UNIVERSITY OF CAPE TOWN

THE PRIVATE PRACTICE WITHIN PUBLIC HOSPITALS IN TANZANIA: AN EXPLORATOTY STUDY AT MUHIMBILI NATIONAL HOSPITAL AND BUGANDO MEDICAL CENTRE

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DECLARATION

This research in its original form is my personal work and has never been submitted to this University or any other higher learning institution for any academic award. Other sources are fully acknowledged.

Signed by candidate

JOSEPH ELIEZA CHILONGANI

Date 14 JULY 2003

This thesis has been submitted for examination with my approval as the University supervisor.

EDINA SINANOVIC

Date: 14 July 2003

DEDICATION

I dedicate this thesis to my parents Reverend Canon Elieza Chilongani and Mama Eunice (The late) who from the early start raised us in a light of understanding the importance of education, and with little resources they had took us to schools. It is because of their inspiration and prayers I have achieved this success. Thank you abundantly. I also dedicate this work to all my brothers and sisters who have been so supportive and encouraging to me throughout the period of my course. Especially to my brother and best friend Shadrack; thank you so much for your constant encouragement.

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LIST OF ACRONYMS

IPD	In patients Department (patients admitted in the wards)
BMC	Bugando Medical Centre
LSHTM	London School of Hygiene and Tropical Medicine
MNH	Muhimbili National Hospital
MOH	Ministry of Health
MOI	Muhimbili Orthopaedic Institute
NHIF	National Health Insurance Fund
HCP	Health care providers
NIMR	National Institute for Medical Research (Tanzania)
OPD	Outpatient Department
PPM	Public Private Mix
Tsh	Tanzanian Shillings
USD	United States Dollars
VIP	Very Important Persons

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ABSTRACT

In the late 1980s, many governments in the low-income countries could not fund their health care budgets adequately due to poor availability of financial resources. This resulted into deterioration of the public health sectors in general. Inadequacy of consumables and other supplies, and low payment for health workers were among the problems faced. Governments in some of these countries introduced public private mix (PPM) to address these problems. In 1996, the government of Tanzania allowed private practice in public hospitals called 'the fast track' service. This study investigated the organizational and management system of this type of PPM, its impacts and the factors determining people's demand for the fast track service.

Data was collected through interviews with health care providers and patients, and document reviews. Systematic and random sampling methods were used to select participants. Data was analysed using STATA package.

The study found that the executive directors of the hospitals headed the fast track management teams, with the executive committees coordinated by the executive secretaries. The committees included specialist doctors involved in the PPM. The study findings also show that about 85% of health care providers reported that the practice played an important role in supplementing the hospitals' budgets as well as health workers' incomes. In one of the study hospitals, the "fast track" services contributed more than 26% of the total income during a 5-year period. Likewise, it has significantly improved the access to health care services. This was achieved through retaining health workers, improving the infrastructure, adequate supply of consumables and drugs, and raising funds to subsidise treatments for poor patients. However, the fast track services resulted in specialists spending less time with public patients. In addition, the standards of private care were still lower in the "fast track" when compared to what is expected in a private health care setting, and private patients were offered very poor diagnostic tests and investigation services. Concerns were also raised about the poor management of the funds generated from private services.

The study also showed that the majority of people utilizing private services were those in permanent employment and with higher education and income levels. About 90% of these patients were urban inhabitants who paid their bills out-of- pocket.

This study found that the practice was beneficial to both health care providers and patients. The main recommendation is that there should be a strong body that will constantly monitor and regularly evaluate productivity, quality, and equity, and to ensure that the practice does not impair access of the majority of people to health care services.

CHAPTER 1
BACKGROUND

1.1 Introduction

In many developing countries private health sector has substantially increased in the past 15 –20 years to complement the public sector in health care provision (Hanson and Berman, 1998). In these countries therefore, involvement with the private sector came following the structural reforms and have been achieved in different degrees. A substantial increase in the private sector was reported in India (Bhat, 1993), while a survey done in Bangladesh found that the introduction of private sector increased access to health care and improved the income of government-employed doctors (Gruen et al, 2002). Likewise, a study done in Tanzania, found that approximately 500 organizations and individuals have registered with the ministry of health as private health care providers since early 1990s (Mohamed et al, 1996). These increased numbers of facilities and health workers have made it possible for 75% of the population to be within 5 km or an hour walking distance from the health facilities (Ministry of Health, 1996).

The reasons frequently given for increasing the role of the private sector are its perceived higher quality and efficiency in service production. Additionally, it is argued that promotion of the private sector would generate extra resources and allow the redistribution of existing government resources to poor people, thus enhance more access to health services and cop with the disease burden. Involvement of private sectors in health sector is called public private mix (PPM).

Public/private mix (PPM) in health care refers to the formal and contractual relationships between the two sectors (Goudge, 1999). The mix can be of various forms depending on who pays and who provides health service. The different forms / types of the mix are *inter alia:*

- Public sector finances and provides health care.
- Public sector finances and private provides health care (the government finances private providers through contracting or subsidizing private care providers).
- Private sector finances and public provides health care (private agents finance health care services which is delivered by public agents e.g. user fees).
- Private sector finances and provides health care (Government's role is only regulatory).

In Tanzania, all these forms of mix do function in different magnitudes in different places, depending on the capacities of both public and private hospital in a particular area.

This study focused on the type of mix in which services are both financed and provided privately using public hospitals and resources. For instance leasing out public beds/wards for private patients, where private providers pay to use public facilities and or some forms of limited private practice where public doctors are allowed to spend a specified number of hours for private practice within public facilities, where they usually work (Sinanovic, 2001). This new type of private public mix was not common in the country and so far is localised in tertiary hospitals only. This study therefore, aimed at exploring the structural organisation of the mix and impacts and implications it may have to the health care provision system with regards to quality and access to health services in both sectors. Further, the study looked at the patterns of utilisation of the private services in these public hospitals.

1.2 Background of the private health care sector in Tanzania

Tanzania is located in the eastern part of Africa and has a population of approximately 33.5 million (Tanzania National website, 2002). Before 1991, 80% of health services in the country were under government responsibility and 20% under voluntary organizations. Voluntary organizations were mostly related to religious organizations that owned 19% of the health facilities in the country. For profit private practice in health care was abolished in 1977 following the Arusha declaration (Ahmed et al, 1996). This had a negative impact on the health delivery system in the country and was therefore re-legalized in 1991 (see table 1 below). Non-governmental organizations and individual qualified medical practitioners and dentists were permitted to manage private hospitals, with the approval of the Ministry of Health (Tanzania National Website, 2002). The majority of private care facilities were small-scale dispensaries owned by individual physicians and staffed by medical assistants and nurses (Ahmed et al, 1996). Most of these facilities are located in urban and peri-urban areas.

Table 1: Distribution of different health facilities in Tanzania

Facility	Agency					
	Government	Parastatal	Voluntary	Private	Others	**Total**
Consultancy / Specialized Hospital	4	2	2	0	0	**8**
Regional Hospitals	17	0	0	0	0	**17**
District Hospitals	55	0	0	0	0	**55**
Other Hospitals	2	6	56	20	2	**86**
Health Centres	409	6	48	16	0	**479**
Dispensaries	2450	202	612	663	28	**3955**
Specialized Clinics	75	0	4	22	0	**101**
Nursing Homes	0	0	0	6	0	**6**
Private Laboratories	18	3	9	184	0	**214**
Private x-ray Units	5	3	2	16	1	**27**
Total	**3035**	**222**	**733**	**927**	**31**	**4948**

Source: Tanzania National Website (2002)

1.3 Problem statement

Promoting public private mix in provision of health services is one of the operational/specific objectives of health sector reforms in Tanzania (MOH, 2000), as one of strategies to improve health care services. Due to limited resources in provision of health care, the government is trying to use the private sector as an alternative to meet these objectives. Different types of partnerships between public private sectors were established and have been operating. One, which had never been in the system, is the 'fast track' service.

Although, this particular type of PPM has been operating for more than 5 years, still little information is uncovered on the benefits, if any, to the Tanzanian public health care system. No details are known of the positive and negative effects of this mix, who uses the private service and why, its magnitude and the way resources are shared between the two sectors within these hospitals. This study aimed at investigating these details and based on the findings make appropriate suggestions to policy makers and other stakeholders on mechanisms that justify existence of the mix and motivations for improving its performance without jeopardizing public services meant for the poor majority in the population.

1.4 Justification

Regarding that the private sector motives are always different from public ones and that the perceptions of quality of services are also different in the two sectors, the study attempted to identify areas that needed to be strongly monitored so that the mix complies with objectives of the government in health care provision.

Hypothetically, there was a need to pinpoint a kind of mix that would create a balance between increasing financial incentives for health care providers and enabling many people access good quality health services, especially the poor people who mainly rely on publicly provided services. Fast track could be the proper one, if would be appropriately planned and managed. A study was therefore needed to see why people utilize these private services and whether patients' decisions to opt for private care are influenced by the co-existence and ways these sectors interact.

It was also necessary to investigate extensively the output and outcomes of this mix before thinking of scaling it further to the lower level health facilities in the public health care system. Based on findings of the study, recommendations would be developed for appropriate policy

making and precise planning of best ways this mix can be managed to comply with the proposed government objectives in health care provision.

1.5 Research question

The study is trying to answer the question, "what is fast track service, what impacts fast track service has to the general health care provision system and what factors influence people in using the fast track services?"

1.6 Aim and objectives of the study

1.6.1 Aim of the study:

The aim of this study was to explore on the private care services conducted in tertiary public hospitals (fast track services) in Tanzania, examine the role and impacts of the private sector in this type of mix and identify major influential factors on utilisation of the private services in these public hospitals.

1.6.2 Specific objectives of the study were:

1. To describe the "fast track" service as a new form of public private mix, i.e. use of public facilities and resources to provide private health services to private clients.
2. To establish the role that the introduction of "fast track" has played in improving quality and access of care to the public sector in place, which would mean to identify the positive and negative impacts this mix has had to health care provision in these hospitals and its repercussions to the public health care system generally.
3. To examine patterns of utilizing fast track services in relation to:
    - Income levels
    - Education levels
    - Urban vs. rural habitants
    - Mechanism of paying for the services

1.7 Format of the thesis

The next chapter reviews the literature on the role of the private health sector and public-private mix. Chapter three outlines the methodology, which includes study design, sampling techniques, and data collection methods and data analysis. The results of the study are presented in chapter four while detailed analysis and discussion of these results is presented in chapter five. The final chapter includes the conclusions, policy implications and recommendations.

CHAPTER 2

LITERATURE REVIEW

Introduction

Public - private mix in health sector are defined as the mechanisms by which the two sectors collaborate, combine their efforts, co-act, co-exist and conflict in the provision, financing and regulation of health services. The partnerships can be tied in formal and contractual agreements on who should finance and or provide services to whom, how and when (Goudge, 1999). Most of the literature describe public private mix in health sector as the existence of the two sectors sharing functions of financing and providing services to the same general population, using the same health workers who practice dual job holding (Gruen et al, 2002), and sometimes using the same infrastructure, management and other resources.

According to Propper and Green (1999) the central arguments made for a mixed system in provision are that first, monopoly public provision is inefficient and competition will improve efficiency, and second, that the private sector will help inject competition. In this case, to be welfare improving, a large role for private sector suppliers must also be accompanied by competition in the market and/or for the market, between suppliers. Supporting these arguments Armstrong, Cowan and Vickers (1994) state that private suppliers who are monopolists may have as few incentives for efficiency as those that are publicly owned.

Propper and Green (1999) still argue that even where there is no direct competition, comparison with private sector may be helpful in improving quality of the public sector in place. They continue by saying that private sector can be used as a "benchmark" for the public sector. Public sector in these hospitals can be compared with private ones in terms of output and efficiency while private practice in public hospitals can be compared with other private hospitals in terms of costs and output.

It is therefore timely and recommendable for governments in developing countries to incorporate the private sector in their health sector reforms, as it is likely to yield positive outcomes and improve general performance in the sector. However, one of the major barrier to coherent, effective policy is simply that very little is often known about the characteristics of the private sector and its performance that could be used to structure effective policies (Newbrander, 1997). Most market-oriented health care reforms are pressing ahead with little information on how private providers perform in transition economies (Nordyke 2000). Unfortunately the health care

sector in most of sub-Saharan African countries have been taking place following policy advices from developed world, which do not rely on the reality of conditions in these countries. Consequently, the implementations of most of these reform policies have had undesirable effects in the health care systems in these countries.

This chapter tries to highlight some of the issues associated with public - private mix that could be of importance to consider when introducing private practice in public hospitals as part of the reforms in health sector. It highlights the positive and negative aspects of the reforms, and the role that state can play towards achieving the intended objectives in health care provision.

Experiences from other countries

Like in Tanzania, in Bangladesh private health sector has substantially increased and has improved access to health care especially in the urban areas. About 80% of doctors who are employees of the government work in the private sector holding dual jobs for financial incentives (Gruen et al, 2002). However, despite little payment, many of them are not ready to drop their public practice for reasons of service satisfaction, prestige and status of the government jobs and job security. Many of these doctors are even considering dropping off private practice if the public sector would pay them higher incomes. It was also found that 68% of the doctors said they would like to use government facilities for private practice if allowed to do so (Gruen et al, 2002). This tendency was more pronounced in the sub-group of doctors employed in tertiary health care facilities.

Roenen et al (1997) highlight the individuals' coping strategies of doctors from sub-Saharan Africa. One of the strategies mentioned was private practice. None of these doctors mentioned to have been using the public facilities and resources for private purposes, though some mentioned that other doctors were doing it. Other sources of incentives mentioned were secondary job and gifts from patients. These could lead to undesired effects for health care delivery through transfer of resources (qualified personnel, time and material resources), from the public to private for profit sector, like was the case in Malaysia as reported by Aljunid (1998). This probably, could be prevented if these doctors were legally allowed to practice private services in their places of work. It only needed a well-organized management and monitoring system.

In a study by Roenen et al (1997); and Goudge (1999), it was found that many doctors from sub-Saharan Africa commended that the private sector provided better quality service and that it could also be a good way of containing consultant doctors from going for private practice during public service hours, and maximizing the use of human, space and other resources in the public

facilities. This would have an effect of increasing access of health services to many people, as reported in an expenditure survey in India, which showed a higher utilization of private sector than public sector (Bhat, 1993). A similar survey done in Dar es Salaam, Tanzania, showed the same trend where 41% and 35% of the population used private and government services respectively (Wyss et al, 1996).

In a South African study by Sinanovic, (1999), it was found that there was a spare capacity in public hospitals in terms of beds, equipment for pathology, radiology, catering and cleaning, theatre time and packing space. The same situation could be at Muhimbili and other tertiary hospitals in Tanzania, which could have the resources and capacity enough to accommodate the additional load of patients from the private sector.

Another study from South Africa reported that in several areas the Department of Health have started upgrading facilities and creating private wards with great sophistication for fully paying patients (Goudge, 1999). Sinanovic (1999) found that some of the positive benefits of such a mix are that hospital assets (buildings and equipment) would be maintained using the income generated from private practice and not left to fall into disrepair. In many public hospitals in developing counties, buildings and equipment get old and cannot be repaired because there are no funds for that purpose. Private practice can therefore, be an alternative solution to this problem.

It is possible that the presence and influence of role model and ethical rules are strictly observed in this kind of a mix. Roenen et al (1997) highlight that in the climate of permissive presently reigning in public health services in Africa, it makes sense to speculate that the ethical rules and ideas physicians have about what is socially accepted for doctors remain important. These rules should try to keep health workers behavior from degenerating into a purely commercial market approach in private sector but maintain hard working quality in the public sector as well. Under this kind of a mix, doctors work in both sectors at the same place and most likely they spend more time serving public patients than private ones. They are not likely to sacrifice their responsibilities on the public sector clients, for a few private clients, who are also potential public clients in the future. Sinanovic (1999) warns that private patients should not be given preferential treatment to the detriment of public patients.

The positive outcomes of increasing the role of private sector

According to the neo-classic argument on private provision, introducing a profit motive encourages providers to become more efficient in their use of resources as they bear financial risk

for their decisions (Nordyke, 2000). He further states that competition between private providers leads to higher quality as doctors strive to attract and keep patients. Also the advantage of the private provision to the public sector is that it leverages private resources to reduce the burden on publicly funded care.

To verify the argument above, Van de Ven (1996) found that the introduction of competitive elements in Sweden appears to have resulted in a substantial increase in physicians' productivity. The number of hospital beds more than halved between 1980 – 1995, leading to some people believing that there was an over capacity in hospital provision. The same author point out that in the Netherlands the introduction of selective contracting on the delivery side in the 1990's has already resulted in reduction of the prices for medical equipment between quarter and a third. It is therefore anticipated that such positive effects could be experienced with introduction of this partnership in the health delivery system in the country like Tanzania. In addition, Gruen et al (2002) suggest that governments in many countries may allow this joint action, as it could be a way of mobilizing further resources, enhancing equity of access for the majority of the population as well as retaining qualified staff in the public health sector. Moreover, there is a great possibility for cross-subsidization and positive collaboration in terms of services utilization, supply of consumables and drugs, diagnostic technology and even expertise.

In some countries private practice in public hospitals was started as a means of getting doctors to work in the departments that they were not interested in. Roenen et al (1997) mention of this practice in West Africa, where a shift of working at casualty department on private base would pay an equivalent of one month's salary. This was reported as a positive move.

A stabilizing effect on the side of doctors by allowing them to attain a standard of living that is closer to what they expected, is another advantage. The time spent for private service permits the realization of their professional goals, which are blocked by deteriorating conditions in the public hospitals. The well-developed infrastructure and human resource invested in the public sector could be exploited fully at cost or even at market price if wealthy people pay for these services (Frank, 1993). This could constitute a source of finance to subsidize health care for the poor, which is the primary mission of public health sector institutions.

The negative outcomes of increasing the role of private sector

There are many postulates however, about the pros and cons of having the two sectors run together, and the significance of each of which depends on the type of the mix, magnitude of each sector, management and other socio-economic determinants factors.

Propper and Green (1999) assess the dynamic of these relationships in terms of private financing, use of public sector and attitudes. They further state that the argument that private financing will lead to a downward spiral towards a 'poor service for the poor' depends upon the premise that support for public sector financing is negatively associated with private sector demand and the demand for private alternative is affected by the quality of the public sector. This argument warns of the possibility of abuse of the public sector in favor of the profit oriented private practice that can easily be experienced in a poorly managed 'fast track' type of mix.

There is a concern on the effect the private sector may have particularly on the human resources in the public sector. As public sector pay, in poor countries with transitional economy to market system, is often fixed by the government policy at a very low level relative to the private sector, the pay gap may draw doctors into the private sector, leaving public clinics understaffed or staffed with less qualified doctor (Nordyke, 2000). In a fast track setting however, this effect may be equally experienced as more qualified doctors (specialists who only practice private care), may become more occupied with private services, ignoring their responsibility to the public sector and leaving younger doctors to take care of the public patients including the referral cases.

Some studies furthermore challenge the 'fast track' mix that such a practice is prone to a possibility of diversion of resources from the priority areas of public health care to the profit oriented private sector (Gruen et al, 2002), since private providers are always profit oriented.

The role of the state in a public private mix system

In their study in health care reforms, Saltman and Figueras (1998) concluded that the greater the reliance on market mechanisms, the greater the need for an invigorated state role. In Sweden it was observed that the lower down in the public sector they decentralized power over the health system, the more important it became to have a central structure to monitor and evaluate performance and prevent opportunistic behavior (Propper and Green, 1999).

New management advocates argue that the private sector can play an important role in service delivery. Theoretical substantiation is based on the fact that by being profit-driven, private sector would be motivated to be responsive to consumers and maintain efficient services (Moore, 1996). However the argument that the growth of the private sector has spillover effects in the form of expansion of access, reduction in administrative costs and financial constraints of the government and the possible increase in overall sector efficiency may hold as long as the growth is well planned and regulated.

The principal-agent relationship that exists in the health care market is another reason for the state intervention in the activities of the private sector to protect the interests of the clients. (Barnum and Kutzin, 1993) Normally, the private for profit and the state have divergent objectives. While the state aims at equitable service provision the private sector is driven towards maximizing profits. Bennett at al (1994) suggest that the challenge for policy makers is to identify the mechanisms and structures to enable the public sector learn more about the private sector. Only if more information about the activities of private sector and state objectives is available, this divergence in objectives can be reduced.

It is therefore suggested that with this growth of the private sector the state would be better placed to monitor output and outcomes, focusing on initiating broad strategic objectives for the entire health care system. It also should be able to regulate public and private providers to make sure that objectives are achieved, especially before thinking of up scaling the fast track services to the lower levels of public health care system.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the descriptions of the study design, methods used in data collection and how the actual data collection process was conducted during this study. Issues of sample selection and sample size as well as brief descriptions of the study sites will also be included in sections of this chapter.

3.2 Study design

This was a descriptive cross sectional; hospitals based study that attempted to describe the situation of the private practice in tertiary public hospitals, as pertained to at the particular time of this study.

3.3 Description of the study sites

The handling capacities of these hospitals are summarized in table 2 below.

Table 2. Description of the study hospitals

Sites	Muhimbili National Hospital	Muhimbili Orthopedic Institute	Bugando Medical Centre
Key features	National Referral Hospital	National Referral Hospital	Zonal Referral Hospital
Location	Dar es Salaam; Cater for central and Eastern zones. Receives patients from other referral hospitals	Dar es Salaam; Cater for central and Eastern zones. Receives patients from other referral hospitals	Mwanza: Cater for Lake and Western zones.
Range of Services	All curative and non-curative, teaching, research and preventive services	All orthopedic & neural surgeries, research, teaching and physiotherapy	All curative and non-curative, teaching, research and preventive services
Staff employed (Full-time)	Professional medical staffs (Specialist doctors, nurse, pharmacists, lab personnel, etc), Non-medical staffs (Drivers, Administrators, accountants, etc)	Professional medical staffs (Specialist doctors, nurse, pharmacists, lab personnel, etc), Non-medical staffs (Drivers, Administrators, accountants, etc)	Professional medical staffs (Specialist doctors, nurse, pharmacists, lab personnel, etc), Non-medical staffs (Drivers, Administrators, accountants, etc)

Data for this study was obtained from the three sites. However the study proposal was designed in a way that Muhimbili national hospital and Muhimbili orthopedic institute would be considered as one site, as the two sites are located at one place (formerly they were under one administrative organ) and that there is no overlapping of activities between the two. Regarding the number of

respondents obtained from both sites, the study referrers MOI as part of MNH, although in some occasions it may be referred as an independent unit.

There are a total of four referral hospitals in Tanzania namely:

1. Muhimbili National Hospitals (MNH), providing services for the Eastern and Central zones
2. Kilimanjaro Christian Medical Centre (KCMC), cater services for Northern zone
3. Bugando Medical Centre (BMC), offering services for lake and Western zones and
4. Mbeya Medical Centre (MMC), which cater services for South and Southern Highland zones.

Muhimbili was chosen to be a study hospital because it is a National Hospital and located in Dar es Salaam. As a national hospital, Muhimbili receives patients from all over the country and thus has a greater diversity of patients in terms of their geographical origins and in their socio-economic status. These would affect the patterns of utilization of private services, which is one of the aspects this study wanted to learn about, and it is more likely to be found in this hospital. Secondarily, being located in Dar es Salaam, the commercial capital of Tanzania, makes it possible to find the diversity in socio-economic status of people that can represent the situation found in the rest of the country.

Bugando was selected for being located in Mwanza, which is the second city in the country, thus has some similarities with Dar es Salaam in diverse in socio-economic status of its inhabitants. In Addition, Mwanza region has got larger scale commercial activities in mining and fishing industries, which involve foreign citizens. These result to interactions among people that may affect their health status and their choice for using the private services. Moreover, local people from areas around the city of Mwanza represent the real of conditions of many local indigenous in the country, whose income largely depend on subsistence farming. Their decisions to use or not to use private services would give a good picture in the study.

3.4 The study population and eligibility criteria

The study population in this research included all doctors employed in the public sector in the study referral hospitals, who were practicing fast track at the time of the study, and patients who were receiving care in the fast track services as outpatients and those who were admitted in the private wards. Only patients who could speak for themselves were eligible.

Other people from any departments would be involved as per requirements of the study and need for the study data e.g. from the financial office, laboratory, records etc.

3.5 The sampling techniques and sample size

A purposive sampling method was applied for selecting respondents among health care providers. It would not be feasible to use random sampling because only specialists were involved in private practice and all were eligible. A researcher visited each department and gave self-administered questionnaires to all willing specialists who would then set the date for a researcher to collect the completed questionnaires. In each hospital, two respondents were interviewed with an in-depth questionnaire. A total of 42 health care providers were interviewed (see table 2 blow). These include 40 self-administered interviews and 4 in-depth interviews, 2 from each site (1 MNH, 1 MOI and 2 BMC). The principal investigator conducted all interviews with health care providers.

As for the interviews with patients, a random selection method was applied to selected respondents. Interviews were conducted in a random order regarding the departments, as attendances to the OPD clinics were different in different days. Likewise, the number of patients in the wards was different with the different departments. Patients were interviewed as they exit from the clinic after consultations and those in the wards were interviewed in the wards. A total of 153 patients were interviewed. These include 147 face-to-face interviews and 6 in-depth interviews, 2 from each site (MNH, MOI and BMC). On aggregate there were 207 different sources of data for the whole study as shown in table 3 below.

Table 3: Data collection tools and the quantity of data achieved in each facility

Source of data	Muhimbili National Hospital	Muhimbili orthopedic Institute	Bugando Medical Centre	Total
Exit Interviews	54	42	51	**147**
Self-administered interviews	20	8	12	**40**
Interviews with management	1	1	1	**3**
In-depth interview with health workers	1	1	2	**4**
In-depth interviews with patients	2	2	2	**6**
Document review	1	1	2	**4**
Total	**81**	**56**	**70**	**207**

3.6 The survey instruments and data collection process

Both qualitative and quantitative data were collected from primary and secondary data sources. Primary data was obtained from the interviews with informants while the secondary data was obtained from reviewing documents as outlined in details below.

The main instruments for data collection were the questionnaires for interviews with health care providers and patients and documents obtained from the hospitals. The interviewer first visited the executive directors in each hospital to seek the permission to conduct the study. After the permission was obtained an in-depth interview was conducted with the director or a person responsible for coordinating private services. The interview was conducted in English, and aimed at collecting the information on the general management of private sector. Relevant policy and management documents were requested and acquire at this stage for review.

Following that, all eligible health care providers in each department were interviewed. Health care providers were interviewed using the structured, self-administered questionnaires. Interviews were carried out on departmental order in different days of the week to avoid confusions and the possibility of bypassing some of the departments. Every respondent was given an information sheet to read and if one agreed to participate in the study would be given a consent form to sign. Only after signing the consent forms a questionnaire was given to the respondent to be collected in his/her convenient time. The questionnaire contained sections that would collect information about the role and impacts of the private practice to the public sector in the respective hospitals. The in-depth questionnaire with health care providers included information about all the objectives of the study, and was conducted in form of conversation after building rapport with the respondents to win their confidence.

Exit interviews were administered to randomly selected patients as they left the consultation rooms using semi-structured questionnaires. Two interviewers were hired and trained to carryout the interviews with patients. The interviews were conducted in different rooms to ensure confidentiality and were in Swahili language, which is a national language in Tanzania. The majority of people clearly understand the language. Professional linguists were hired to do the translations English - Swahili and back translations of the questionnaires and other documents. The interviewer read the information sheet in Swahili to the respondent, and if the respondent agreed to participate in the study, he would sign the consent form, after which the interview was conducted in Swahili language. The semi-structured questionnaire contained sections relevant to

objectives of the study and particularly how patients viewed the introduction of private practice in public hospitals. Questions were also set to investigate about who utilize private services and why, which would bring a sight about factors linked with the pattern of using the services. Likewise, in-depth questionnaire with patients included relevant information to be obtained from patients.

All interviews were conducted commencing with a rapport to get respondents relaxed and build confidence. It was particularly important for patients to know that their health care providers would not see information they were going to give, which was successfully done. At the end of each interviewing day, the Principal Investigator reviewed all the completed questionnaires to countercheck for any possible errors made by interviewers, and where necessary and possible the interviewers would be requested to correct the errors.

The necessary documents were obtained from the managements and financial departments. Review of these documents was done and where necessary copies of the documents were obtained with permission from relevant authorities, for further analysis. All results were compiled and taken for analysis.

3.7 Data management and analysis

All the required information was contained in the questionnaires. All the self-administered and face-to-face questionnaires were entered using DBASE program, then transferred into STATA program for the analysis. STATA was used in obtaining the statistics and table of results to show how the different variables interact.

Results obtained from in-depth interviews with health care providers and patients were presented in a table of comments and were used in discussion and comments. Information obtained from review of documents was included as reference in the text and was fully acknowledged.

3.8 Ethical approval

Ethical approvals for this study were obtained from UCT ethics committee and from the ethics committee of the National Institute for Medical Research, Tanzania.

3.9 The scope and limitations of the study

The design and hence results of this study could have been affected by the following limiting factors:

1. Biases
   - Selection bias- selecting only patients who were receiving private care (fast track) could have introduced the possibility that only wealthy people were more likely to be involved in the study.
   - Information bias- Interviews were done only with doctors involved in the fast track practice. These doctors were more likely to give information in favor of their situation. They would most likely report of the positive aspects of the practice. Likewise, patients using fast track services would most likely report in favor of the practice.
   - Recall bias- having paid money for the services, private patients were more likely to remember all the services received and the perceived quality for these services. Over or under stating was most likely to happen in this case.

2. Non-responses- this resulted from some respondents not returning the completed self-administered questionnaires and were lost to trace, other respondents returned incomplete questionnaires while others refused to participate in the study.

3. The study used cross-sectional data, which might not accurately depict the trends in peoples' choices for the fast track services with time as this may differ with change in time. However, despite these limitations the study explored significant findings about the fast track services.

CHAPTER 4

RESULTS

4.1 Description of the private services

4.1.1 Introduction

Introduction of health sector reform in Tanzania in 1990's realised the role of private sector as an important player in health care provision. Initially, the government only allowed public sector employees (doctors, nurses, laboratory workers) to be involved in private practice as an extra income generating activity. This measure created problems like private hospitals charging fees unaffordable to the majority of people, and doctors who owned private hospitals or practiced in private hospitals split their allegiance. To overcome these problems the government in 1996 passed a Parliamentary Act that allowed government health delivery institutions to practice public-private mix (PPM), henceforth limiting health care providers employed by the government from practicing in or owning private hospitals, but conducting private services in these institutions.

Following this Parliamentary Act in 1996, referral hospitals took the initiative forward and started the practice. Muhimbili Orthopaedic Institute (MOI) started the practice immediately in 1996. A year later, Muhimbili National Hospital (MNH) established public/private mix and called it "Fast Track Service," while Bugando Medical Centre (BMC) began the practice in 1998. Fast track then, became a common term for this type of PPM in all the hospitals and in this report it is frequently used to demote private practice within public hospitals.

The Fast track practice covers all clinical and non-clinical services that are offered by the public sector and are within the capacity of that particular hospital. Fast track does not employ its own staff but uses employees of the public sector in place. As an internal arrangement, only specialist doctors were allowed to practice fast track services. The reason being for most patients having paid higher fees would prefer receiving care from highly qualified medical personnel. It also aimed at refraining unnecessary complaints from patients for mishandling of these highly sensitive patients, hence spoil reputation of the practice in the market. Other cadres were participating according to intra-institutional arrangements.

This chapter presents results of the survey conducted in the government hospitals practising PPM in the name of fast track. It covers the major reasons for establishing the practice, outlining how the practice is being run and the advantages and disadvantages of the practice to the health care

system in Tanzania. Finally it presents the socio-economic characteristics of the patients who use fast track services in terms of their education levels, income levels, types of dwelling, payment mechanisms and the degree of access they have to private services. In interpretations of results in all tables, in most cases Muhimbili is mentioned to denote a combination of both MNH and MOI, except for tables 5, 6, 7, 8, 9 and 16.

4.1.2 Reasons for establishing public/private mix

The deterioration of the infrastructure in public hospitals had gone beyond imaginable state due to the inability of the state to finance in full hospital budgets. Moreover, poor payment had demoralised health workers resulting into internal as well as external brain drain. The establishment of fast track type of PPM would therefore, aim at increasing the hospitals' capacity to improve the infrastructure and subsidise treatments for poor patients, retain health care providers (HCP) in their hospitals by improving their working environment and enabling them earn extra income. Another aim of fast track would be to increase access of patients to quality health care by increasing number of working hours for health workers.

Around 62% of respondents (HCP) in all the study sites agreed or strongly agreed with the statement that establishing private service in public hospitals was aiming at increasing access of health services (see table 4 below).

Approximately 52% of HCP disagreed or strongly disagreed with the reason that establishing the private practice aimed at maximising the use of spare space capacity in public hospitals and about 60% of respondents (HCP) agreed or strongly agreed that it would improve use of resources and management of space available in these hospitals.

More than three quarters of respondents (HCP) agreed or strongly agreed with a statement that establishment of PPM would help to retain health workers in government hospitals.

A large proportion of health care providers (82.5%) agreed or strongly agreed with the statement that the establishment of private practice was meant to improve the hospitals' budgets and 90.0% of them strongly supported that the private practice would greatly help to boost incomes for health care providers.

Table 4: Reasons for establishing PPM (% respondents by facilities)

Reason	Muhimbili NH and MOI N=28			Bugando M.C N=12			All facilities combined N=40		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Increase access	71.43	3.57	25.00	41.66	33.33	25.00	62.50	12.50	25.00
Maximize spare capacity	35.71	7.14	57.14	16.67	41.67	41.66	30.00	17.50	52.50
Maximize resource use	60.71	7.14	32.14	58.33	25.00	16.66	60.00	12.50	27.50
Retain Health workers	71.43	14.29	14.28	91.66	8.33	0.00	77.50	12.50	10.00
Improving service quality	75.00	14.29	10.71	83.34	8.33	8.33	77.50	12.50	10.00
To raise funds for the budget	82.14	8.93	8.93	83.34	8.33	8.33	82.50	8.75	8.75
More income for workers	89.28	3.57	7.14	91.67	0.00	8.33	90.00	2.50	7.50
Challenging other hospitals	28.58	17.86	53.56	58.33	25.00	16.66	37.50	20.50	42.00

4.1.3 The way private services work

The management / administration system

As this practice is done in the public hospitals, publicly employed staffs form the management team. The management systems are almost similar in all the hospitals.

The executive directors of these hospitals are in-charge of both public and private practices. In each hospital there is a committee that runs private practice. The coordinator (secretary) is among the doctors practising fast track practice and the director of medical services coordinates the initiative for MOI. Members of the committee include all doctors involved in private practice, and nurses have their representatives. To run the practice smoothly, each department may have internal arrangements and organizations.

Since there was no detailed practice guides from the ministry of health, each institution through their committees, created the rules and outstanding orders to guide on how the practice should be conducted. These were based on medical ethical conducts as well as protecting the rights of both public and private patients (Guidelines for private practice). Some of these rules are outlined below.

The guiding principle

The main guiding principle for operating public/private mix is based on providing thorough information about the services available at the hospital and full authority to patients to choose voluntarily which of the two services they would prefer. All emergency cases are treated under public service line unless patients or their relatives insist on registering as private clients.

Registration and fees

Patients are registered to the clinics after having paid consultation fee of Tanzanian Shillings (Tsh) 5,000.00 at MNH and BMC or 8,000.00 at MOI (1USD is approximately =Tshs 1,000.00 in 2003). All payments are done at the public/private mix cash office. Each consultation visit is separately paid for. The total costs depend on the required treatment procedures, number of investigations needed and the types and amount of medications required to cure the disease.

Consultations

Muhimbili National Hospital's private OPD clinic consultations start at 2.00 p.m. and are conducted in a different place from other clinics. There are three rooms for medical, surgical and gynaecological consultations, each with an examination bed and other instruments. These rooms have visual but no full audio confidentiality. Other departments conduct clinics in their respective places.

Contrarily, at Muhimbili Orthopaedic Institute and Bugando Medical Centre, consultation rooms are the same for both public and private clinics except for the difference in consultations time. Several consultants seat in one big consultation room and examinations are done in privacy. Private clinics start at 12.30pm for MOI, and at 2.00 pm for BMC. However, at BMC private consultations could start immediately when public patients' clinics are through, regardless of the stated time. This saved waiting time for patients so long as it did not impair public services or interact with it. During consultations two or more nurses assisted in organising, running the clinics and assisting doctors when examining patients.

Investigations

Private patients are given special forms that indicate the investigations ordered by the doctor. Payments for particular investigations are done at the cash office. The rate paid is higher as compared to the normal public services so that they receive the services quickly. At BMC for example, during clinics private patients pay 20% more to the existing highest laboratory

investigation fee paid by public patients. Results are taken back to the consultant for interpretation and further management. This process may result to other consultation appointments that are separately paid for. However, some patients complained of the poor investigation service.

Admissions and private wards

Admissions in private wards are based on patients' willingness to use and ability to pay for private services. There are two private wards at MNH, one for males and one for females, each with 14 beds. Patients in each ward share a toilet and a bathroom. In addition, the so-called side rooms in each ward have been renovated for use as private wards. Patients pay a lodging fee of Tsh 3500.00 per day, which cater for their three meals, bedding and nursing care.

At Bugando Medical Centre private wards accommodate two patients sharing a toilet and a bathroom. On admission private patients deposit a specified amount of money thought to be the approximate figure adequate for their full hospital stay and treatment. An addition amount may be charged or a balance returned to the patient, depending on actual amount spent. The bed charge per day is Tshs 6,000.00 and includes bedding, 3 meals and nursing care. A separately amount of Tshs 1,500.00 is paid for each ward round.

There are special wards for dignitaries wherein government officials and other important people are admitted. These have been further improved, self-contained rooms, each for one person only. Deposits and other costs are charged at twice the rate of the other private care.

The Muhimbili Orthopaedic Institute private wing has 5 rooms each with 3 beds, which are partitioned by curtains. Each partitioned room is used by a single patient and has a cupboard, wall alarm and is air-conditioned. Three patients share a toilet and bathroom, refrigerator, a TV and one wheel chair. On admission each patient pay Tshs 150,000.00 as fixed deposit and non-citizens pay double the amount. The lodging fee of Tshs 30,000.00 per day, covers three meals, bedding and nursing care and is included in the deposit paid. Patients can choose types of meals from the menu. Parallel supporting services, physiotherapy and orthopaedic workshop, offer services to both public and private patients and charge a separate fee. Medication, ward rounds and surgical procedures are also separately paid for.

In all the hospitals, non-resident patients are charged twice the rates for citizens payable in dollar currency or an equivalent amount in Tshs using the market exchange rate.

The management of funds

The co-ordinator of the PPM at MNH reported that the fund is allocated in terms of proportions as follows:

- 50% is distributed among service providers.
- 50% goes to MNH for other expenditures including subsidizing the publicly serviced patients.

In MOI the allocation of funds generated through private practice is also done in proportions:

- 40% is used for paying the doctors (consultants) servicing the patient.
- 30% for paying nurses and other stuff directly involved in providing the service and
- 30% remain within the institution to be spent for other services including subsidies for treatments of public patients.

The BMC private practice management committee agreed on the use of actual terms for nomination of the amounts to be allocated to each care provider involved in providing private service instead of the use of percentages as is the case in other hospitals (See table 5 below).

Table 5: Allocation of generated funds to different beneficiaries at BMC in Tshs in 2000

Person Responsible	Operation Group I (Major)	Operation Group II (Medium)	Operation Group III (Minor)
Surgeon	30,000	20,000	10,000
Assistant Surgeon	8,000	5,000	3,000
Anaesthetist	8,000	5,000	3,000
Assistant Anaesthetist	5,000	3,000	2,000
Instrument Nurse	5,000	3,000	2,000
Circulating Nurse	5,000	3,000	2,000
Laundry person	1,000	500	500
Ward attendant	1,000	500	500
Accountant	1,000	500	500
Recovery nurse	1,000	1,000	200
Assistant recovery Nurse	1,000	500	200
Private practice registration	500	500	100
Hospital (BMC) fund	20,000	10,000	3,000
Total	**93,000**	**52,000**	**27,000**

Source: BMC Guidelines for Intramural Private Medical Practice-2000

NB: These figures were estimated in the year 2000 and may not hold to date, but fund allocation system still follows the same order.

Table 5 above represents the system for allocating funds generated from private practice to the respective health care providers in Bugando Medical Centre. Surgical cases are categorised/classified in three groups (minor, medium and major surgeries) depending on the severity of the illness. Surgeons decide which category should a particular case belong to, which

therefore determines the amount of fee to be paid. This money carter for surgery only while costs for other services are paid independently, as explained above. The fees amounts are reviewed each year basing on the running costs and the inflation rate.

Other departments at BMC (e.g. Dentistry, obstetrics and Gynaecology, Medicine, Paediatrics, Ear Nose and Throat) have fixed rates of fees for each service offered. Likewise the services are categorised in groups depending on the severity of illnesses, which also determine the amount of fee to be paid for each particular case.

4.2 The role of private practice in health care provision

This section presents the results obtained from documents review and interviews with health care providers as well as with patients. It aims at exploring the role of private practice within the surveyed hospitals. The exploration of the role was done basing on looking at the positive and negative impacts of the private practice during the 5-year experience in these hospitals. General views and other issues that rose during the in-depth interviews with health care providers and patients were also categorised as positive or negative impacts and presented in this section.

The variables for positives or advantages of the practice mentioned were categorised in terms of financial gains, enhancing more access to health care and improvement of quality of services in the hospitals, which are presented from both structured and in-depth interviews. They were measured using the percentages of respondents who agreed or disagreed with these variables.

As for the negative impacts the criteria observed were the possibility for health care providers to induce demand for health care with financial motives, tendency of biases for health workers towards private patients. The issue of private services being affordable was assessed from patients' perspectives to determine if costs impaired access of patient. Also it was investigated if deterioration of the public sector in these hospitals was neglected in order to create demand for private care.

Results are presented in tables expressing the percentages of respondents agreeing or disagreeing with the variables measuring these criteria and statements expressing views of patients about the services.

4.2.1 Positive impacts of private practice in public hospitals

Financial gains

Public hospitals have for a long time been running with deficit budgets, as the government could not fully finance them. An introduction of private practice in these hospitals has created an alternative fund raising mechanism to supplement the budgets. Table 6 below shows the amount of funds generated locally at Muhimbili Orthopaedic Institute in a 5-year period. Of all the funds generated, 77% came from private patients who make only 20% to 32% of all patients serviced at the Institute in that period. This substantial amount of fund would not have been realised without the introduction of the private services (Museru and Uma, 2003).

Table 6: Income generation within the Institute

Year	Private Patients	Public Patients	Total
1997	212,122,240	29,302,240	241,424,480
1998	252,738,944	42,517,925	295,256,869
1999	219,504,329	77,106,059	296,610,388
2000	221,983,341	94,856,216	316,639,557
2001	251,888,275	99,282,610	351,170,885
Total	**1,158,037,199**	**343,065,050**	**1,501,102,179**

Source: Museru and Uma 2003. 1USD=1,000Tshs

The total income of the institute in 5-years, including the government subvention was estimated to be more than Tshs 4.35 billions. Private practice contribution to this amount was more than 26% (see table 7 below).

Table 7: Total Institute income

Year	Institute	Government	Total
1997	241,424,550	360,165,581	601,590,131
1998	295,556,869	467,473,164	762,730,033
1999	296,640,388	458,950,136	755,560,524
2000	316,639,557	644,231,772	960,871,329
2001	351,170885	919,420,332	1,270,591,217
Total	**1,501,102,249**	**2,850,240,985**	**4,351,343,234**

Source: Museru and Uma 2003. 1USD=1,000Tshs

A document reviewing one year of private practice at Bugando Medical Centre states that on average the total collection from private practice was between Tshs 17 - 20 millions per month. This document also mentioned that the income of specialist doctors rose by Tshs 250,000.00 per month (BMC-PPM review meeting, 2001).

In interviews, health workers appreciated the financial gains as about 85% and 75% of all respondents agreed or strongly agreed that private practice has respectively improved the hospitals' budgets as well as their incomes (see table 10 below). Moreover, 97% of all respondents (HCP) suggested that improvement of the public health sector is possible if, among other issues, the government improves health workers incomes.

Increase of access to health care

Establishing private practice within public hospitals could mean doubling the work of health care providers consequently increase the total number of people receiving health care in these hospitals in a given time. Naturally this implies that more people can access health care services. During this study reviewed documents and interviews conducted with health care providers and patients assessed accessibility in two ways:

Firstly, whether the practice has affected access in terms of increasing or declining total number of clients utilising the services, consequently the total unit productivity of health care using the same staff and facilities and Secondly, whether there are some aspects thought to be advantages of private practice that directly or indirectly, influence access of the people to health care services. These include retention of health workers in place, maximum use of available resources, improving quality of services, increase number of supplies and generating more funds that subsidize public patients.

i) Number of people utilising private services

Review of the documents revealed that number of patients receiving private health care has been rising progressively during the 5 years period of the service in the surveyed hospitals as shown in the tables 8 and 9 below.

At Muhimbili National Hospital there have been tremendous increases in number of private patients from 1,940 to 10,340 in the period of 1998 –2002 whereas the number of patients in 2002 is 5.3 times higher than it was in 1998 (see table 8). The greatest influx is noticed between the years 2000 (2,404 patients) and 2001 (9,612 patients), an increase of 7,208 patients in one year. This increase could be the result of more publicity and perceived good quality of care offered by private services in government hospitals.

Table 8: Number of private OPD clinic patients in the past 5 years at MNH

Time range	Fast track	Public service	Total
1998	1,940	385,799	387,739
1999	2,100	389,817	391,917
2000	2,404	194,167	196,571
2001	9,612	188,809	198,421
2002	10,340	185,303	195,643

Source: OPD records – MNH 2003

The shrinking tendency noticed on the column of total number of patients as time increases, could probably be explained as being the results of increase in efficiency in physicians' productivity of quality services in both sectors, leading to cutting down the long waiting lists in the pubic services.

Table 9: Number of patients seen at OPD and Inpatient Departments at Muhimbili Orthopaedic Institute in 5 years

Year	Private patients		Public patients		Total	
	OPD	IPD	OPD	IPD	OPD	IPD
1997	4,146	240	8,537	4,871	12,683	5,111
1998	4,023	289	9,178	4,931	13,201	5,220
1999	3,099	327	10,013	5,552	13,112	5,879
2000	3,922	347	10,914	5,802	14,836	6,149
2001	5,027	334	10,498	5,434	15,525	5,768
Total	**20,217**	**1,537**	**49,140**	**26,590**	**69,357**	**28,127**

Source: Museru and Uma, MOI 2003.

In MOI, the total number of private patients seen at the outpatient clinics and inpatients has also progressively increased from 4,386 in 1997 to 5,361 in 2001, an increase of 22.2% (see table 9 above). The proportions of private patients to public patients have remained between 25 – 32% for outpatients. For inpatients, however, private patients contributed only about 5% (1,537) of the total attendees (28,127) during the 5-year period. Museru and Uma (2003) also report of an increase in general number of surgeries in MOI, from 762 in 1998 to 1,186 in 2001 using the same theatre facilities. This may have been possible because of improved availability of consumables obtained through private practice and higher working morale of staffs.

Generally, tables 8 and 9 above explain some details on how introduction of private services in these public hospitals, have noticeably increased accesses not only in the quantity of services but also the quality of services provided.

ii) Advantageous factor contributing in increasing access

Interviews were carried out with health care providers as well as patients to assess if criteria like health workers retention, good management of resources to facilitate quantity and quality of services provided and improving the number of supplies to accommodate more patients, were among factors helping to increase access of people to health care.

Results in table 10 below show that more than two thirds of all health care providers in all hospitals agreed or strongly agreed that private practice has increased access of people to health services. However the difference was noted as 75% of HCPs from Bugando agreed versus 50% from Muhimbili (MNH and MOI). Access in association with enhancing maximum use of the present resources was supported by 55% of respondents on aggregate. Again a difference in rating was noted on the issue of health workers retention. About 83% of respondents from Bugando and 50% respondents at Muhimbili supported this reason. There was a noticeable increase in the qualities of services in general in the hospitals, which was supported by 67% of all respondents. About by 46% and 83% of respondents from Muhimbili and Bugando respectively, supported the statement that quality in care production could have increased due to improved workers – patients' relationship.

Table 10: Advantages of private practice (% Respondents by facilities)

Reason	Muhimbili NH and MOI N=28			Bugando M.C N=12			All facilities combined N=40		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Increase access	75.00	3.43	21.43	50.00	29.16	20.83	67.50	13.75	18.75
Maximise spare capacity	42.86	7.14	50.00	33.33	25.00	41.66	40.00	12.50	47.50
Maximise resource use	53.57	23.21	23.21	58.33	25.00	16.66	55.00	22.50	22.5
Retain Health workers	50.00	10.71	39.28	83.34	8.33	8.33	60.00	10.00	30.00
Improve service quality	60.72	17.86	21.43	83.34	16.67	0.00	67.50	17.50	15.00
Raising funds for budgets	85.71	3.57	10.71	83.34	16.67	0.00	85.00	7.50	7.50
More income for workers	67.86	17.86	14.28	91.67	8.33	0.00	75.00	15.00	10.50
Workers – patients relationships	46.42	42.86	10.71	83.34	16.67	00.00	57.50	35.00	7.50

More than two third of interviewed private patients acknowledged that they received care without having to follow the bureaucratic referral system and for more than half of these patients this was not the first time to use the private services in these hospitals. Many patients expressed their satisfactions with the services and pledged to continue using it in the future if they get sick.

From the in-depth interviews this was the comment from one respondent on the issue of access: *"private care provides good and quicker services, which enable patients to access service offered by specialists who are highly qualified"* (doctor - BMC). On the same issue another respondent commented: *"the service has helped to decongest the overcrowded and long lists for public services because a number of patients are opting for private services and therefore a few resources available in public services cater for the very needy people who could not afford private services. Likewise private practice subsidises these patients in terms of consumables, drugs and even costs for their treatments"* (doctor - MNH).

Improving quality of care

Quality of health service is a wider and complex subject to study, as there are many variables to look at. This study observed some aspects of quality of care, which were the improvement of physical structures including hygiene and sanitation, availability of adequate supplies and drugs that uplift quantity and quality of care provided and improving time of waiting for appointments and treatments and all results are presented in table 11 below.

Table 11: Quality of Private Services (% respondents by facilities)

Reason	Muhimbili NH and MOI N=28			Bugando M.C N=12			All facilities combined N=40		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Waiting time	85.72	6.57	10.71	50.00	11.67	33.33	75.00	7.50	17.50
Number of invest, drugs	48.20	14.29	33.92	30.80	30.80	33.33	40.00	17.50	32.50
Availability of doctors	78.58	10.71	10.71	66.67	16.66	16.67	75.00	12.50	12.50
Availability of supplies	67.86	17.86	14.28	41.67	25.00	33.33	60.00	35.00	5.00
Improved sanitation	71.43	7.14	21.43	66.67	16.67	16.67	70.00	12.50	17.50
Friendlier and keen doctors	57.14	16.07	26.78	58.33	16.67	25.00	57.50	16.00	26.50

For many patients waiting time for consultations as well as treatments has been made shorter and three quarters of respondents agreed or strongly agreed with this statement. However, again there was a noticeable difference on the proportion of respondents from the two sites, as 85% of Muhimbili staff agreed with this, only 50% from Bugando did so (see table 11 above). Quality improvement has been associated with reliable availability of doctors in the hospitals, which on aggregate was supported by 75% of respondents. There has been reliable availability of supplies as the statement was supported by 60% of respondents from both Muhimbili and Bugando. About 71% and 66% health care providers from Muhimbili and Bugando respectively agreed with the statement that sanitation and hygiene of wards and other premises have also been improved more than they were before.

4.2.2 Negative impacts of private practice in public hospitals

Variables assessed on negative effects of the private practice looked at how this practice could possibly lead to deterioration of the general public patient services. These variables were grouped into effects due to behaviours of the health care providers and the circumstantial deterioration of conditions in public sector that could promote private sector market in place. Also some aspects associated with private care were observed to see if they limited access of people to the services. In-depth interviews with both health care providers and patients assessed their perceptions towards private services. Opinions about the adverse effects of private services, its organisation and weaknesses are presented in this section.

Behaviour of health workers

Interviewed health care providers did not agree with the statement that health care providers pay more attention to private patients for financial incentives and therefore neglecting non-paying public patients. Three quarters of all respondents disagreed or strongly disagreed with this statement, and 80% of them disagreed with the statement that HCP have a poor relationship with non-paying patients (see table 12 below). Furthermore, 65% of HCP opposed the statement that health care providers are biased in servicing of patients. Likewise, half of these health care providers said they do not divert patients to private services and disagreed by 82% to be over treating patients with financial motives that could mean inducing demand of care to patients.

Table 12: Disadvantages of private practice (% respondents per facilities)

Reason	Muhimbili NH and MOI N=28			Bugando M.C N=12			All facilities combined N=40		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Reduce care to public patients	10.72	3.57	85.71	0.00	16.67	83.34	12.50	12.50	75.00
Biased health workers	32.14	14.29	53.27	33.33	8.33	58.33	22..50	12.50	65.00
Divert patients to private care	21.43	25.00	53.57	50.00	8.33	41.67	30.00	20.00	50.00
Inequity of health care	46.42	17.86	35.71	25.00	16.67	58.33	40.00	17.50	42.5
Over treatment for money gain	0.00	10.71	89.29	8.33	25.00	66.66	5.00	12.50	82.50
Poor relations to public pint	7.14	7.14	85.71	12.50	20.84	66.66	7.50	12.50	80.00
Conflicts among worker	50.00	10.71	39.29	25.00	25.00	50.00	42.50	15.00	42.50

Deterioration of public sector

As for reasons of deterioration of public sector, two third of respondents agreed or strongly agreed that more people use private services because of lack of drugs, poor supplies and poor equipment resulting into poor quality of services in the public sector (see table13 below). About 60% of respondents on aggregate, supported the statement that private service premises are cleaner and of good quality therefore attract people. In addition, majority of respondents (95%), agreed or strongly agreed that one reason making private practice popular is that people do not have to wait longer for their treatments on the contrary of public services.

Table 13: Reasons for using private care (%respondents per facilities)

Reason	Muhimbili NH and MOI N=28			Bugando M.C N=12			All facilities combined N=40		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Malinformed	14.28	21.43	64.29	33.33	50.00	16.67	20.00	30.00	50.00
Diverted to private sector	14.29	14.29	71.42	33.33	33.33	33.33	20.00	20.00	60.00
Poor supply of consumables	64.29	14.28	21.43	33.33	16.67	50.00	55.00	15..50	30.00
Less attention from doctors	50.00	10.71	39.29	33.33	16.67	50.00	45.00	12.50	42.50
Good Private sanitation	64.29	17.86	17.86	33.33	33.33	33.33	55.00	31.25	13.75
Quick private services	96.43	0.00	3.57	91.67	0.00	8.33	95.00	0.00	5.00

Other negative outcomes of the private practice

Costs

Regarding demand of the private services as a factor determining access, interviewed health care providers and patients, not surprisingly, had contrasting opinions (see table 14 below).

Table 14: Costs for private service (% Health care providers' response per facility)

Costs	Muhimbili National Hospital and MOI		Bugando Medical Centre		Average	
	Health care providers	Patients	Health care providers	Patients	Health care providers	Patients
Affordable	17.86	2.08	27.27	3.92	20.51	2.72
Relatively Affordable	67.86	40.62	54.55	45.10	64.10	42.18
Not Affordable	14.29	57.29	18.18	50.10	15.38	55.10
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

A very small percentage of patients (2.72%), agreed that the private services were affordable, as compared to 20% of health workers, meanwhile 55% of patients stated that costs were not affordable, and only 15% of health care providers agreed with that statement. One health care provider gave an opinion that " *the costs were fair regarding the services provided but yet were not well affordable to majority of the people"*(doctor-MOI). Nevertheless, 64% and 42% of health care providers and patients respectively, supported the statement that costs for private services were relatively affordable.

Moreover, during the in-depth interviews, many patients complained that cost is a hindrance factor to access private health care. Some of complaints are as follows:

"Lodging fees are too expensive especially at MOI (TShs 30,000 per day) that many people cannot afford and this limit them using the service. Moreover, the services provided here are poor as compared with the amount of money we pay. Sometimes we are kept longer in the wards to spend more fees for lodging and for other services. This is not fair"(patient – MOI).

"Consultation fees paid on each visit makes the service unaffordable. If possible fees for consultation should be paid only for the first visit and free or less amount should be paid for the subsequent visits during one episode of illness. Actually, this has become an incentive for doctors to set repeated appointments with patients"(patient – MNH).

Private service therefore still seems inaccessible to many people due to higher and unaffordable levels of fees.

Distance

To determine whether distance was a limiting factor for some people to access private service, interviewed private patients were asked of their residential areas. Undoubtedly, result in table 15 below shows that almost 90% of patients came from urban areas mainly where these hospitals were situated. Distance had put a barrier to people from far to access this service by limiting their access to information as well as act on their financial capacity.

Table 15: Number of patients by residential areas (% respondents per hospital)

Place	Muhimbili National Hospital and MOI		Bugando Medical Centre		Average	
	N	%	N	%	N	%
Urban	86	89.58	47	91.84	133	90.47
Rural	10	10.42	4	7.84	14	9.52
Total	**96**	**100.00**	**51**	**100.00**	**147**	**100.00**

Operating time

In all the hospitals, private services were scheduled to start in the afternoon (12.30 or 2.00 pm), assuming that by that hour doctors would be free from services in the public sector. Apart from being well informed of this, still some private patients raised their concern about time as not convenient to them and suggested of the possibility to start the service early in the morning. At Muhimbili Orthopaedic institute, private consultations for morning hours have been introduced but are charged higher than the afternoon ones. The current working schedule in other hospitals therefore, seems to limit access for some patients to this service.

Results of the in-depth interviews

Response to open answer questions and in-depth interviews from both health care providers and patients, revealed some crucial areas of weaknesses of the current private practice. Health care providers were mostly concerned with issues of mismanagement of funds, insufficiency of payments and poor working conditions while patients were concerned with higher fee levels and poor services from providers.

Results in table 16 below present general opinions of respondents from all hospitals. Whenever specific issues were raised against a specific hospital, the concerned hospital is mentioned to avoid generalising the comments for all the hospitals.

Table 16: Comments from the in-depth interviews with health care providers and patients (Responses from all study hospitals)

Muhimbili National Hospital (MNH),, Muhimbili Orthopaedic Institute (MOI) and Bugando Medical Centre (BMC)			
Complaints		**Compliments**	
Health care providers	Patients	Health care providers	Patients
Mismanagement of fund and payment • Administrators divert fund to other issues and no impact on public care • 40% allocated for doctors insufficient • Specialists unavailable for public patients, only junior doctors serve them and consult seniors on phones (MNH)	Higher costs for the services • Too expensive Lodging fees especially at MOI (TShs 30,000 per day) • Consultation fees paid for each visit makes the service too expensive • Sometimes doctors ordered expensive investigation out of this hospital	• Increased supplies and drugs for public patients • Improved working conditions • Increased access to health care services • Has improved workers' incomes and morale for work	• Private practice has improved the working conditions for doctors • Private provides better and quicker services
Management in general • Poor working environment. No accessory facilities to fasten services • Inadequate operating rooms (e.g. in gynaecology - MNH) • Very poor laboratory support as well as other investigation services • Decision-making is not participatory that some doctors quit or been expelled • Poor consultation premises, hotel services and drugs supplies (MNH) • Should allow all doctors to practice thus remove inequity among workers • Nurses are least considered for benefits apart from enormous work they do	Management in general • Poorly organized investigation system for private patients (No fast services) • Poor rehabilitation services for orthopaedic patients (MOI) • Uncomfortable OPD waiting rooms • Inconvenient consultations time • Poor and unprofessional nursing care • Often (MNH) private patients were not being visited on ward rounds • No enough privacy in private wards • Doctors (MNH) did not keep time of starting the clinics • Poor supervision of clinic proceedings and people violated the queue (MNH)	• Shorter waiting time for treatments and consultation • Has reduced corruption to minimum • The prices are fair for the work done though not well affordable • Better management of patients and personnel • All staff, regardless of their participation in practice, are offered free breakfast (BMC) • Maximum use of the present resources (human and non-human) • Has decongested the public services proving room for the poor and needy	• Private services have helped to decongest the overcrowded and long lists in public services • Costs for private services are cheaper as compared to the costs of services in pure private hospitals • Gives opportunity to get better services directly offered by specialists

The degrees to which health care providers were either happy or unhappy with their local administration and management differed from one hospital to another. Most of complaints mentioned above, came from Muhimbili National Hospital and Muhimbili Orthopaedic Institute from where 67% of respondents expressed their dissatisfaction, while in Bugando Medical Centre only 25% of respondents were unhappy with administration and management. Likewise, majority of patient complaining of poor services and higher fees were from Muhimbili National Hospital and Muhimbili Orthopaedic Institute.

4.3 Utilization patterns

This section presents the results obtained mainly from interviews with patients and aimed at learning about the patterns associated with utilising the fast track services. In this theme the study wanted to see the associations between different determinant factors affecting people's decisions, abilities and willingness to make use of the fast track services. Factors observed were gender, employment status and type of work, levels of education and income. The study also observed if living in urban or rural areas has any association with fast track care utilisation. Types or mechanism of payment commonly used by the people when paying for private care was also studied in order to see its influence in use of the service.

Results presented in tables 17 – 20 below show the percentages of respondents in each category of determinant factors chosen for assessing its effect on utilisation of private services. The overall majority of patients interviewed were males who represented two third of all private patients at Muhimbili and 47% of respondents at Bugando Medical Centre.

About 42% of private patients in both sites were those permanently employed by either public or private sector and were in professional jobs (see table 17 below). Those mentioned to be permanently self-employed mainly dealt with business activities and represented 18% of respondents. Surprisingly, the third and fourth groups were of unemployed and retired people that represented 18% and 14% of all respondents respectively.

Table 17: Employment status of respondents (number and % respondents interviewed in each hospital)

Employment type	Muhimbili National Hospital and MOI		Bugando Medical Centre		Combined	
Permanent employed by government or private sector	*N*	%	*N*	%	*N*	%
	44	45.83	19	37.25	63	42.85
Permanent self employed	19	19.79	8	15.69	27	18.36
Temporary employment	6	6.25	5	9.80	11	7.48
Unemployed	14	14.58	12	23.53	26	17.69
Retired	13	13.54	7	13.73	20	13.61
Total	**96**	**100.00**	**51**	**100.00**	**147**	**100.00**

Although people from all categories of education level utilised private health services across the sites, yet majority of them were those with higher level of education, as more than half of all respondents were from this category. The pattern however, was not in a pyramid model based on levels of education because primary school levers (30%) outnumber the secondary and college leavers who represented only 17% of the respondents (see 18 table below).

Table 18: Education levels of respondents (N and % respondents per facilities)

Education level Completed	Muhimbili National Hospital and MOI		Bugando Medical Centre		Combined	
	N	%	N	%	N	%
Primary Education	25	26.04	18	35.29	43	29.25
Secondary / college	16	16.67	9	17.65	25	17.01
Higher Education	55	57.29	24	47.06	79	53.74
Total	**96**	**100.00**	**51**	**100.00**	**147**	**100.00**

Usually ability to pay is determined by the levels of income, yet the middle-income group has taken the fore front in utilising private services. This is the group of people receiving a monthly salary ranging from Tshs 60,000.00 to 120,000.00 and comprises of majority of professionally working civil servants (27.53%), as shown in table 19 below. Private care attracted even people from the lowest income group that are 9% of respondents from all the sites. It is however surprising that people from the income level between 120,000 to 250,000 represented only 8% of respondents from all the sites.

Table 19: Income levels for private patients per month (% respondents per hospital)

Categories of Income level	Muhimbili National Hospital and MOI		Bugando Medical Centre		Average	
	N	%	*N*	%	*N*	%
No Income	4	4.17	3	5.88	7	4.76
Less than 30,000	6	6.25	7	13.73	13	8.84
30,001 – 60,000	24	25.00	15	29.41	39	26.53
60,001 – 120,000	27	28.12	13	25.49	40	27.53
120,001 – 250,000	8	8.33	4	7.84	12	8.16
Above 250,000	27	28.12	9	17.65	36	24.49
Total	**96**	**100.00**	**51**	**100.00**	**147**	**100.00**

Although people from both urban and rural areas had equal access to fast track services, it was however observed that almost 90% of all respondents came from urban areas. This has been mentioned above (see table 15 above) as being the effect of distance. In addition, the socio-economic disparities of people in the two settings also have its influence on who can or cannot afford the service. Most of rural people are poor as compared to urban people.

The study also looked at the types of payments commonly used by the private patients to pay their bills to see if that determines usage of the service. Table 20 below shows that almost 71% of patients paid the bills out of pocket while employers covered bills for the remaining third of patients.

Table 20: Payment mechanisms for private services (% of respondents per hospital)

Payment mechanisms	Muhimbili National Hospital and MOI		Bugando Medical Centre		Combined	
	N	%	N	%	N	%
Out of pockets	64	66.67	40	78.43	104	70.75
Paid by Employers	32	33.33	11	21.57	43	29.25
Total	**96**	**100.00**	**51**	**100.00**	**147**	**100.00**

A review of the document from Bugando Medical Centre has revealed some facts on the issue of payment through National Health Insurance Fund (NHIF). The document states that clients with NHIF cards were denied the services unless they pay cash. The reason given was that the maximum amount of benefits covering treatments for beneficiaries was less than the average amount charged for private services. Considering a tedious process of calculating the differences

the patients should top up, and other bureaucratic procedures to be involved on the claims of the fund from the plan, the accounting department refused to accept payment through this system of funding (BMC PPM review meeting). Other organisations contracting with BMC are the Bank of Tanzania and other commercial Banks that operates through private insurance companies with which BMC has never had problems regarding rates of payments.

4.4 Summary

The overall findings of this study have shown a successful launch of private practice within public hospitals and that not only it was possible to have the two practices running together using the same facilities and resources, but also have had more positive impacts induced to the general health care system, if well managed. The results have shown a progressive increase in number of people opting for private services in all hospitals with an enormous amount of generated funds that was used in motivating health care providers, improving quality of care and general infrastructure and most importantly, subsidising treatments of poor public patients. In other words, private practice has created more rooms for people to access better quality health services both in private and public sectors. The successful side of the practice was revealed in the positive perceptions of respondents on issues of improving access, quality of care, workers morale and increasing the budgets of the hospitals.

On the other hand, some issues emerged as negative impacts associated with this practice. These were linked with poor management and administration, selfishness and unprofessional conducts of health care providers and particular issues as for private practice. The majority of respondents, both workers and patients, complained of the poor system of investigation for private patients. Patients also mentioned some behaviour of workers as unpleasant to them. Likewise, fee levels and system of charging rose complaints from patients on affordability of the services that impaired access.

Variables for patterns of utilisation of the services were also assessed. It was noticed that the practice has gathered people from all categories of employment status, education levels and income levels, though rate at which they used the services differed from one group to another. A big difference was also noticed on the number of people from rural and urban areas among private patients whereby almost ninety percent of them were urban dwellers. Generally, all issues of concern have to be addressed and rectified if the government's objective is to ensure that health care services are available to everyone according to their need and not their ability to pay.

CHAPTER 5

DISCUSSION

5.1 Introduction

Tanzania is presently undergoing structural reforms in all sectors, including the health sector. The previous state ownership of major means of the economy and public services provision has had little achievements. Ongoing reforms in health sector focus on best ways the public sector can collaborate with or handle over to the private sector the responsibilities of financing and / or provision of health services, while the state remains with regulatory and monitoring roles. Results presented in the previous chapter give an overview of the type of public private mix operating in public referral hospitals in Tanzania. This was established after the government realized that it was loosing many of its skilled manpower, specialist doctors, who moonlighted to increase their income in the private sector both in and outside the country. Therefore, the government through Parliamentary Act in 1996 allowed health workers to run private services within public hospitals, starting with referral hospitals. The Ministry of Health, however, did not issue the guidelines on how the practice should be run and gave autonomy of administrating and managing the services to local hospital authorities.

This is a particular type of public private mix conducted within public hospitals using the same public facilities and resources, especially human resource, to provide services to both public and private patients. At Muhimbili National Hospital it is called "fast track service," while at Muhimbili orthopedic institute and Bugando medical center they just call it private service. It was one of major interests of this study to explore in detail what this practice is all about, how it is run, and which positive and negative impacts it has to health care provision system in these hospitals. Finally, the study looked at how the targeted community members perceived and accepted it. The findings answering all these questions are discussed in this section.

Management and Administrative Structures: In all these hospitals executive committees were established and guidelines and principles set up to run the practice under well-planned management framework, which was almost similar in all the surveyed hospitals. The differences were in implementing the guidelines to meet the goals. This private practice (fast track) offered all ranges of clinical services and other non-clinical services associated with hospital stay like hotel services and laundry.

5.2 The positives aspects

Introduction of private practice has led to higher overall quality of services as doctors strive to attract and keep more clients. On the other hand, intensive use of private resources has reduced the burden on publicly funded care. The findings show an overall improvement in quantity and quality of health care services in these hospitals, as the number of people attended in private sector has been progressively increasing. Physical infrastructure has been improved including wards, consultation rooms and theatres, resulting into an increased number of procedures performed for both public and private patients. Improving infrastructures aimed at changing the image and perceived poor quality of services for these public hospitals and also uplifting quality to levels equal to other private hospitals in order to attract private clients, who already knew of higher reputations of specialist doctors working in public hospitals. Likewise, highly motivated doctors and nurses are now willing to stay beyond their government services hours to offer services to private patients. Health workers-client attitude was improved through workshops on "change management" and visiting other private hospitals to learn about customer care. The possibility is that these good outcomes affected both private and public sectors, as these workers operate in both sectors.

The service has increased access to health care through retaining health care providers within the hospitals, as specialists and other cadres are now happy and free to run private clinics in their hospitals. This has reduced corruption that existed before, whereby doctors used to treat their private patients from other private hospitals in these hospitals using public resources.

There is reliable availability of supplies and drugs as private patients directly pay fully for all the services they consume. Therefore a few public resources would be used for the needy poor patients. Private services has greatly decongested long lists of patients in public services because some public patients opt for private services and the postponed operations are now being performed since supplies and funds to subsidize treatments for poor patients are available. The data has shown a progressive increase in number of patients from different socio-economic groups opting for private services. In addition, private practice has become an alternative fund raising mechanism that helps to bridge gaps between real budgets of hospitals and actual amounts that the government provides to run these hospitals. An enormous amount of revenue has been generated since the start of private practice in these hospitals. The revenue was used to subsidize workers' incomes, improve infrastructures and supplies in hospitals and more importantly, subsidized treatments of poor public patients hence giving them more access.

5.3 The negatives aspects

Inappropriate policy advice and inadequate experience in this particular type of mix has raised some problems in managing and delivering services concurrently. This reveals, especially when differentiating varieties of stakeholders and the concern of health care providers to the poor and vulnerable population that use public service, and their need to earn more income from private patients. The unexpected negative effects are sub grouped and discussed as follows.

Behaviors and attitudes of stakeholders

Health care providers

Although the majority of health care providers refuted the possibility of being opportunistic, but still with this type of public private mix it may become difficult for them to be absolutely fair to both types of clients. Practicing in private health care they tend to becoming less supportive of public sector simply because they see little return from public services. According to Propper and Green (1999), "support for public sector is negatively associated with demand for private care and demand for private care, on the other hand, is affected by quality of the public sector in place." Many patients interviewed in this study, mentioned that they use fast track services because of the lack of supplies and drugs and generally poor quality in public sector in the study hospitals. Increase in number of private patients in these hospitals could simple imply the shifting tendency of public patients who have been frustrated by the poor quality of services in public sector. Therefore, for the local managements and health workers not being concerned with improving quality of public services would mean that they indirectly divert patients to the private sector and thus induce demand for private service.

Health care providers directed their complaints mainly to the management and administration teams. The majority of doctors who practice PPM were not satisfied with the amount of money they received as incentives and believed that it was possible for them to earn more with the current fees, if funds were well managed. Also there were complaints that managements had not done enough to improve services for those who pay, especially with investigation services. Fast track patients are frustrated with the poor system of diagnostic tests and investigations, as they have to stand on queues like other patients while they pay more to get quicker services. Likewise, there were complaints that management had not done enough on improving working conditions for doctors, as still there are poor consultation rooms at Muhimbili National hospital, poor hotel services and inadequate operation rooms.

Another issue of concern was about barring the non-specialist doctors to practice in private sector. Some practitioners regarded this as selfishness and unjust to fellow practitioners, which resulted in inequity and hatred among some young health workers. Being juniors, they are compelled to obey 'rules of the game,' sometimes even attending private patients in the wards for free, as may be ordered by their senior colleagues whom they call 'chiefs.' Unpleasant part of this was when junior doctors, including interns, dealt with cases from other public hospitals referred for specialized care, with little or no assistance from specialists who were busy with less severe cases in the private service. This behavior denied these public patients of their rights for specialized care and best service they deserved. Specialist would see private patients, regardless of severity of their illness because referral system is not applicable and moreover only specialists practiced private (fast track) services.

Most of private patients opted to be treated only by doctors specialized in their problems, instead of starting with general practitioners. These patients chose doctors because they were told that they had that right. According to one respondent, *"this was meant to give an opportunity to people who opt to see specialists for their health problems without having to go through the referral system and to avoid problems and complaints that could result from mismanagement or dissatisfaction of clients treated by junior doctors. It was also meant to give incentives for specialists to earn extra income for their work."* (doctor-BMC). Allowing patients to opt for doctors based on qualifications could divide health professionals and create individualism instead of working in a team and maintaining the hierarchy in care giving. Moreover, all health workers need to earn an extra income, not only doctors or specialists. Thus this opportunity should have been equally provided to all cadres and in all levels of qualifications. In these hospitals therefore, if well organized, fast track can still work without such exclusions. Involving junior doctors in private practice could maintain hierarchy of care provision and give specialists chances to balance their time well for services in both sectors. Yet considering the little numbers of specialists in these hospitals and in the country, it is really not feasible to exclude the non-specialized doctors from practicing fast track services at least in these referral hospitals.

Adversely, these few specialists work hard to cop with increasing number of their private patients in the market. This means they are working more hours than they should, the consequence of which is falling of quality of care and automatically loosing these clients later. Arrangements should therefore be revised and possibly give chances to junior doctors be involved in the private practice to achieve sustainable improvement of quality of service in both sectors. It should be

borne in mind that in other private hospitals (e.g. Aga Khan, Hubert Kairuki, Regency Medical center etc), doctors of all levels work in collaboration abiding with hierarchy of care provision and ethics and provide good quality services. Specialists in these hospitals are just part of the teams and not the only care providers.

Patients

During in-depth interviews, patients raised their complaints on two crucial issues among others: higher costs for the private services and poor management of the current practice. Patients claimed that paying the consultation fee for every visit is an expense that makes the service unattainable to many people. They also postulated it as being an incentive for doctors to keep setting many appointments with patients to augment their income. There were suggestions that consultation fees should be paid on the first visit and free or little amounts paid for subsequent consultation visits on same disease episode. Patients, specifically in MOI, complained of the lodging fee of Tshs 30,000 per day, as being very expensive and inconsiderate of incomes of majority of people. Although this study did not consider comparing these prices with prices in other private hospitals, it is known that private care prices were comparatively cheaper in public hospitals. One respondent commented "*prices are fair for the services provided though not well affordable by many people*" (doctor – MOI). As a matter of fact, private care is not meant for every individual in the society. In other countries private care was introduced following the demand of rich individuals who wanted extra comfort in hospitals. As Besley and Coate (1991) argue that "the system in which there is *de jure* universal provision, but in which richer individuals are *de facto* allowed to 'opt-out' can redistribute income from rich to poor, even when the provision is financed by a non redistribute such as a head tax. All individuals (rich and poor) pay for public service. The public sector provides a homogenous good of a given quality level. If the quality is not 'too high' richer individuals will pay for a higher quality of the good in the private sector, so provision of the publicly funded will go only for the poor". Universal provision of quality high enough to induce both rich and poor to participate is not welfare improving as there is loss of efficiency whenever a good is provided 'in-kind'. This implies then that if 'in-kind' transfers are being used for redistributive purposes then to achieve this without reducing social welfare requires the existence of a private alternative for which the rich can opt. Prices for private services therefore are determined by the market situation and not public opinions. Inequalities in ability to pay for private service may be equitable in this case. Lowering the fee levels for the fast track services would probably result into difficulties to manage the incentives, poorer quality of the care and thus spoil its marketability.

Other complaints from patients were directed to the way private services are managed. Patients complained of inconveniency associated with doing tests and investigations, as these procedures take longer than expected and paid for. Patients also mentioned issue of uncomfortable waiting rooms during OPD clinics, and that evening time was not suitable for them. At the same time, many of them raised their concern on poor punctuality of doctors during OPD clinics. Frequently doctors came late and patients suggested that doctors should strictly observe time and be prompt. Patients in the wards raised their complaints on unprofessional nursing care they received. It is possible that this was associated with inadequate training of nurses on patients' care, poorly motivated as they receive little or no incentives for working in private services or maybe, after having paid full fee for services, these patients become unnecessarily too demanding for nursing care.

Lastly, establishment of the VIP units under private services has its negative side as government officials are entitled to this class of service. These officials may like the quality of services they receive and no longer consider themselves as potential beneficiaries of the public service thus exert no serious efforts in improving the public health sector.

Moreover, generating funds in private services should not be considered as an alternative but a supplementary way of rising funds. Results have shown that majority of people paid fees for private care out of their pockets. Since these individuals pay tax that would have provided them with good health care service through the public sector, utilizing private care therefore, means they pay double costs for the same service. Surely, the government has no intension of making its hospital budgets sorely dependant on money from private patients, as this would mean entirely turning these hospitals into private ones thus limiting access of many people to health care. Results showed a limited enumeration to the budgets of these hospitals from the government, which was supplemented by funds from the private practice. This should not be the trend of events towards total privatization of these hospitals.

Furthermore, the ministry of health has not shown convincing commitment over the fast track practice, not even has if given any guiding policy or monitoring on how this absolutely new practice should be conducted focusing on objectives and equity in health care provision. Therefore, policy focusing on parallel strategic improvements of public and good monitoring of the mix is a necessary intervention from the highest level of policy-making organ.

5.4 Utilization patterns

In general, people from all socio-economic groups were found utilizing private care though in different percentages. The majority of interviewed patients were males. This may imply that males are more financially enabled than females, which means more males than females are educated and have formal employment hence earn enough to afford private service. Results confirm this hypothesis as among all private patients the largest group was of people formally employed in either public or private sector and were in professional jobs. Likewise, the majority of private patients were people with higher education and middle-income levels. Non-surprisingly, unemployed and pensioners were also found among private patients. These were unemployed spouses, parents or relatives of people who could afford the service.

Only a small fraction of private patients were from rural and distant places. Most of them were urban dwellers and especially from towns where these hospitals were located. This might be due to the fact that people living far from these hospitals were poorly informed of this service. The other possibility was in economic disparities between rural and urban areas in the country, as most of people in rural areas are poor.

Results showed that most of private patients paid their service bills out of pocket. Employers covered only one third of patients. A review of the document from BMC, revealed some facts on the issue of payment through National Health Insurance Fund (NHIF). The document states that clients with NHIF cards were denied the services unless they pay cash. This was so because the maximum amount of benefits covering treatments for members of the fund was less than the average amount charged for private services. Therefore, the accounting department refused to accept payments through this system of funding. However, other organisations contracting with BMC (the Bank of Tanzania and other commercial banks) operated through private health insurance companies with which BMC has never had problems regarding rates of payments.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

This study has looked at a particular type of public private mix (fast track), whereby the two co-exist in one and the same place using the same resources in service provision. It was aimed at exploring the mix, learning the roles of the private sector under such mix and also to investigate the different patterns of utilizing private services and factors determining these patterns.

The study findings have indicated that it is really feasible to have public private mix in public hospitals using the same management, facilities and resources to provide services to both private and public clients. Although the ministry of health did not prepare detailed policy documents to guide in running the private services, the local hospital authorities managed to set guidelines and management principles to get the practice going. These included, for private services, the flow of events during service provision, fee levels and payment procedures, timing and other issues. Management committees were established and included doctors involved in the practice and members from other cadres like nurses.

The on going practice has played a positive role to the health care provision in these hospitals as a supplementary fund rising mechanism. Funds from private practice bridged the budgets deficit since the amounts provided by the government was not sufficient. These funds are utilized in paying incentives to health care providers, which has uplifted their motivations and efficiency. Under this mix, doctors and nurses now spending their extra time in public hospitals providing services to private patients and earn extra incomes. The practice has also been beneficial to public sector in place because some of revenues obtained from private care are used in improving general quality of care in public sector and providing treatment subsides for the poor public patients. The practice has played an important role in enabling more people to access good quality health care services in general, since numbers of patients and theatre procedures have increased. All these successes would not have been attained if private services were not established in public hospitals.

Conversely, little experience with this particular type of PPM, the fast track service, may have exerted its effect on the opposite side that could result from the potential misuses, jeopardy and sabotage from opportunistic behaviors of some health workers especially as this practice is more vulnerable to such possibilities.

The study findings revealed lavish misuse of the funds meant for general care expenditure, thus lesser improvement of the public sector to date and private premises are still below the required standards. There is a poor monitoring of the system and monitoring of the quality of the services delivered for instance if private patients are not attended by ward rounds and / or some public sector referral cases do not receive specialized care, then the reputation of the practice is spoiled and its' progress deterred. Laboratory test and investigation system for private patients also need to be well organized. Higher fee levels were also mentioned in a relative approach, as negative outcomes that obstruct many people from utilizing private services.

The pattern for utilizing PPM was found to be positively associated with education, employment status and income levels. More males utilized the services than females and almost ninety percents of the patients utilizing the service were urban inhabitants. The results showed that majority of patients paid out of their pockets, as the insurance industry is not yet fully developed in the country.

The introduction of this practice, which has competitive element within the same health system, may have substantial results in increasing productivity of individual health care providers and productivity between the two health sectors in place. As specialists are trying to express highly reputable professionalism to attract more private clients on their names, basically they have to do a better quality work for public sector patients, which is a pool of potential private patients. Consequently, both public and private patients receive good quality health care. The total outcome of this is a reduced number of cases in hospitals i.e. disease burden and thus reduction in costs of care incurred by the health sector in general.

This study found that this type of public private mix is beneficial to both health care providers as well as patients, if well managed. Through this mix the poor public patients directly benefited from the pockets of richer individuals within the society, without the later complaining about this cross transfer of resources. However, if the fast track services are to work for the public interests, then the authorities should take serious measures in raising the standards of services to the required levels, even if that would mean increasing levels of fees for services. Having highly qualified care providers alone is not an issue if patients are still being frustrated with the current sub standard services that carry the name fast track services.

6.2 Recommendations and policy issues

1. This practice is part of the new reforms in health sector in Tanzania, and is a new form of PPM. Therefore, the effects that could be associated with this new mix were not foreseen prior to its establishment. Scaling this practice countrywide before having in place a strong regulatory and monitoring systems may result into deterioration of the entire public health care system leading into the evolution of "**poor services for the poor.**" This therefore, justifies the great need for the government to have an official, central organ that will constantly monitor, evaluate and regulate the implementation progress of the practice and that will lead to improving health service provision for both the public and private sectors.

2. Dissatisfaction with local administration and management was a concern frequently mentioned, mostly in MNH and MOI than in BMC. Several issues mentioned as weakness of the practice were within the managerial capacity of local administrators. Although there are executive committees that run the practice, yet it seems like the management was not transparent in handling funds (i.e. incentive systems and subsides). It is recommended that a more transparent and fair system in handling incentives and general funds should be put in place to increase efficiency and productivity of work. The Bugando Medical Centre's system of allocating incentives could be taken as an example, as it clearly outlined how much money each individual participant is allocated and it included almost all categories of caregivers.

3. Decision-making was not done in a participatory way and lower cadres were poorly represented in the committees. Some departments were not involved in the practice though basically they indirectly offered services to private patients (e.g. central sterilization, laundry, mortuary etc). It is therefore recommended that decision-making committees should include representatives from all cadres and it should be participatory oriented in decision-making.

4. Private patients should have their diagnostic tests and investigations done faster and in comfortable ways. Every investigation unit should have a permanent staffs to deal with private patients. These personnel should be paid from the funds generated by the practice. Private services could also make use of the capacities of research laboratories in these hospitals for more convenience and faster services. Only proper arrangements and agreements are needed.

5. Since patients are given the right to choose their consultants, it is obvious that most patients prefer being treated by specialists. This was one of the reasons that justify involvement of only

specialists in the practice. But as a matter of fact, the specialists who are currently active in practice are very few compared to the requirements of the health sector generally. Moreover, most of these specialists are old and work on contracts and the gaps between them and their junior colleagues in terms of qualifications and experiences are so wide. Firstly, barring junior doctors to do private practice in favor of the so-called patients' demands is unprofessional conduct and is unethical. Patients should not choose consultants by their qualifications, as is the case in all systems of health care provision (in public sector and / or other private hospitals). Rather the hierarchy of service provision should be maintained by allowing all levels of caregivers to participate in the private services. Secondly, there should be strategies focused on a well-defined program for training more young doctors to higher qualifications. The government at ministerial and institutional levels should use any available opportunities on capacity building to train more health care providers to strengthen health services countrywide. Strengthening capacities in referral hospitals alone and giving them an incentive of practicing private services would result into these hospitals providing services that were supposed to be provided at levels of dispensaries or health centres.

6. It is recommended that doctors should attend patients, as it may be needed depending on the severity of the illnesses. All genuine public referral cases are supposed to be attended by specialists assisted by junior doctors.

7. The study found that most of private patients paid out of pocket. The National Health Insurance Funds, a health insurance plan for civil servants, pay low premiums for treatment of beneficiaries; levels that do not conform to actual curative costs in the private sector. Arrangements should be made to synchronize the premiums and health benefits coverage to reasonable rates that are acceptable in the health care system in general. This will enable members of the plan to have an alternative and a stable payment mechanism for health services.

6.3 Further research

For further research in this area, this study recommends the following:

- A similar study could be conducted but it should include the issues of equity. This could be conducted in all the four tertiary hospitals in the country in different seasons of the year. Interviews should involve health care providers who practice and who do not practice PPM, and patients who utilize the fast track service as well as those utilizing public services.

- Another study could be conducted to investigate the quality of private care services provided in public hospitals and other purely private hospitals. The idea would be based on looking at how the subsidizing of public services impact on the quality of private care provided by the fast track service.

References

Aljunid, S. (1998) "Private practice for public providers: An illustration of key issues from Malaysia." Research report, University of Malaysia.

Armstrong M, Cowan, S and Vickers, J (1994) Regulatory reform: Economic Analysis and British experience, Massachusetts: MIT in Propper C and Green K, (1999) " A large role for the private sector in health care? A review of the arguments, Centre for Market and Public Organization. University of Bristol, CMPO Working Paper No. 99/ 009

Bennett S, and Ngalande-Banda E (1994) Public and Private roles in health: A review and analysis of experience in sub-Saharan Africa. Geneva: World Health Organization.

Besley, T. and Coate, S. (1991) "Public provision of private goods and the redistribution of income," *American Economic review* 81(4), pp. 979 - 984

Committee coordinators (2002) *"BMC Intramural private medical practice" Specialists review meeting.* Bugando Medical Centre.

Bhat, R. (1993) " The private/public mix in health care in India". *Health Policy and Planning* 8(1): 43 – 56.

Gruen, R. Raqibul, A. Tahmina, B. Killingsworth, J. R. Normand, C. (2002), "Dual job holding practitioners in Bangladesh: An exploration." *Social Science and Medicine* 54(2002) 267 – 279.

Goudge, J (1999) "The public/ private mix within the health sector in South Africa" Centre for Health Policy, Public Private Mix net Report, University of Witwatersrand.

Goudge, J (1999) "The private / public mix." *The South African Health Review.* Health System Trust, Durban.

Hanson, K and Berman, P (1998) " Private health care provision in developing countries: A preliminary analysis of levels and composition," *Health Policy and Planning* 13(3): 195 – 211.

Ministry of Health, (2000) "Government Statement on the Health Sector at Consultation Group Session of the Consultative Group Meeting," Ministry of health Dar es Salaam.

Museru, L. M. and Uma, G. (2003) "Public /private mix: An alternative funding for public hospitals in developing countries: A 5 years experience of Muhimbili Orthopaedic Institute (MOI) Dar es Salaam Tanzania (Not published yet)

Newbrander W and Parker D (1992) The public and private sector in health: Economic issues. *International journal of health planning and management* 7:37 – 49

Nordyke, R.J. (2000) "Privatization of health care provision in transition economy: Lessons from the Republic of Macedonia. *Rand publications [www.rand.org/publications/RGSD/RGSD115/]* Visited on 20th June 2003

Propper C and Green K, (1999) " A large role for the private sector in health care? A review of the arguments. Centre for Market and Public Organization. University of Bristol, CMPO Working Paper No. 99/ 009

Roenen, C. Ferrinho, P. Van Dormael, M. Conceicao, M.C. and Van Lerberghe, W. (1997) "How African doctors make end meet: An exploration." *Tropical Medicine and International Health*, 2 (2): 127 – 135

Saltman, R.B and Figueras, J. (1998) "Analyzing the Evidence on European Health Care Reforms," Health affairs 17(2), pp. 85-108

Sinanovic, E. (1998) "Leasing out public facilities / services to the private sector" Research Report, Health Economics Unit, University of Cape Town

Tanzania National Website-Health (2002) "The ministers budget speech to the National Assemble. URT: http://www. TheTanzania National Website_files\health.html

Van de Ven, W. P. M. M. (1996) " Market oriented health care reforms" Trends and future opinions," *Social Science and Medicine* 43(5), pp 655 - 666

Wyss, K. Whiting, D. Kilima, P. McLarty, D.G. Mtasiwa, D. Tanner, M. and Lorenz, N. (1996). "Utilisation of government and private health services in Dar es Salaam." *East African Medical Journal*, 73(6).

Appendices

Appendix –1 **Patient's ID No** |__|__|__|__|

QUESTIONNAIRE FOR HEALTH MANAGERS AND HOSPITAL ADMINISTRATORS

Date: _____

Facility code |__|

Department: _____

Interviewers' code: |__|__|

Circle the number against appropriate answer(s).

1. Position of the interviewee

	1=Yes 2=No
Director	
Assistant Director	
Head of Section/Department	
Manager (section)	
Others (specify)	

2. Gender

	1=Yes 2=No
Male	
Female	

Questions about fast track services:

3. What was the rationale and aims for establishing the fast track services in this hospital? Give brief outline please.

4. When was the fast track service established in this hospital?

Year

5.Are there any policy documents governing the fast track services?
If Yes circle 1 and ask for copies of the policy documents for review

Yes	1
No	2

6. What is the arrangement of management and administrative positions for the fast track leadership? (How is fast track services/unit managed)?
Start from top to bottom for the leadership positions

7. Is there policy on fast track services for the following issues:
   i). Patients' rights (patient's charter) _____
   _____
   ii). Conditions of the wards and beddings_____
   _____
   _____
   iii) What determines the grading of wards to grades A, B?
   _____
   iv). Number of patients per ward in grades
   _____
   v). Other issues concerning patients' services _____
   _____

8. What is the ground for setting the levels of fees for fast track services?
   i). Fee level based on diagnosis

	1=Yes 2=No 8=NA
Depending on diagnosis group (surgical, medical, gynecology etc)	
Depends on severity of the case regardless of diagnosis	
Flat rate for all diagnosis but depend on the grade of the ward	
Not Applicable	
Others (specify)	

ii). Fee depending on the level of qualification of the consultant
If Yes, enter numbers 1,2,3,4 from highest to lowest fee levels.
If No (does not apply) put a tick (V) on Not applicable and enter 8 for the rest

	8=NA
Supper specialist's consultation (Professor)	
Specialist's Consultation	
Resident's Consultation	
Registrar's consultation	
Not applicable i.e. Fee levele does not depend on the qualification level of the consultant	
Others (specify)	

iii). Fee depending on the mechanism of payment for the service
If Yes, enter numbers 1,2,3,4 from highest to lowest fee levels category
If No (does not depend on payment mechanism) put a (V) on Not applicable and enter 8 for the rest.

	8=NA
Out of Pocket	
Contract with organizations/NGO	
Social Health Insurance	
Private health insurance	
Others specify	

iv). Other factors determining the level of fees for fast track services
*(Please explain*_____

9. What is the policy guide for the allocation of revenue generated from fast track service?
(What proportion of the revenue goes to each of the following beneficiaries?)

Enter the proportions of the amount for each section or (NA) not applicable if no revenue is allocated to a particular section

Services paid for	**%**
Paying for the building rental and overhead costs	
Paying for use of the laboratory	
Payment the consultant (doctor who provided service)	
Payment for other staff involved (Nurses, lab workers etc)	
Pharmaceuticals and medical supplies	
Other areas of allocation (Specify).	

10. Are there any systematic arrangements for possible cross subsidizations of funds from fast track to the public sector services within this hospital?

If Yes, state how this is done; If No such arrangements, enter 8 = not applicable, and skip to next question.

Service paid for by the fast track funds	1=Yes 2=No 8=NA
Repairing Buildings (re-elevation of walls, expansion works, painting etc)	
Maintenance of equipment (X-ray, MMR, Lab, Laundry and sterilizer etc)	
Maintenance of vehicles (Ambulance and others)	
For general hospital hygiene and sanitary activities (sweeping,	
Funding blood bank reserve	
Funding special selected services	
Other services (Specify)	

11. Does fast track as a unit employ its own staff or use only the government employees in this hospital?

If Yes, mention categories of workers employed,
If fast track does not employ workers enter 8=NA.

Category of staff employed	1=Yes 2=No 8=NA
Doctors	
Nurses	
Administration and Management staff	
Financial department Staff	
Operational Staff (Drivers, Attendants, Cleaners, Security)	
Others (specify)	

Number of patients

12. How many patients attended public and fast track services in the following periods?
Request the records and study the patterns for the past six months and record the number of patients in the table below.

Time range	Fast track	Public	Total	% Fast track
The past two weeks				
The past month				
The past six months				

Appendix – 2

Patient's ID No |_|_|_|_|

PATIENTS' EXIT INTERVIEWS

Date: _____

Facility Code |_|

Department: _____

Interviewers' code |_|_|

Personal Information:
Enter 1, 2 or 8= as appropriate to the answer provided

1. Gender of the respondent

	1= yes, 2= No
Male	
Female	

2. How old will you be at your next birthday? _____Years

3. Which of the following describes your employment situation

Employment status	1=Yes, 2=No, 8=NA
Employed full time	
Employed part time	
Self employed full time	
Self employed part-time	
Not working at all	
Others (specify)	

4. Can you describe what type of work you do?

	1=Yes, 2=No, 8=NA
Not working retired	
Not working - Disabled	
Professional	
Service (hotel, bar, café)	
General laborer/Contract work	
Domestic worker	
Others (specify)	

5. What is the average monthly income of your household?
(Ask even if respondent is not working)

	1=Yes, 2=No, 8=NA
Bellow Tsh30, 000	
30,001 – 60,000	
60,001 – 120,000	
120, 001 – 250,000	
Above 250,000	

6. What level of education do you have right now?

Level of education		*1=Yes2=No8=NA*
Primary education std 1 - 7		
Secondary education:	Form 1 – 2	
	Form 3-4	
	Form 5-6	
Post secondary Certificate and /or Diploma		
Advanced diploma and or University Degree		
Other (specify)		

7. Where do you live?

Region		Region	
Municipality... ... ... District ... ... Ward... ... ... Street... ... ... Village... ... ... Others...		District... ... ... Ward... ... ... Street... ... ... Village... ... ... Others...	

8. What type of house do you live in?

Type of dwelling	1=Yes, 2=No, 8=NA
Formal house (Roofed with iron sheets or tiled)	
Traditional dwelling	
Flat in a block	
Renting room in a flat	
Others (specify	

Health care utilization

9. Were you referred from another health facility or you came straight from home/work?

Referred from other facilities	1=Yes, 2=No, 8=NA
Directly from home	
Directly from work/other places	
Others (specify)	

10. Was this your first time to use fast track services at this hospital?
Circle the answer

Yes	1
No	2

11. How did you know about fast track services in this hospital?

Source of information	1=Yes 2=No 8=NA
Was told by colleague at work/neighbors/ relative	
From health worker when arrived here (doctor, nurse, others workers)	
From other sources (specify)	

Diverting patients

12. Why did you choose to use fast track services and not other service lines?

	1=Yes, 2=No, 8=NA
Was told I would get faster and good services	
I knew it offers faster and good services	
Has cleaner wards and toilets	
There is a nursing care all the time	
Doctors are keen and friendlier than for the general track	
There is more privacy	
Other reasons (specify)	

13. Were you convinced by a person working in this hospital to use the fast track services? ***If Yes, who that was? If No enter Not applicable***

	1=Yes, 2=No, 8=NA
Doctor	
Nurse	
Other hospital staff	
Not applicable	

14. Did you come for a specific kind of service for fast track service? What kind of service was it?

_____

15. Will you use the fast track services again in the future? Why?
1. Yes. _____
2. No. _____
3. I do not know _____

Complaints

16. Do you have any complaints about the way you were serviced by the fast track? Can you specify to whom your complaints are particularly directed?

	1=Yes 2=No8=NA
Management workers for bureaucratic procedures	
Attitude of some workers (doctors, nurses)	
Poor equipment and lab services	
Delay of investigation results	
Unclean wards and toilets	
No privacy in wards	
No running water for all the time/some times	
Others (specify	

17. What do you think about the rate/costs for the fast track service?

	1=Yes, 2=No, 8=NA
Relatively fair as regard the services provided	
It is too expensive for majority of people	
Cheap as compared to service quality	
Others (specify)	

Payment mechanisms

18. Who paid for the services you received?

	1=Yes, 2=No, 8=NA
Out of Pocket	
The organization I work with pay for health care of all staffs	
Social Health insurance	
Private Health Insurance	
Others (specify)	

19. What are your general opinions about the fast track service?

_____

Appendix - 3 **IDNo** |__|__|__|__|

QUESTIONNAIRE FOR HEALTH CARE PROVIDERS

Date:_____

Facility Code |__|

Department: _____

Personal Information

1. Age_____

- ***Please Circle the number on the right of the box that is relevant to your situation.***
- ***In certain circumstances you can choose more than one variable of answers.***

2. Sex

	1=Yes, 2=No
M	
F	

Qualifications

3. What is your current qualification?

	1=Yes, 2=No, 8=NA
Specialist/consultant	
General practitioner (doctor)	
Nurse	
Laboratory Worker	
Others (specify)	

4. What is your area of specialization?

	1=Yes, 2=No, 8=NA
Surgery	
Obstetrics and Gynecology	
Physician	
Pediatrician	
Ophthalmology	
ENT specialist	
Anesthesiology	
General Practitioner	
Others (specify)	

5. For how long have been practicing in the public health sector?

	1=Yes, 2=No, 8=NA
Less than 1 year	
1-3 years	
4-6 years	
7-9 years	
10- 12 years	
More than 12 years	
Not applicable	

6. Have you ever practiced in private sector apart from fast track practice?

Enter number of years you have been in private practice.

If No, circle 2.

1. _____Years_____Months
2. No

We are trying to find out more about how people working in public health facilities with private practice (fast track) feel about their work and what factors influence the two practices working together. Below you will find a series of statements relating to some of these factors. Please read each of the statements and *for each statement mark only once,* in a box to whether you agree, disagree or uncertain about it.

Impacts of fast track

7. Why do you think it was necessary to establish fast track services in this hospital?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
To increase access to health care					
To maximize capacity of the hospital space					
To maximize the utilization of resources (Human,					
To retain health care providers (consultants, doctor, nurses) from going for private practice elsewhere.					
To raise funds for local hospital use					
To improve quality of services within public sector					
To enable doctors earn more income					
To challenge other private hospitals in quality of care					
Others (specify)					

8. What do you think are the positive impacts (advantages) of fast track practice in this hospital and generally in health sector?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Has increase access to health care					
Has maximized capacity of the hospital space					
Has maximized the utilization of resources					
To retain health care providers (consultants,) from going for private practice elsewhere.					
To raise funds for local hospital use like repair of buildings, purchase of supplies etc)					
Has improved quality of services in public sector					
Has increased workers' motivation and efficiency					
Has lead to good doctors to patients relationships					
Others (specify)					

9. What do you think are the negative impacts (disadvantages) of having fast track services in this hospital?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Has reduced availability of health care providers for public sector patients resulting in long waiting time and poor services					
Has introduced bias to health workers in serving private than public sector clients (money oriented)					
Health workers divert patients to use fast track services even if patients did not aim to use this private service					
Create inequality of care provided to patients within the same ward or hospital					
Leads to over treatment of patient (Prescribing more drugs and investigations than necessary)					
Poor providers-patient relationship					
Emerging conflicts among practitioners, health workers for financial incentives					
Others (specify)					

10. Do you think fast track offers higher quality services than general public service? If Yes; In which aspects?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Rational waiting time for patients (consultation and receiving treatment)					
Rational number drugs and investigations per diagnosis					
Reliability and availability of health personnel when needed (Doctors, Nurses, anesthesiologists					
Reliable availability and supply of drugs and other consumables supplies like gloves, bandages etc)					
Improved sanitation and hygiene (beddings, toilet					
Doctors are more keen and friendlier when attending fast track patients					
Others (specify)					

Reasons for using 'fast track' services

11. In your opinion, many patients prefer paying for private services (fast track) though they could get public health care for lower costs because

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
They are malinfiromed					
They are diverted by doctors to private practice (fast track) though treatment is available in public.					
Lack of drug and equipment in public health care					
Less attention by doctors and nurses in public care					
Improved sanitation and hygiene (beddings, toilet					
Short waiting time for consultations or treatment					
Others (specify)					

12. The presence of fast track services (private practice) within public hospitals could help in improving the quality of public health sector in the following ways:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Rational waiting time for patients (consultation					
Rational number drugs and investigations per diagnosis					
Reliability and availability of health personnel when needed (Doctors, Nurses, anesthesiologists e					
Reliable availability and supply of drugs and other consumables supplies like gloves, bandages etc)					
Improved sanitation and hygiene (beddings, toilet)					
Doctors more keen and friendlier to all patients					
Funds generated through private services used to repair buildings and other activities for the benefit of public sector					
Others (specify)					

Incentives

13. What are the incentives for you continuing work in the public health sector?

	1=Yes, 2=No, 8=NA
Job security	
Career perspectives and possibilities for training	
Responsibility to the Nation by helping people	
It's the source of financial to sustain living (salary)	
Others (specify)	

14. What are the incentives for you working in fast track services?

	1=Yes, 2=No, 8=NA
Earning more income	
Increase scope of my practice	
Increases access of people to medical care	
Comfortable working environments	
Others (specify)	

15. Which issues should the government address in order to improve conditions of employment in public health care sector?

	1=Yes, 2=No, 8=NA
Salary	
Training	
Career perspectives	
Housing for health workers	
Education facilities	
Medicine and supplies	
Others (specify)	

Fee levels

16. Do you think the fees for fast track services are affordable by the majority of the people?

	1=Yes, 2=No, 8=NA
Affordable	
Relatively affordable	
Not affordable	
Other (specify)	

Management issues

17. Are you personally satisfied with the way fast track unit/service is managed?
Please circle 1 for Yes or 2 for No and Give a brief outline as to why Yes or No

Yes	1
No	2

_____

_____

18. What is you general comment on this study?

_____

_____

Appendix – 4

4.1 SCHEDULES FOR THE IN-DEPTH INTERVIEW WITH HEALTH MANAGERS AND ADMINISTRATIVE STAFF

(Answers should be taped and notice taken during the interview)

Date of interview: _____

1. Can you please explain to me what fast track service is?

2. What do you think are the benefits of having fast track services in this hospital?
   - For the facility side (infrastructures, equipments etc)
   - For the health care providers (Doctors, nurses, lab workers etc)
   - For patients
   - For health care service production process as a whole
   - Others

3. What do you think are the disadvantages of having fast track services in this hospital?
   - For the facility side (infrastructures, equipments etc)
   - For the health care providers (Doctors, nurses, lab workers etc)
   - For patients
   - For health care service production process as a whole
   - Others

4. Are there any complaints you get from patients or other people in the community about fast track services? What are they about-if any?

5. Do you think the fees for fast track services are affordable by the majority of the population? Why do you think so?

6. Are there any conflicts and misunderstandings arising between management and health worker or among health workers that are attributed to fast track services in this hospital? Give some few examples of such.

7. Do you hold meetings to discuss problems that arise with patients and / or among staff regarding the fast track services?

Thanks very much for your cooperation

4.2 SCHEDULE FOR IN-DEPTH INTERVIEWS WITH PATIENTS

(Answers should be taped and notice taken during the interview)

Date of interview: _____

1. Age_____
2. Gender _____
3. Level of education _____
4. Place of domicile_____
5. Income level _____
6. How did you know about the fast track services at this hospital?
7. Why did you decide to use fast track services?
8. Did anyone among hospital workers encourage you to use fast track services, which was probably not your preference at first?
9. Do you think there is a difference between using public services and fast track services? (If yes) What are the differences that you have noticed?
10. What impression and general opinion do you have about fast track services at this hospital and in health sector as a whole? (Positive and Negative).

Thank you