover, LGAs in most cases were hesitant to carry out some training and career development plans for local staff fearing their trained staff might be transferred to other places without their consent because the transfer powers remained with the central government. The practice of centralized transfers was identified by most of the health workers who were interviewed as demotivating LGAs from training and developing healthcare staff since they are always cautious that they would be investing for loss. It was noted that this predicament was devastating for both the healthcare staff and LGAs. Many LGAs were unhappy to invest in training and professional development of local healthcare staff and then find that the same staff is deployed elsewhere without their consultation and sometimes without or much-delayed replacement.

Further, regarding human resources management, the reform assigned the ministry responsible for health to continue with healthcare policy oversight powers and supervision of tertiary healthcare facilities. On the other hand, the ministry responsible for local government was to coordinate primary healthcare and enforce healthcare policy in those facilities; and LGAs provide primary healthcare services. However, LGAs had limited jurisdiction when it comes to the supervision and disciplining of facility staff at different levels including facility managers. Since all three ministries had a stake in health management issues, the study found that in some cases they provided contradictory directives that drag local healthcare staff into dilemmas leaving them in a state of indecision and inflexibility when it comes to important decisions regarding the management of facility-level services. A related observation was provided by a facility manager from Dar es Salaam who observed that the powers of both the council and the two parallel ministries are recognized and are supposed to be respected. This kind of relationship is complex because at least it involves two kinds of duality: first, among

the CG ministries that sometimes tend to provide contradicting directives on one hand; and second, the LGAs which extend down from the council to the village government. This kind of divided loyalty creates inconsistencies that tend to confuse healthcare workers and sometimes affect the management of healthcare services.

4.2. Duplication of planning approaches

The study found further that there was a duplication of planning approaches as a result of HSR. The reform created duplication and unresolved links between planning approaches applied in the healthcare sector. The Ministry responsible for public service management encouraged the application of the Planning and Management Systems (PMS) approach while the Ministry responsible for Finance promoted the use of the Medium-Term Expenditure Framework (MTEF) approach.

Logically, the two approaches namely MTEF and PMS aim to achieve closely related things. However, their design and implementation as separate tools imply duplication of costs. For example, the MTEF as a strategic policy and expenditure framework seeks to balance what is affordable against organization priorities. It involves matching the estimated current and medium-term costs (normally three years) with the available resources to create greater predictability of funding according to priorities. It seeks to shift the psychology of budgeting from needs to the availability of resources mentality. PMS on the other hand provides the means to improve the effectiveness by aligning individuals, teams, and the service objectives and results. It is holistic in structure and scope and considers all aspects of performance, focusing on how each of the components can contribute to the desired performance outcomes at organizational, departmental, and individual levels. Therefore, integration of the two across the ministries would have reduced the cost but significantly maximized the benefits.

This lack of integration created unnecessary unresolved conflicting links between strategic, medium-term, and operational plans. Because of this, healthcare staff in strategic positions appeared to have not only lost focus and commitment but also got confused with planning prerequisite signals from these parallel approaches. As a result, little consistency and sustainability of healthcare programme management have always been difficult following the introduction of reform-related interventions. This confusion created the continuation of healthcare services management problems, especially in the areas such as healthcare planning and consequently performance in the healthcare facilities.

4.3. Ineffective monitoring mechanisms

Reform success requires effective monitoring systems to ensure that set objectives are met. It was found that the implementation of Health Sector Reforms in Tanzania was not accompanied by effective monitoring and regular inspection to ensure compliance to reform set standards. In all the healthcare facilities visited during the research, it was found that there was no adequate inspection to ensure that services are properly offered. Ministries, regions, and council authorities did not conduct regular visits to healthcare facilities to check how the actual delivery of services was managed. In the attempt to understand why there was limited monitoring, the key factors identified by senior officials at the ministries responsible for healthcare and local government were an acute shortage of financial, transport and human resources. Inadequate supervision and irregular inspection caused laxity among healthcare staff, created unhealthy communication in the healthcare system, and contributed to limited adherence to the guidelines set in line with the design of the reforms. Because of inadequate supervision, few improvements were gained as anticipated by the reforms. It was further found that because of ineffective monitoring and evaluation, healthcare facilities could not effectively implement approved plans. Thus, little institutionalization of monitoring systems in healthcare facilities negatively impacted the management and performance of healthcare facilities to the expected levels.

4.4. Inadequate supervision of healthcare facilities

Supervision was one of the areas that HSRs sought to strengthen to improve healthcare management and consequently provision of healthcare services. Effective supervision ensures efficiency in the use of available meagre healthcare resources to generate expected outcomes. To achieve this, the government focused on the improvement of the performance of core healthcare functions and decided to outsource non-core functions to other entities. In this regard, non-core functions such as preparation of food, washing, cleanliness, and security services were outsourced. However, managing these extended relationships required facility managers with managerial skills and competencies in managing contracts. Surprisingly, most primary healthcare facilities are managed by middle-level professionals (non-degree holders) with inadequate management training and the government did little to improve their management skills through on-job training. Due to that deficiency, these managers gave little attention to the aforementioned non-core functions to the detriment of the healthcare system. The inattention to these non-core functions has contributed to the misuse of facility

properties and consequently poor performance. This study observed a series of poor supervision incidences in healthcare facilities in the visited healthcare facilities.

Further, during the study, the slackness of health workers was witnessed in many facilities visited. Such sloppiness caused unnecessary long queues and congestion of out-patients, especially during peak hours of the day. It was discovered that such inattentiveness of healthcare workers was partly contributed by the limited management capacity of healthcare managers, the unwillingness of managers to hold healthcare staff under them accountable, lack of reliable internal communication, and weak facility management committees that could effectively supervise and oversee facilities healthcare functions.

4.5. Patronage in public-private partnerships

Another theme that emerged from the analysis was the existence of patronage that affected the intended effects of private sector engagement in healthcare services delivery as part of the HSRs. Patronage involves entering a formal contractual relationship in which one of the parties is favoured and protected by the other due to the loyalty that the party enjoying favouritism pays back to the one that favours them (the patron). Different types of patronage were identified during this study. In the first place, the government entered into partnership agreements with some private healthcare service providers to offer healthcare services. However, there were anecdotes that some of these service providers got those contracts because they had some godfathers in the healthcare system or the government at different levels. In Dodoma and Coast regions, some private health facilities had an agreement with the government to provide services to the communities. However, there were anecdotes that they were engaged because they had godfathers. As a result, the local authorities could hardly replace them with other providers who would be accountable and responsive. In addition, there were claims that the agreements with these providers were unclear, difficult to monitor, and in most cases motivated by self-interest.

In other cases, there were some agreements in which the government had agreed with the private healthcare facilities to provide healthcare services on behalf of the government. The government was providing subsidies in return. However, the private sector did not honour the agreements and created monopolistic situations that stifled competition that is recommended by HSRs as a means for improving the management of healthcare services.

The study further discovered that inadequacy of resources, lack of clarity regarding the regulatory framework guiding the partnerships, and inappropriateness of governance structures at the local levels were among the limitations for effective public-private partnerships. Most of the partnerships thus remained under the oversight of the central government rather than the community-level authorities. The absence of governance structure and especially effective partnerships coordination units at the local level made the monitoring of partnerships at that level difficult, hence poor healthcare services.

According to the interviewed senior official from the ministry responsible for health, private healthcare facilities in partnerships have little transparency in their performances and usually violated established referral protocols. In most cases, healthcare facilities in partnership offered unnecessary referrals to tertiary hospitals bypassing their above healthcare facilities causing unnecessary congestion in tertiary hospitals. This habit, which was also reported by the management of Dodoma and Amana hospitals caused an unnecessary burden to referral facilities. In that case, it is the observation of many interviewees that public-private partnerships had little to contribute to addressing healthcare management problems than claimed.

4.6. Inefficient referral management system

The other shortcoming identified in connection with the reforms has been that HSRs have not been able to adequately address referral challenges in the country. A healthcare referral is a process in which a healthcare services provider at one level of the healthcare system having insufficient resources (medicines, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in or take over the management of the client's case. Thus, a key reason for deciding to refer a patient is to seek another facility for therapeutic or diagnostic services not available at the initiating facility, more expert opinion regarding the patient's health condition; admission for better management of the patient, or additional or different services for the patient. To ensure that referral services are meaningful, there are procedural conditions that need to be met before the patient is given a referral. The referral chain is complete when these procedures at various

Despite the existence of clear procedural requirements, the study found many limitations in the current referral management system. First, the referral system in Tanzania considers only conventional healthcare services and leaves out traditional and alternative healthcare services. Second, the system follows the health facility hierarchy instead of the professional hierarchy. In that sense, it is rare to seek a referral to a facility at the same level. This has caused a lot of implications for the accessibility, continuity, and efficiency of referral

services. In most of the facilities visited, referral services were significantly affected by the lack of ambulatory services.

Further, Tanzania referring facilities, are rarely informed of the progress of their referred patients something which is against prudent referral procedures. It has become a practice in the country that once a patient is given a referral, it is as if they have been suspended or dispatched forever.

In addition to the aforementioned challenges, this research identified other six important to note challenges confronting the referral system. These challenges need to be addressed to improve referral services management in the studied facilities and the country in general. These challenges touch the facets of human resources, services delivery, financing, ICT, supply chain, and leadership and governance. In line with these challenges, the table also documents the solutions proposed by respondents to improve the management of referral services.

To improve the referral system in the country, the actions provided in Table 5.2 have been identified in this research to be useful. However, these are more general and health system-focused. Healthcare facilities need to understand the essence of referral services to ensure that referrals are efficiently and diligently managed.

4.7. Shortage of human resources

The healthcare sector is a very labour-intensive sector. Therefore, in a large country with a widespread population like Tanzania, delivering deserving healthcare services requires many qualified health workers from the dispensary to the tertiary hospital levels. However, for a long time, the sector is understaffed. Despite placing the human resources question at the centre of HSRs, acute shortages of this resource have continued relentlessly. The study revealed that the total number of available staff in the healthcare sector is less than half of the required number. All cadres of health workers, especially clinicians, nurses, pharmaceutical technicians, laboratory technicians, radiographers, physiotherapists, and health officers are insufficient. The shortage is more pronounced in areas with less modern social-economic infrastructures such as rural areas where social amenities are poor. In that regard, this study discovered that there is less shortage of health workers in facilities around towns and city centres and more shortage in facilities located in rural areas and those located away from service centres such as Seleji (Kongwa DC), Kisiju Pwani (Mkuranga DC), and Kongowe (Kibaha TC) in the study area. This is indeed a reflection of what is reported in other countries of Africa that have both rural and urban contexts [15, 16]. Most health workers prefer working in areas that are easily accessible and having access to basic human services including transport, schools, markets, electricity, and recreation and entertainment services. In this case, the management of healthcare services fails to balance the allocation of skilled healthcare professionals between rural and urban communities.

The persisting shortages of human resources for health have been in a cyclic interplay with the implementation of HSRs. While HSRs sought to ensure adequate availability of healthcare professionals in health facilities, the shortage of health workers has been affecting the implementation of HSRs in all the phases of the reform program. Observed from this study was also the limited motivation of health workers both in rural and urban facilities which affect the quality of healthcare services delivery. As observed by previous studies, the lack of motivation affects improvement in the performance of health workers [16, 17] and thus poor service management and delivery. Accordingly, as verified by previous studies, reform intended outcomes cannot be realized without adequate, well-balanced, and motivated human resources [18].

Apart from motivation, this study revealed limited support and participation of the health workers in the implementation of HSRs. As indicated in [1] 'Multiple Stream Framework', many reformers normally employ solutions that they believe are useful in their perspective as devised by academia, think tanks and other experts rather than communities. In that regard, HSRs in Tanzania were centrally initiated without adequate local consultation; but implementation necessitated cascading down to facility-level stakeholders. In some cases such as in the rural healthcare facilities, it was noted that even the waves of the reforms did not exist. This is partly because of the distance from the centre and a limited preference for skilled health workers to stay in rural areas. Thus, even those few health workers working in rural areas express a negative view regarding the reform-related changes.

Together with the above-mentioned government efforts to reduce healthcare staff shortages, the government also initiated efforts to improve the remuneration of healthcare staff, intensified the collaboration with the private sector in healthcare provision, and introduced retention programmes, in-service training, and other measures. However, despite these efforts, the problem of shortage of healthcare staff remained frightening. All these create evidence that HSRs have not been able to address healthcare services management and ensure the realization of intended reform outcomes.

4.8. Shortage of financial resources

Shortage of financial resources emerged as a cross-cutting theme during the entire reform. Money is needed at different levels to facilitate the planning and implementation of activities that relate to delivering

healthcare services. The finances used to deliver health services at different levels come from different sources. The sources for the councils include block grants, basket funding, and other sources such as local taxes, donors, and contributions from health funds and other user fees. The block grants are provided from the government budget of which the estimate is formulated in line with detailed micro-economic forecasts on future growth, inflation, and external export trends. In the budgeting process, the government in theory uses a bottom-up approach but in practice increment approach is the common practice. In this process, the requirements from the bottom healthcare facilities are compiled according to the respective year budget guideline. At the council level budget is prepared through CCHP. In practice, the incremental approach is used by simply reflecting the amount of funding from the previous year with a possible adjustment for inflation or changes in overall government spending. Because of this, CCHP prioritization and resource allocation tend to be rudimentary and ad hoc, leading to ineffective budget allocations.

The study found that health block grants and basket funds are allocated using a needs-based formula incorporating four factors (70/10/10/10: population 70%, poverty count 10%, under-five mortality 10%, district vehicle route as a proxy for the size of the area covered 10%). From interviews in Dar es Salaam, Coast and Dodoma, it was revealed that a substantial part of general tax revenue for the health sector allocated to councils is distributed through other mechanisms that potentially do not contribute to enhanced equity. One example is the matching grant provided to each council based on CHF revenue generated. While this is an incentive to the council to generate as much CHF revenue as possible and promotes the sustainability of these community-based sources, it has an adverse equity impact. It has been verified that the councils that can generate the most CHF revenue are those with a high-income population. Therefore, they are not in short of resources compared to the ones that cannot.

The research also revealed that the government budget and expenditure data in Tanzania are not disaggregated by rural-urban but by expenditure code and therefore the allocations of Personnel Emolument (PE) and Other Charges (OC) to local government were used as a proxy to show the rural-urban budget allocation shares. In this study, it has been discovered that, generally, regions with big cities and towns receive a higher allocation of funds than do more peripheral regions in remote areas because the allocation formula is mainly driven by population (70%). The factors that seem designed to increase allocation for rural areas were the vehicle route and the poverty rate but these factors carry very low weight in the allocation formula.

Further, it was verified that the PE budget is allocated based on where staff is stationed therefore it favoured urban areas because they have higher postings. It was found also that, the total government expenditure on health has not reached the Abuja target of 15%, and there was no clear strategy to increase it. It was also revealed that councils' funding for healthcare services was fragmented, uncoordinated, and had no clear information on how cost-sharing income is used. It was noted that, there were also delays in getting disbursements from the Central Government, and that Council healthcare services faced the problems of low geographical coverage of healthcare services, inefficient referral system, and poor healthcare infrastructure partly due to inadequacy of financial resources.

For instance, it was found that, up to now, many councils have the problem of inadequate funds for emergency preparedness and response; therefore, they cannot handle occurring disasters and emergencies effectively. It was learned that, though, public expenditure in the healthcare sector increased substantively during the reform period with both external and domestic sources of funds contributing to the rise; the increase was less than national and international targets. The allocation of on-budget resources over the reform period has been characterized by a gradual but steady decrease in the share allocated directly to LGAs, although their overall spending has risen significantly. In addition to the shortage of funds mentioned above, there was also the serious problem of the inefficient management of the available funds. So, the deeper problem has been noted to be more on the management of available funds than the shortage itself. This is evidenced by the difference in the impact of the same amount of funds provided to councils with similar characteristics.

4.9. Shortage of pharmaceuticals and medical supplies

The severe shortage of pharmaceuticals is very common in public healthcare facilities in Tanzania. The shortage is believed to be contributed by inadequate financial resources for the sector, poor record-keeping, mismanagement of the received funds, and also oversubscription of medicines. The CAG audit for the financial year 2020/2021for instance revealed that about 6.96 billion worth of medicines were unavailable ("out-of-stock") in 29 hospitals audited because the MSD did not provide the required medicines [19]. While this was happening MSD held 14.1billions of such hospitals contrary to public procurement regulations that require MSD to procure and supply medicines according to the approved plan [20]. At the same time, NHIF also refuted claims of 3.18 billion in the mentioned hospitals. Among the four visited hospitals, there was a shortage of medicines worth 925,610,207 shillings, while MSD held their 3,003,100,088 shillings without supplying medicines and NHIF refused to refund 940,395, 755 shillings to such hospitals after offering healthcare services. If the withheld and refused amount would have been provided to these healthcare facilities to procure medicines

on their own competitively, they would have remained with a surplus of more than three billion to improve other healthcare services (3,943,495,843 - 925,610,207 = 3,017,885,636). The details are shown in Table 5.3 below. This shows that not only the inadequacy of financial resources contributes to the shortage of pharmaceuticals in the country but also the management of the available financial resources and procured pharmaceuticals.

4.10. Persistence of moral and ethical complaints

One of the main issues widely complained about by many healthcare service users in public healthcare facilities was healthcare workers' little adherence to moral and professional ethics [21]. This research found that unethical behaviour such as bad language and favouritism, absenteeism, corruption, and negligence remains the common problem in all public healthcare facilities. This is revealed by both secondary and primary sources. In some of the facilities visited unethical behaviour of healthcare staff was astonishing. In some facilities, health workers were spotted charting during official hours instead of attending to thronged patients waiting for services.

It was also discovered that Complaints and Grievance Handling Systems and 'Ethics Complaints Framework which were part of the HSR interventions were not adhered to. Bribery was one of the main problems that were admitted by most of the respondents. Both the awareness and adherence to the Public service Act, 2002, Public Service Regulation, 2003, and Public Service code of conduct and ethics, 2005 among others were reportedly low in all visited healthcare facilities. Ethics Committees existed in every healthcare facility for the sake of being, but they rarely met to deliberate on ethical concerns at the facility level. The study generally found that the introduced mechanisms to reinstall ethical culture among healthcare staff were ineffective. Thus, introduced ethics control and management tools such as 'complaints and grievance handling procedures' were not effectively utilized. Similarly, constituted 'facility ethics committees' did not conduct regular meetings to handle ethical matters, create awareness against unethical conduct, investigate the presence of unethical behaviours and advise the facility management on the correct action to be taken. Because of these shortcomings, unethical practices in public health facilities continued despite the reforms carried out to eliminate them.

In this research, the identified reasons associated with the prevalence of unethical behaviour of public healthcare servants include little adherence to the professional code of ethics and conduct, little income received at work contrary to expectations, unfavourable working conditions, and irresponsible management. Because of these, the positive responses that are implemented under the HSR as a reform package can hardly yield the expected results. Therefore, unethical behaviour continued and in some cases is likely to intensify. The respondents suggested that more efforts should be done to address ethics-related concerns in any of the innovations implemented to address healthcare service management and delivery problems if actually, the government needs to improve healthcare services in Tanzania.

V. CONCLUSION

Reflecting on the findings, it is clear that the HSR had positive transformative intentions. The design and implementation of the reform-related programs and activities were expected to comply with the obvious requirement to transform the minds and hearts of healthcare stakeholders to steer and respect Ministries and the inclusion of facility-level and community-level stakeholders was relatively weak. Therefore, apart from the fact that there were so many factors that affected the realization of the reform outcomes as expected, it is clear that the failure to a greater extent contributed to the inability of the reforms to address the existing health services management problems. A follow-up in-depth study is recommended in the future to explore how the distribution of roles and responsibilities between three main actors affects the implementation of healthcare reforms-related programs and interventions within the councils in Tanzania. These actors are the ministry responsible for health, the ministry responsible for local government, and local government/grassroots authorities.

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