

Voluntary Hospital Experience – Hospital management in relation to Public Private Partnership - The challenges of the public private partnership as seen from a rural, VA perspective.

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Introduction:

Being a large hospital in the bush, there are many particular challenges to the Public Private collaboration at national and district levels. Many of the challenges presented in this paper will nevertheless be common to many of the Voluntary Agency health facilities, and we believe, to other service delivery sectors as well. This paper will present some of the key challenges needing increased attention as the public private partnership agenda is being formed. The content of the paper relates to government institutions both at national and district levels, but also to donors and voluntary agency coordinating bodies.

History and brief background of HLH:

Since its' inception in 1955, Haydom Hospital has practiced a holistic approach to health care for its patients, attempting to meet the "total needs of the person" including spiritual, social, and health needs. This has involved contributing to local development, including building of roads, bridges, primary and secondary schools and churches, also involvement in water and agricultural projects, and maize distribution during the recent famines.

The hospital opened in 1955 with 50 beds, and has grown considerably since that time. It was built at the request of the government at the time, and has been part of the national health plan ever since. Only ten years later, the hospital was expanded extensively to meet the needs of the growing local population. We were honored when in 1967 these new extensions were opened by the late Mwalimu Julius K. Nyerere.

In 1971, Haydom opened the Pre-Nurse School, in order to help local young people to prepare for further education within the health sector. In 1982, the

Haydom School of Nursing was opened, and we were once again honored by the presence of the late Mwalimu Julius K. Nyerere.

The increasing population in the surrounding community and region meant that in the 1980s it was again necessary to expand the hospital facilities. Therefore, in 1981 a laboratory and the first pediatric ward was built.

Haydom Lutheran Hospital continues to grow today: In January 2003, a second 100 bed pediatric ward was opened by Honorable Prime Minister Fredrick T. Sumaye. Since 2000, the hospital has responded to growing problems in the region by adding an eye department, psychiatric clinic, epileptic clinic, and diabetic clinic, and will soon develop a clinic to help victims of alcohol abuse. The hospital has set up a prevention and educational program for HIV/AIDS and STIs, which is named Haydom Voluntary AIDs Control Program (HAVACOP). In addition, a treatment and care program has been started, with medical treatment and support being given to AIDS patients already in need of treatment. Finally, the hospital has expanded its' health care coverage in the region to include several health centers (3), dispensaries (2) and mobile reproductive and child health services (27).

As the hospital and local community continue to grow and expand, plans for the future include the ongoing hospital refurbishment, acquisition of a new CT Scanner, a 50th anniversary jubilee gift by the Norwegian "Friends of Haydom", and the development of the collaboration with Kristiansand Hospital. In addition, there are plans to develop and modernize the leadership of Haydom Lutheran Hospital through the on-going organizational review.

The guiding principle in all the work of the hospital through the years comes from Ephesians 1.14 – To His Praise and Glory

Vision and Objective

The vision of the hospital is – (ref. Strategic Plan 2002 – 2006)

To Cater for the Needs of the Whole Human Being- Physical, Mental, Spiritual and Social

This vision is the basis for the main objectives defined as

- Reducing the Burden of Disease
- Poverty Alleviation
- Building and Maintaining Institutional Capacity of both HLH and its Partners
- Improved Collaboration with Likeminded Institutions, donors and Government

In achieving these objectives, the hospital has decided upon a set of strategies for medical care, capacity building and poverty alleviation. These main strategies give the foundation for the core activities of the hospital.

The total immediate catchment area of the hospital comprises 268,120 people, (according to the national Census 2002 and extrapolated using an annual population growth rate of 3.8% for Manyara Region and 2.3% for Singida Region). The total greater reference area is extrapolated to 1,795,632 people. The breakdown of these can be seen in the table below.

Table I. Target population

Immediate Catchment Area			Greater Reference Area	
District	Division	Population	District	Population
Mbulu	Dongobesh	135309	Mbulu (3.8% ann.)	288399
Hanang	Basotu	62914	Hanang (3.8% ann.)	122059
Iramba	Nduguti	69898	Iramba (2.3% ann.)	385260
Total		268120	Meatu (3.3% ann.)	265651
			Karatu (4.0% ann.)	192994
			Singida Rural (2.3% ann.)	420548
			Singida Urban (2.3% ann.)	120721
			Total	1795632

Maintaining a high quality of medical care is the central theme of the Hospital. The Hospital relies on the trust of the people it serves, and to maintain this trust, a high quality and accessibility of health services is needed. The medical care incorporates a close link between the curative, preventive and palliative care. In addition to this, because of the remote location of the hospital, adequate physical support services are essential.

The official number of beds at HLH is 350, although the Hospital actually accommodates over 400 beds. The hospital directly caters to a population exceeding 300,000 people and has a wider reference area of 1,8 million people from the neighbouring districts including Mbulu, Hanang, Iramba, Meatu, Babati, Karatu and Singida.

2004 was a very busy year at the hospital with a total of 11,029 admissions and 79,077 outpatients treated. The hospital conducted 4566 major operations and minor operations, and the number of laboratory examinations was 88,306. The number of deliveries reached 3096, with 454 caesarean sections performed. 26,905 mothers visited our 27 Reproductive Child Health Services (RCHS) outreach clinics and 77,588 children were examined at these clinics alone.

The financial situation improved in 2004. This was mainly due to the grant for the running budget from the Royal Norwegian Embassy in Dar Es Salaam. We have applied for more grants from the Government of Tanzania, but we have had no official reply yet.

During the year there was a sharp rise in the salaries (from 30% to 50% for the different categories). The annual budget for 2004 was TSh 1,206,010,437 (approximately USD 1,150,000).

This covers:

- The hospital running budget
- The Nurses Training school
- The large Reproductive and Child Health Services (RCHS) work with 27 outreach clinics
- The Outpatient work
- The 24-hour ambulance service

Table II. Financial overview

Income	Percent of total budget 2003
Grants from the Tanzania government (bed and staff):	5.7%
Grants from the Norwegian government:	51.8%
Patient fees:	26.8%
Gifts for scholarship from Finland and Norway:	2.0%
Gifts for running budget:	2.2%
Other income:	11.5%
TOTAL	1,2 billion TSh

Challenges to the Public Private Partnership agenda

It is interesting that the theme of this year's Joint Health Sector Review is the Public Private Partnerships. IN celebrating its 50th anniversary on the 14th to 16th of January this year, the hospital arranged a one day symposium in which the Prime Minister Honorable Frederick T. Sumaye, the Honorable Minister of Health Anna Abdallah, and several other core policy departments from the Ministry of Health were present. Key donors, the Royal Norwegian Embassy, regional and district authorities and key stakeholders were also present. The theme of this symposium was

Government and Voluntary Agencies – how to meet the challenges of holistic health care in rural Tanzania.

The reflections below will therefore include many of the topics, discussions and recommendations following this symposium.

1. The relationship between the government and voluntary agencies in Tanzania

The government of Tanzania realises the important contribution of Voluntary Agencies (VA's) in providing health care access. VA's provide health coverage for many rural and under-served areas. They own 40% of hospitals in the country and 38% of all health facilities. The government is increasingly trying to improve the relationship with the VAs since they provide a direct link to the local community. For example, the Tanzanian government is using some of the VA hospitals as District Designated Hospitals (DDH) as a measure to increase health care coverage in areas where there are no government hospitals. If a VA hospital is designated as a DDH the government covers 100% of the running costs and there is an agreement that no other hospitals will be constructed in the area. **In fact all health facilities receiving government support towards provision of services are regarded as public health facilities, regardless of ownership. (Private hospitals regulation act 1977 with amendments 1991)** Despite these measures to improve relations, the strength of the relationship between the government and faith-based organisations is threatened by problems of communication, lack of funding, lack of other types of assets such as drugs and human resources and lack of acknowledgment of the need for a strong and effective civil society, also at the point of service delivery.

2. Funding

Budget Support or Project Funding

The shift in policy approaches is hampered by fundamental problems with programme funding. The fundamental question is: "Can the donors be relied upon to give sustainable support?" At present, money is donated to a general account and the government is responsible for establishing benchmarks, distribution schemes and accountability. However, will support such as basket funds continue in the future or will donors move toward other types of budget support schemes? What will happen to projects delivering health services owned by VAs or Civil Society in general?

We understand the need for donors to coordinate their activities and also the increased possibility of real priority setting provided to the government as the funds are provided without strings and to government allocated budgets through budget support.

We do however, see potential challenges to the private not for profit sector if this support is provided at the expense of support from the donors to the civil society service deliverers. The issues are common to those raised as the basket fund

was introduced. Budget support reallocated from previous government support to increased government autonomy has many positive elements as the government better can prioritize as they find useful to reach their objectives. From a VA point of view however, as these funds are distributed using pre determined formulas, it is important that there is an open, fair and transparent priority setting process, and that the capacity to implement the guidelines are present at district level. Our experience with the formulation and implementation of the basket fund reminds us that this is not the case, and we foresee similar challenges with increased budget support.

In addition, if the budget support is channelled from support to the civil society service deliverers to government service delivery, there are many issues needing increased attention. It is likely that these are unintended consequences but need to be included in the overall budget support picture, particularly by the donors, but also by government.

The first issue has already been elaborated previously in this paper, as there are unintended consequences related to the actual implementation of the support. This is due to the lack of understanding or capacity within the government sector, particularly at local levels, to channel the funds in an appropriate and efficient way. Even if they are given clear guidelines and formulas, these may not be adhered to, and they may not be efficient from the outset as civil society and government will have different strategies to reach the same objectives.

It is further not likely that the government is willing to channel the resources previously provided to voluntary agencies from donors, through the budget. The implications of this are dramatic as these facilities experience an immediate lack of funds, and are closed down. The government does not have the capability to replace the services, and the only real losers are the public.

Channelling funds to the government sector only has implications on the effective mix of public private service delivery. It is also likely to be inefficient as the voluntary agencies have mechanisms for eliciting resources otherwise not available to the government sector. These mechanisms are triggered by values such as solidarity, equity, trust and diaconia.

Voluntary agencies also have the ability to “top up” funds from large donors with funds from smaller donors, enabling an effective gathering of resources that otherwise would not have benefited the society. The small donors funds are not enough to sustain the activities and are lost if large donors divert to budget support only.

A further unintended consequence of budget support at the expense of support to civil society is the role voluntary agency facilities often have in adapting delivery strategies to evidence quickly. It is much easier for VA facilities to change routines and absorb scientific and managerial evidence, and as such

provide information on related effects and challenges to the government sector in a fruitful dialogue. It also provides a more efficient bridge of the “know-do-gap” from research to implementation.

It is further important to support civil society delivery mechanisms as they are needed (as also acknowledged by the government) for advocacy, monitoring and evaluation of government policies. VA's are often intimately integrated with the population, and will know how government policies are effectuated and their effect on the population. These policies can only be monitored efficiently however, if a qualified infrastructure within the civil society is maintained.

In addition there is the actual delivery of services. VA's contribute substantially to service delivery in Tanzania (and many other developing countries), as they also did throughout the history of Europe and other developed countries. By channelling funds away from these services the population will be left with a dramatic reduction in services, and thousands of health workers are left unemployed. The VA's contribute greatly to the Tanzanian economy and household income, not only because they reduce burden of disease and as such increase productivity, but maintain the ability of many households to sustain a livelihood through income and professional development.

VA's also provide a large bulk of the vocational health training, and as such contribute greatly to the pool of health workers available within the health sector. It is not likely that the government has the capacity to replace the vast number of educational facilities provided by the voluntary agency sector in health. The same applies for the continued education facilitation provided by these institutions.

It is further clear that the population in rural areas largely depend on the services provided by the voluntary agencies and private not for profit sector. The equity dimension that would follow a break down of these services due to the unintended consequences of budget support is immense. It would be directly counterproductive to the efforts and objectives of processes such as the Poverty Reduction Strategy plans and the Millennium Development Goals. Voluntary Agency service delivery is therefore crucial for these processes to succeed. Reducing health service availability in rural areas will also increase the pressure on urban areas, both in terms of utilization of services and migration.

Finally, as mentioned also later in this paper, increased budget support at the expense of support to civil society could jeopardize the availability of generalized, comprehensive services to the people. Voluntary agencies have a history, and often as a main objective, to provide services at all levels and for as many needs as possible. They also provide services, not interventions, as they consider all of the ailments and needs of the patient as they walk into the facility reception, and are not confined to treating only their malaria; HIV/AIDS or TB. Increased funding through budget support, coupled with the massive international and

national pressure on cost effective interventions, is likely to increase funding towards vertical and focused interventions, rather than comprehensive, horizontal services. It is ultimately a question of trust and human rights. Would any resourceful citizen of Dar Es Salaam, Brussels or Washington DC accept anything less for themselves than a health service providing care when needed? Interventions to reduce Malaria do nothing to help the victim of a traffic accident or the child suffering from severe burns after falling into the fire. These patients also have the right to quality health care. In fact continued rolling out of these vertical interventions leave those of us trying to provide a comprehensive health service with less and less available and flexible human resources as these interventions take their lions share of our qualified personnel. We realise, in the current cost effective mode of thinking, that it will take considerable political will and courage to continue to advocate for services that fall outside of the global funding mainstream.

Basket funds and Joint Rehabilitation Funds

The concept of the basket fund is central to Tanzanian health funding. The intention of the basket fund was to provide donor funds, which were free of donor restrictions and conditions, which the government was responsible for distributing. As such the basket fund has created an important awareness of the health sector in Tanzania that can be used in the future for increasing Tanzania's independence from global vertical schemes by allowing them to set their own benchmarks for funding and establish their own criteria for accountability. In addition, it is an important source of money that may be difficult to replace with individual donations.

However, there are several problems with the basket fund. Many stakeholders, including the Haydom Lutheran Hospital, question the initial distribution formula as well as distribution schemes, auditing policies, transparency of accounting records, and timeliness of support. In general, the voluntary agencies feel they have been left out of much of the planning for the use of basket funds and other money.

Another problem related to basket funding is the problem of distribution of the available funds. Despite clear guidelines governing basket fund distribution, voluntary agencies often end up not receiving this money. VA's are finding it increasingly difficult to run health centres and dispensaries without this support. A case study from Haydom Lutheran Hospital illustrates the financial consequences of non-provision of basket fund support, even though the policies are clear and this support should be distributed by the district authorities. The table below is from this case study.

Table III. Basket Fund Case Study from Haydom Lutheran Hospital

Facility	District	Deficit 2003	Basket Funds received	Haydom Lutheran Hospital Subsidy
Gendabi Lutheran Health Centre	Hanang	2,765,017.70	0	2,765,017.70
Balangda Lutheran Health Centre	Lalu Hanang	5,195,627.25	0	5,195,627.25
Kansay Lutheran Health Centre	Karatu	5,268,278.85	0	5,268,278.85

Transparency

Another issue is the transparency of government schemes for purchasing medicine and the timeliness of the receipt of medical supplies. This can be exemplified through the initial problems with the Anti Retro Viral (ARV) treatment programme where the first distribution of paediatric formulation for ARVs for Haydom was forgotten and an alternative source could not be found because of a government shift to more centralised distribution. A similar problem is encountered with the ARV treatment for adults: Haydom only received treatment for 20 patients while the hospital actually treated 88 patients. Fortunately the hospital was in a position to acquire additional medicines from elsewhere. This was stopped as the government centralized procurement protocols, and we are now totally dependent on the availability at the Medical Stores Department. It should be added that after the symposium in January this year the situation has improved, and we now have more than 130 patients on Highly Active Antiretroviral Treatment regimens and more than 250 patients in the HIV/AIDS treatment programme.

We realize the difficulty faced by the government but encourage a more open, fair and transparent drugs procurement and distribution policy. For example, in the ARV treatment programme the government only had supplies for treatment programmes for 2000 Tanzanians. In reality, about 400,000 – 500,000 people are in need of ARVs. Unfortunately, despite the centralisation of purchasing and formulation of treatment regimes, ARVs are not easily available. Currently, the government is updating and refining treatment regimes and allocation schemes in an attempt to increase overall ARV availability.

Community Health Funds

One funding issue is the development of the health insurance system, where each family pays 10,000 TSH per family per year as a way to help fund hospital costs.

There are however at present no funds available for voluntary agency hospitals or institutions, from these Community Health Fund schemes, and the worry is that these schemes become yet another form of Basket Fund in which the money is distributed according to the District Medical Officer's (DMO) perceived needs in the district. The households will lose the incentive to insure the household members unless quality is perceived to improve and the choice of service delivery is left open. It is also a problem in the perception of household leaders as to the usefulness in purchasing health coverage that they are not in immediate need of. Issues on moral hazard and adverse selection have not been adequately resolved, and we do not think it is feasible to force whole villages to enter into the scheme unless they are ensured quality improvement of the available services in their area. Finally we are worried about undebated, and therefore probably unresolved, legal issues as the purchase of insurance entitles the customer to a package of services. It is unclear what recourse mechanisms are available to the households, and consequences to the provider, if these packages are not supplied.

Bed grants

Currently, bed grants are allocated as one bed for every 1000 people in a district. However, medical needs are changing and it is necessary to review and increase this proportion. The government is working on amending allocation formulas so that data on distance to health centre and disease burden in the area are considered in the calculation. In addition, in July 2004 the grant per agreed bed increased from TSh15,000- 30,000 per year. It had remained at TSh 7500 from the beginning of the 1970's up to only a few years ago. It should be realized that even a grant of TSh 30000 per year per bed only covers a fraction of the costs of providing this bed at a hospital. It costs Haydom Lutheran Hospital about TSh 10,000 per bed per day. The hospital is further granted support for only 250 of its 350 beds. The bed grant therefore covers only 3 days running costs of two thirds of the hospital beds. The remaining 100 beds, and the remaining 362 days of the year for the 250 beds, have to be funded elsewhere.

3. Human Resources

Staff grants and training facilities

Another issue is the allocation of staff grants to private not for profit hospitals. Staff grants are provided to hospitals according to a formula based on the number of staff that has received required government certification. However, it is increasingly difficult to upgrade staff because of a lack of facilities for training and lack of clear guidelines about upgrades. In fact, it seems that voluntary agencies are last in the line for places at the training institutions.

As an example, for a long time there was only one school for nurses teacher training, and although Haydom tried for many years, only recently have students from Haydom been admitted. Upgrading to AMO has been difficult for Haydom

as well, and for the last two years Haydom has not succeeded in upgrading clinical officers. Our director, Dr Olsen has established a scholarship programme that enables up to 35 qualified people every year to upgrade. However placement is difficult because of a lack of training facilities.

Recent changes in staff categorisation have also created a problem. In Haydom, those who were before classified as “nurse B” are now classified as “enrolled nurses” due to changes made by the Nurses Association. This has created problems for many hospitals because the decision was made without discussion with the nurses or local health facilities, and has resulted in a downgrading of the staff at many local hospitals. Haydom tried to send eight people for upgrading but managed only one because of lack of training facilities. At Haydom about 60 “enrolled nurses” are presently working, and to get them upgraded seems almost impossible.

During the mentioned symposium at HLH the Minister of Health responded to this question by explaining that the government was working to increase voluntary representation in training facilities. She stated that, **“as long as voluntary agencies have 40% coverage of health in the country they should also get 40% coverage in training facilities.”** The Minister went on to say that it is not fair to have two sets of personnel, one supported by the government and one with only church support. She noted that church hospitals need to recruit their own staff according to their needs and their visions, and the government should support the salary regardless of affiliation. Seconded staff is subject to the regulations within the voluntary agency institutions, and should not consider themselves outsiders to be treated differently.

There is a problem with the general lack of training centres in Tanzania that contributes to the “brain drain” and inability of voluntary agencies to find qualified personnel.

4. Planning together: Communication, representation, and implementation

The issue of participation in planning, and the use of a bottom-up/grassroots approach to planning is of particular concern to the Haydom Lutheran Hospital. It is important, as underlined also by the Minister of Health, to make policy based on the needs of the people and not based on the needs of the donors or the government.

Decentralisation

One such issue is the issue of decentralization. The Millennium Development Goals (MDGS) are examples of centralised targets pushed from centralised global policy makers, and not by health workers or the target population. Therefore, there are inconsistencies in the feasibility of aspects of these policies when applied “on the ground.” Failures in implementation are often blamed on

low salary or low worker morale. However, failures may also be due to the fact that health workers and local health agencies are not involved in policy planning and target setting. A concern has been the muted voices of the Christian Social Services Commission (CSSC), Evangelical Lutheran Church of Tanzania (ELCT), and voluntary agencies in the policy debate. These voices are not given the direct information used by policy administrators when constructing targets.

Role of the VA in Policy Making and Information Dissemination

The Haydom Lutheran Hospital has set upon itself to be a change agent for the Tanzanian health services. HLH realises the importance of participating in the policy debate because a substantial amount of information is being generated by the hospital, both through direct implementation of health policy and through the research associated with the hospital. Therefore, the hospital is generating information that is necessary for the policy makers in order to make decisions.

Disseminating information from health research back to the local community is also a priority for the hospital. By providing this information, the hospital facilitates capacity building and allows the community to take control of their own health decisions. "Ownership of information" is important at all levels.

Furthermore guidelines and policies are not disseminated efficiently between local, district, and central governmental levels, and health staff are often accountable for implementing or responding to policies they have never seen. We as service delivery institutions are left without information about policies and processes. Similarly we experience challenges as statistics from the hospital are included in the district statistics at an inconsistent level. The MTUHA reporting is a major part of our activity, and it is discouraging when it is not included in the district annual statistics, such as was the case of our TB statistics for many years. In practical terms it meant that we were not allocated TB medicines from the district because it did not appear in the district health plans that we were in need of them, despite more than 600 new TB patients every year. It is also discouraging as we spend a lot of effort on MTUHA but the importance and benefit of these statistics are not conveyed back to us from health authorities

Guidelines and Implementation of Service Upgrades

There is also a lack of efficiency in communication of guidelines for upgrading services and personnel training: Guidelines and policy documents produced in the Ministry of Health are sent out to government health facilities with the help of the District Medical Officer. The VA's often do not receive these documents automatically. Consequently, it is necessary for representatives of the VA's to go to government offices in Arusha or Dar Es Salaam to ask for copies of the most recent guidelines. In addition, VA's are often not informed when new guidelines come out and are then criticised for not observing current policy. VA's are often either not informed or not invited to training sessions, and are later criticised for not attending. Improvements are needed in the dissemination and implementation of guidelines and advertising of training opportunities.

We suggest alternative means of communication, such as web sites, and the dissemination model utilised by the Tanzanian HIV programme. In this programme, the government is now putting a lot of effort into increasing communication, more effective distribution of policy documents, and increased policy discussion with voluntary agencies. This effort should be extended to all health services, not just vertical programmes.

5. Holistic Services: The Issue of Trust

The main barriers to service delivery have often been identified as lack of motivation, lack of funding, lack of human resources and lack of political will. We argue however, that several programmes have started and failed because the trust of the community towards the health facility and policy makers was not taken into account.

Frameworks

The question is whether policy frameworks themselves are barriers to implementation. Some of the framework elements are particularly important for services such as ours.

Prevention versus Cure

We believe that a holistic approach to health care is the most effective method for treatment and prevention. It is not a question of either prevention or cure. Dr. Olsen has exemplified the need for holistic thinking, with his story of the man who came to the hospital with a sick child:

“If I answer this man by telling him how to prevent the child from being sick and not treat the child who is sick, he will look at me as a very stupid man and certainly not trust me with the health of his child later. If I treat the child, and then tell him how to prevent it from happening again, he will not only trust me, but also trust my message of prevention”

Comprehensive or Selective approaches

We are increasingly surrounded by vertical programmes such as Roll Back Malaria, Stop TB, Gates Foundation, PEPFAR etc. Although presenting valuable additional private and global assets, they are slowly taking over the available health resources at the service delivery level. The problem with this is that people with problems other than malaria, TB or AIDS are forgotten in the system. Health workers are left administering interventions aimed at reducing major burdens of disease, but the result is the erosion of the horizontal services important to the trust of the patient to the services. Apart from the obvious challenges at district level, we also experience these challenges at facility level as the HIV/AIDS prevention and treatment programme at the Haydom Hospital demands increasing attention from our staff in terms of donor reporting, training regulations and management.

Interventions or Services?

As a hospital providing holistic services, we are increasingly worried about the increasing focus on interventions, often at the expense of services. Interventions are easily funded and eagerly researched. Services are more than the sum of interventions, and important to the trust of the services within the population. Hospitals, health centers and dispensaries provide services, not only interventions. We would therefore advocate increased attention to services, both in government and donor policies and thinking.

Opportunities and the way forward

The way forward can be summarized in 10 main points, as was done at the symposium in Haydom on the 14th of January this year by government, donor and voluntary agency participants alike.

1. Government and voluntary agencies are both part of the public health system and are not competitors. Government must therefore be willing to increase the support to the Voluntary Agency service deliverers
2. The Government struggles to increase the availability of funds to the health sector, and is still largely reliant on external assistance
3. The priority setting mechanisms for health sector funding need to be improved for accountability, relevance and transparency
4. Voluntary agencies should be given increased involvement in policy formulation through early and representative representation as well as through timely and adequate distribution of policy documents
5. There is a need for a revision of the Basket Fund and Joint Rehabilitation Fund guidelines to reflect more accurately the contributions by the voluntary agencies
6. Present Basket Fund guidelines should be adhered to when funds are distributed as many voluntary agencies do not receive their allocated share
7. Donors need to consider the important independent role of civil society, in particular in rural areas, as change agents, service providers and policy monitors as more funding is provided through budget support
8. There is an increasing need of training facilities to improve the availability of human resources
9. Voluntary agencies need to be provided improved access to training facilities
10. It is important to provide holistic, horizontal services with the aim of sustaining and improving trust in the services, as availability of quality comprehensive care is a human right.

Conclusion

Many challenges remain to arrive at an effective mix of public and private delivery of services. These include inclusion of VA's in policy formulation, dissemination of policies to the VA's, transparency of policy formulation and priority setting, funding of services, training and management of human resources, and securing comprehensive, rights based services to the population.

Haydom Lutheran Hospital recognizes the increasing emphasis given to the private sector in recent health sector reform initiatives. This is a positive development, and reflects the good cooperation needed to succeed in providing adequate quality health care to the Tanzanian people. This trend represents an opportunity for further cooperation and should be continued and strengthened. As a major point of service delivery in the country we will continue to work for the success of this collaboration.
