Unresolved Challenges in Health Service Delivery in Tanzania under Public Private Partnership: Stakeholders Views from Dar es Salaam Region

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Abstract

Background: The public-private partnership in the health sector, which was introduced to improve the delivery of health services, has existed for decades in Tanzania. Contrary, the anticipated outcomes have not been realised. This paper attempts to underscore the challenges that have permeated the provision of health services under public-private partnerships.

Methods: A qualitative case study design was used. Institutional arrangements under public-private partnerships in the delivery of health services was used as a case. Fifteen (n=15) in-depth interviews were conducted with participants from both the public and private sector. Relevant documents were also reviewed to inform this study.

Results: Findings revealed that, although public-private partnerships is hailed for supplementing government's efforts in the provision of health services, institutional arrangements for the smooth provision of these services is lacking. Several challenges including inadequate resources, ineffective monitoring and evaluation of public-private partnerships performance, insufficient consultations between partners as well as varying goals and strategies were noted.

Conclusion: Challenges facing institutional arrangements for public-private partnerships may either be influenced by inadequate legal and policy framework as well as ineffective implementation practices. Therefore, effective and smooth interface can be achieved by strengthening implementation practices through development of strong and adequate supportive policy framework that can ensure adherence to contractual agreements.

Background

The government of Tanzania launched comprehensive Health Sector Reforms (HSR) in the 1990s as a policy response to the Structural Adjustment Programmes (SAPs) [1, 2]. In health service delivery context, SAPs led to introduction of user fees, pre-paid system and health insurance [2, 3, 4, 5]. However, the capacity of the community members to pay user fees was impinged by the heightened poverty that was aggravated by SAPs [2, 6]. This situation needed to be revised. Several strategies were therefore adopted to influence organisational changes in providing better outcomes in health service delivery. These included among others, engaging community participation in primary healthcare services and introduction of the private/non-state sector in service provision [7, 8]. This resulted into the establishment of institutional arrangements that constituted the private and public sector, popularly referred to as Public-Private Partnership (PPP) in healthcare service delivery [1, 2, 9]. The introduction of PPP aimed at improving the quality of, and expanded access to health services; increasing the opportunities for private sector to invest in healthcare; and formalise the system of non-profit organisation to involve in healthcare service provision [10, 11]. Significantly, it was also aimed at enhancing efficiency and effectiveness of services to achieve value-for-money, encourage innovation and develop more user-sensitive services

appropriate for a particular context [9]. In this regard, PPP is also seen as a way of improving resource management [12].

To implement health service delivery under PPP, Tanzanian government established policies and regulations such as the Public-Private Act of 1991, the PPP policy 2009 and the PPP regulation of 2011. PPP is also guided by the Tanzania Investment Act of 1997, Public Procurement Act of 2012, and the Public-Private Partnership (Amendment) Act of 2014 [2]. The guidelines on legal and institutional framework aimed at strengthening partnerships among stakeholders (government, development partners and private sector) to support healthcare service delivery and accessibility. Sevilla emphasises that the specific format of PPP in any given situation depends on the policy and regulatory framework, which often needs to be adjusted to accommodate new types of institutional arrangements, partnerships and collaboration [13]. Mahoney and Thelen note that institutional arrangements are therefore important in determining power relations which in turn determine partners' decision making [14].

Effectiveness of PPP in health service delivery is predicated on the nature of a particular institutional framework (formal and informal rules and constrains) which provide guidelines for implementations [15, 16]. The rules define private property rights and their allocation; the relationship between participants in the partnership; conventions governing participation such as competition, fair business practices and mutual trust [16, 17]. The necessity for ensuring effective institutional arrangements in the context of health service delivery is aimed at implementing strategies to improve the quality of healthcare services, increase universal and equitable access to healthcare service delivery [1, 18, 19]. The government of Tanzania has therefore, adopted three modes of health service delivery under PPP namely contracting out, offering subsidies and privatisation.

Under the contracting out mode, the government provides all necessary infrastructures, human and financial resources which are handed over to the private health entrepreneur. With regard to subsidies, the government provides some incentives and financial assistance to private health hospitals in order to facilitate the provision of specific health services such as maternal and child healthcare. Within the privatisation mode, the government either surrenders its health facilities and infrastructures to private individuals/institutions or allows the latter to develop their own infrastructures and the government offers them subsidies in terms of tax and supplies [20]. The existence of different modes of partnership reveals that universal access to healthcare services has improved. According to Ministry of Health and Social Welfare (MoHSW) the country had a total of 7507 health facilities of which 2677 (35.6%) health facilities work in partnership with the private sector as shown in Table 1 [21].

Table 1: Public and Private Health Facilities by Levels

Health Facilities	Public	percentage	Private	Percentage	Total
National Hospitals	5	100	0	0	5
Zonal Referral Hospitals	2	40	3	60	5
Regional Referral Hospital	23	70	10	30	33
Hospitals at Council levels	78	38	128	62	206
Health Centres	491	71	196	29	687
Dispensaries	4231	64	2340	36	6571
Total	**4830**	**75**	**2677**	**35**	**7507**

Source: MoHSW (2011)

The establishment and implementation of PPP in the health sector in Tanzania has contributed to the reduction of challenges associated with health services delivery and accessibility of preventive and curative measures [22]. The reduction of maternal and infant mortality, for example, can be attributed not only to government-owned facilities but also the existing private health facilities that are in partnership with the government [23]. It also facilitated accessibility of health services in remote areas, reduction of emergency cases at public hospitals, improvement of health services delivery due to competition and extension of employment opportunities [24].

Scholars in Tanzania have identified the phenomenon of health sector deterioration and suggested the participation of the private sector under PPP as a major critical solution for the vice [1, 2, 25, 26]. Studies done by Itika and Mwageni, and Mihayo indicate that despite various challenges that PPP has faced in Tanzania, its benefits cannot be ignored [10, 27]. This is because the public is aware of the existing system and its associated benefits such as reduction of distance, health cost reduction and improvement of the types of healthcare delivery among other things. PPP has also supplemented the capacity of health services delivery [10, 28]. However, PPP arrangement has not been without challenges. A review study by Basu et al. in the performance of PPP in the low and middle income countries revealed that it was faced with various challenges such as violation of the medical standards, inefficiency in the private sector (hospital), while the public sector struggles with inadequate human resources, equipment and medications [29]. Kamugumya and Olivier, observe that PPP in the reproductive and child health services in Tanzania has encountered challenges regarding informal partnerships, governing structure reflecting power disparities which leads to unaccountability among partners and less power to the established

bodies for instance the Council Health Services Board [22]. Other studies for instance of Maluka and Maluka et al. focused on contractual arrangements between based institutions providing health services and the government [30, 31].

Notably, the discussed studies have either focused on benefits of the PPP in the health services delivery, while others have analysed its challenges within the specific issues such as reproductive health. Furthermore, some studies used a review method while others focused on the PPP between the government and faith based organisations. Although there are common challenge of PPP arrangements some varying according to establishment and other challenge arise out of the nature or health service been delivered under the arrangement. There is congruency that there have been challenges that have been addressed. This paper, therefore, focuses on addressing issues affecting the effective interface between partners in health service delivery and associated challenges. The paper is divided into four sections in attaining the aim of the study. The first section comprises introduction of the study, methods are discussed in the second section, and the third section presents the findings of the study. Section four discusses the findings while, in the last section, conclusion and recommendations are provided.

Methods

Study design and sites

The concept of PPP is a complex phenomenon within the health sector and thus, requires an explorative approach. It is noted that the qualitative approach as a design for health science research is valuable for not only assessing programs but also, designing development interventions among others [32].The paper thus, employed a qualitative case study design in order to capture information regarding institutional arrangements and emanating challenges in the implementation of PPP in Tanzania. The sites' selection was based on the following three criteria: (i) complex, heterogeneous and densely populated areas; (ii) high concentration of healthcare facilities in PPP arrangements; (iii) facilities reported to have PPP implementation challenges. Kinondoni Municipality in Dar es Salaam was therefore chosen as suitable for the criteria for the study site. Within Kinondoni Municipality, the study focused on four wards namely Kijitonyama, Magomeni, Mikocheni and Sinza. These wards are densely populated; they have a variety of healthcare infrastructure, including both public and private healthcare facilities.

Sampling of participants and health facilities

Fifteen (15) in-depth interviews were conducted with participants selected purposively from the Ministry of health, departments and health facilities. Officials from the Health Ministry and District health department were selected by virtue of their responsibilities and experience in the implementation of PPP as indicated in Table 2. The Chief Medical personnel from both private and health facilities were selected as administrative focal persons from sampled health facilities. The criteria for selecting health facilities was based upon; (i) health facilities offering both public and private services; (ii) facilities with PPP institutional arrangement challenges. This was an informed decision guided by the document reviewed from the Ministry of Health, as well as information received from health officials at the region and district. Thus, the following health facilities were sampled: three hospitals namely; Sinza Government Hospital, Marie Stopes private hospital and Herbert Kairuki private hospital. Two health centres which are Mama Ngoma Health Centre (private), Magomeni Health Centre (government), and three dispensaries; Mwenge Dispensary (government), Arafa Capricon Dispensary (private) and Mico Sinza Dispensary (private) were also sampled.

Data collection methods

In-depth interviews and document analysis were used to collect data. The interviews enabled collection of detailed information regarding institutional arrangements in health service delivery. Questions asked during the interview addressed the roles and power of partners in decision making (planning, budgeting and implementation) under PPP. Enforcement of regulatory requirements, collaboration and information flow from national to local authorities for both public and private entities were also explored. An interview guide with key themes regarding information to be collected was used. Interviews were conducted at the participants' place of work with prior appointment for the scheduled time. These interviews were recorded by the tape recorder after seeking consent from the participants. Documented evidence was collected and examined in order to elicit meaning, gain understanding and develop knowledge regarding existing challenges emanating from institutional framework under PPP. The reviewed documents included the Comprehensive Council Health Plan (CCHP) for Kinondoni district of 2015 and 2016, National Public Private Partnership Policy endorsed in 2009 and the Public Private Partnership Regulation of 2015. Other reviewed documents were the Health Sector and Social Welfare public-private partnerships policy guideline of 2011 and the National Health Policy of 2007.

Data analysis and ethical issues

The researcher applied a thematic analysis approach to analyse the study findings. At the end of each day, transcribed field notes were read several times in order to identify patterns of experience (categories of common ideas). Tape-recorded in-depth interviews were transcribed verbatim and translated from

Swahili into English. Collected data were arranged and categorised into emerging themes of the study as presented in Section 3.This research was approved by responsible institution in the country for ethical consideration including Ardhi University on behalf of the government and Tanzania Commission for Science and Technology (COSTECH). The regional and district authorities in their respective administrative areas also provided research clearance. Prior to data collection, participants were briefed about the purpose of the study so as to obtain their consent for participating in the study. In addition, the information given was treated with confidentiality.

Table 2: Participants characteristics

Category	Location and Position	No.	Responsibility	Experience
Government	Ministry of Health; Director Policy and Planning and Head of Division Public and Private Health Facilities	2	Formulating, reviewing, implementing and monitoring of the Ministry's policies.	10+ years
	Kinondoni District Medical Officer	1	Implementation and monitoring of health programmes within the district and providing guidance and assistance to personnel. Liaising with other district authorities, higher authorities in the health sector and also performing other administrative duties in the district	7
	Kinondoni District Health Secretary	1	Planning and budgeting for health service delivery in the district; mobilise financial, medical and human resource, monitoring, support supervision and evaluation of health services.	6
	Kinondoni District Health Officer	1	Preparing district level health development plans on the basis of national policies and direction. Preparing annual district level health plans and programs approved by the district health committee. Conduct day to day administrative work	6
	Sinza Hospital; Medical Officer in Charge	1	Overall supervision of health services delivered at the facility and supervision of staff. Ensures smooth implementation and mainstreaming of government programs at the facility. Offers medical services and guidance.	3
	Magomeni Health Centre Medical Officer in Charge	1	Preparing the dispensary budget, ensure safe custody of medical supplies and equipment as well as offering professional medical services.	4
	Mwenge Dispensary Medical Officer in Charge	1	Providing and maintaining up to date inventory of all dispensary facilities, supervision of health service delivery at the dispensary and oversee implementation of health-related activities in the community.	5
Private	Marie Stopes Hospital; Centre Manager	1	Preparing budget for the centre and supervising the procurement process. Ensuring safe custody of medical supplies and equipment. Coordination with stakeholders.	5
	Herbert Kairuki Hospital: Chief Medical Officer	2	Overall in charge of the general administration and discipline of all staffs, responsible for preparing budgetof the	6

	and Deputy Chief Medical Officer		hospital, and conduct periodic progress and review meetings of the hospital.	
	Medical Officer in charge Mama Ngoma Health Centre	1	Providing and maintaining up to date inventory of all dispensary facilities. Ensuring efficient and effective delivery of services to health seekers. Supervising health education of patients and the community around.	4
	Arafa Capricon Dispensary Manager	1	Making proper diagnosis of diseases, prescribe treatment, treat minor injuries, attend general outpatient clinics	4
	Medical Officer in charge Mico Sinza Dispensary	1	Ensuring that patients attending the dispensary are well examined, treated and handled according to medical procedure, providing health education to patients and the community around. Also providing and maintaining up to date inventory of all dispensary facilities	5
Total		**15**		

Results

The provision of health services in Kinondoni Municipality is hinged on existing public and private institutions working either together or separately under the existing national health policy. In the context of PPP, provisions of health services are highly determined by existing institutional arrangements binding both partners. Implementation of PPP depends upon modification and development of supportive legislation, clear governance structures and sustainable funding mechanisms. In order to understand the provision of health services under PPP, this study investigated the prevailing institutional environment as presented in the next sub-sections.

Public and private health facilities in Kinondoni Municipality

In Kinondoni Municipality, findings from the Comprehensive Council Health Plan (CCHP) of 2016, reveals that the district has more private health facilities than public. According to availed data from the CCHP, the Municipal Council has 24 hospitals, 16 health centres and 158 dispensaries. Of all the existing health facilities, private facilities account for 78 per cent, whereas, public facilities make up to 22 per cent. Further analysis shows that the Municipality has 22 hospitals, 15 health facilities and 118 dispensaries,

which are privately owned, while 2 hospitals, 1 health centre and 40 dispensaries are publicas shown in Figure 1.

Figure 1: Distribution of Public and Private Health Facilities in the Kinondoni Municipality

***Source**: Kinondoni Municipal Comprehensive Council Health Plan, 2*

The existence of a number of private health facilities does not contravene the Tanzania National Health Policy of 2007 and the Public Health Policy Act of 2010 which state that, where there is a private health facility, the government should not construct another health facility of the same nature. Figure 1 reveals that the private sector responded positively to the call to participate in health service provision in Kinondoni. This response implies that the private sector will continue to dominate the district in terms of the number of health facilities in the foreseeable future. Under PPP, the government put in place appropriate infrastructure, as well as giving some autonomy to these private facilities to run important duties that were previously performed predominantly by the public health facilities. These include provision ofclinical services to pregnant mothers, children under five years' vaccination and the inclusion of health insurance.

Institutional arrangements for the provision of health service under PPP

Documents reviewed indicate that provision of health services under PPP in Tanzania and Kinondoni Municipality in particular, follows the established institutional arrangements that guide its implementation. The discussion with health officials at the district revealed that the existing interface between the public and private actors that are bound by the established institutional framework influences directly and indirectly the synergy of two partners (public and private) when providing services. Despite the contract, participants from the private health facilities lamented that there are inequalities regarding power in decision making and implementation of activities under PPP. This has hindered smooth implementation of partnerships. Kimenyi and Meagher, Amarakoon as well as World Health Organisation (WHO) also contend that health systems under PPP in many developing countries are plagued by poor design of institutional framework, complex relationships among partners and weaknesses in public health policies [33, 34, 35]. Therefore, Tanzania just like any other developing country faces challenges emanating from inadequacies of institutional arrangements.

Obstacles to health services delivery under PPP

Provision of health servicesunder PPP in Tanzania has faced significant challenges. These have resulted from existing interface of institutional arrangements for implementation of PPP activities that vary from

the state, community or partners. In this study, several challenges were revealed ranging from policy compliance to inadequate resources as explained in the following sub-sections.

Regulatory issues

The findings reveal that there are inadequate regulatory mechanisms as well as non-compliance issues. Notably, despite the existence of regulatory framework guiding PPP, the study reveals implementation challenges attributed to inadequacies in guidelines. It was observed that PPP governance structures at local level were lacking and therefore implementation of PPP activities was overseen by the Ministry of Health. Local authorities implementing the PPP arrangements were thus denied the mandate to manage partnerships. This creats bureacratic governance issues where by, sometimes partners at the local levels are answerable to the highest office. Although the Ministry of Health has developed guideline regarding the implementation of PPP, lack of PPP units at Local Government Authorities (LGAs) thwarts this effort. LGAs under this arrangement are contractual authorities with the PPP budget responsible for building the capacity of some personnel at LGAs to implement PPP health service delivery activities. The study reveals that the PPP policy of 2009 was built upon structures already established under the Health Sector Reforms (HSRs). Therefore, the policy may not adequately address the emerging challenges under PPP.

In addition to inadequate guidelines, the study also reveals lack of compliance to the existing policies. Kinondoni Municipality through its District Medical Office (DMO) enforces regulations and standards guiding healthcare provision and ensures adherence to the professional conduct of ethics. To ensure universal access to healthcare service for all, the District has put in place regulations to guide both public and private healthcare providers. This includes treatment of patients in emergency cases regardless of their ability to pay for the services. It was revealed that this policy has not been upheld because in some health facilities, healthcare providers establish their own prices, most of which were too costly for the majority of the vulnerable poor. In an interview with private facility health officials, one of the participants had this to say:

“…this facility was established for income generation and hence offering free services to some emergence complicated cases is costly and yet the government has not been supplementing the resources we have…If the facility has to be sustained, charges must be levied on every client regardless of economic or health status.”

This portrays that the partners have not been provided with adequate support to enable them to adhere to regulations. The PPP policy guideline of 2013 also indicated that partners need to participate and agree upon all matters related to budget and other plans. Additionally, private health services providers also noted lack of transparency in the guideline for the CCHP especially in the location of funds within the budget framework, hence, hindering effective implementation of the service agreement. Officials from

private health facilities also lamented that decisions are drawn by the government (top-down approach). This analysis was also revealed in the study done by Maluka [30]. It was also noted that private health facilities were by-passing hierarchy of referral systems emphasised by the ministry of health as revealed by one of the participants from the private health facility. This was due to the fact that formulated health bodies such as Council for Health Service Board (CHSB), Council Health Management Team (CHMT), District Health Planning Team, and the Hospital Governing Committee had failed to implement the existing regulations and laws to guide health care providers, particularly those from the private sector.

Inadequate resources

Implementation of the PPP policy, practice and monitoring of activities was paralysed by inadequate resources. The government has not been able to deliver on its promises in the PPP arrangement on key issues especially provision of financial support and requirement. This has affected the provision of health service through the National Health Insurance Fund (NHIF) due to the delay of the government in disbursing funds, as one health facility manager noted during the interview that:

"…it is difficult for us to accept the use of the NHIF card in our health facility because at first, we tried it but always the government delays to make the reimbursement….as you can see our capital is too small to run this business."

The disbursement of funds is a concern between the local government and ministry of health as well as between the local government and health facilities. The government's delay to disburse NHIF funds after the private health facilities have provided services affects the mutual trust among partners. Problems of trust exist between local government personnel that handle health-related issues such as the CHMT, CHSB, and Health Facility Governing Committees (HFGC), on the one hand and private health service providers on the other. The underlying problem is exacerbated by the failure of these municipal organs to fully involve the private health providers in the decision making processes. As a result, most of the decisions reached by these bodies were suspiciously considered by the private health facilities. Inadequate resources were also noted as hindering effective information flow in the decentralisation of health service delivery. Therefore, most of the health providers in Kinondoni Municipality did not have the capacity to respond to collaboration needs. Consequently, anticipated positive changes in the provision of health services cannot be attained.

Ineffective monitoring and evaluation of PPP activities

Successful implementation of PPP largely depends on effective monitoring and evaluation of the agreed performance indicators among partners as developed by ministry of health. These include; the degree of

collaboration among partners in terms of numbers, contribution of the private and public sector in partnership and client satisfaction rate. These performance indicators were used in monitoring and evaluating the performance of health care providers at the municipal level as revealed by one of the district health officials that:

“Our district has designed monitoring and evaluation mechanisms which demand partneradheherence. We always evaluate how partners follow agreed procedures in all implemented activities in order make informed decisions.”

This revelation indicates that the government has been keen on monitoring to ensure efficiency and effectiveness of health service delivery under PPP. Overall, the central government is mandated to periodically monitor and supervise activities in line with PPP service agreements with partners. In line with decentralisation guidelines, primary health services are supposed to be monitored by LGAs, while regional hospitals are under the supervision of regional authorities [18, 26, 30, 31, 36]. The discussion with government officials revealed that reports from partners were sometimes not submitted, or written and hence, the monitoring team lacked a foundation to assess progress. It was also revealed that enforcement of compliance was ineffective because of limited funds. The district health officials consulted admitted that supervision costs were very high for the municipality and therefore adequate supervision was not conducted.

Insufficient consultation and communication

Private health facilities are mandated to send representative of the respective bodies at Municipal level in Kinondoni. Findings revealed that these representatives are not always consulted. The discussion with Medical Officer in-charge in one private health facility revealed weaknesses in the consultation accountability processes. The process of referral procedures, for instance, from a private facility to government facility is affected by poor consultation among the partners. The same issue was reported by the administrative managers in two private hospitals who noted that although the planning approach is bottom-up and allows for involvement of private sector, they were not consulted enough during the planning process; hence, participation in planning, budgeting and management of resources remained the authority of the Council for Health Management Team (CHMT) at the Municipality instead of being done collaboratively with the private sector. During the interview with one of the Medical Officer in-charge from the private health facility, it was asserted that:

“…when, the Ministry of Health introduced Big Result Now[1] (BRN) plan for implementation for the purpose of attaining the Development vision 2025, Partners were never consulted hence our ideas are not incorporated in this plan….the realisation of the vision is thus doubted”

This indicates that the public sector, especially at the national and local government level, insufficiently communicates with their partners (private sectors) over the initiatives that are undertaken.

[1] Big Result Now (BRN) is a delivery methodology focused on delivering specific goals within a stipulated timeline. It applied in the health sector to evaluate health service delivery and outcome.

Discussion

The paper aimed at unravelling existing challenges that have emanated from the interface of institutional arrangements under the PPP in health service delivery in Tanzania. It is evident that implementation of PPP in the health sector has not been short of challenges. This has affected the quality of service delivery as well as accessibility of health services. Inadequate resources are a significant limiting factor for effective implementation of PPP agreement. The problem of disbursing financial resources through National Health Insurance Fund (NHIF) for instance, emerged as a critical hindsight. Insufficient funds are not only experienced in Kinondoni Municipality but cuts-across other regions in Tanzania. The study by Maluka also noted that the government had delayed to disburse funds to faith-based hospitals in the four districts studied [30]. The situation in Tanzania is quite similar with some of the African countries. In addition to Tanzania, Boulger et al, also notes that in Chad, Uganda and Cameroon, limited finances hinder proper execution of PPP among partners [37]. Funding is critical for the sustainability of the contractual relationship between the government and partners for meaningful PPP arrangements.

Monitoring and evaluation of PPP activities is mandatory according to the Tanzanian National Public Private Partnership Policy of 2009 [38]. The policy states clearly that the government in collaboration with the private sector will (i) prepare monitoring and evaluation framework, including performance indicators and benchmark; (ii) set up a timeframe for evaluation; (iii) review the policy and associated legislation as when need arises. The execution of PPP is not monitored and evaluated adequately according to policy requirements and indicators. Similar challenges have been highlighted by other scholars in other regions in Tanzania. Raman and Bjorkman concluded that the problem of ineffective monitoring and evaluation of PPP in the health sector results from paying less attention to performance indicators [39]. This is congruent with what Itika et al, found in Dodoma region that, undertaking of PPP was characterised by ineffective monitoring ofthe quality of staff [40]. Basu argues that the problem of monitoring and evaluation of PPP is exacerbated by the fact that the government does not have power to monitor and evaluate the private sector [29]. These observations suggest that, to a large extent, enforcement procedures could also be weak, accountability mechanisms are lacking and therefore, partners become reluctant in the implementation of PPP activities.

Ineffective information or communication sharing adversely affects the health institutional frameworks in Tanzania, as well as other developing countries such as Ghana, Zimbabwe and Kenya [29, 41]. Barnes for instance argues that effective PPP needs to be incorporated with a clear taxonomy of effective communication that helps practitioners to design successful implementation plans and establish realistic

expectations [42]. Daniele emphasizes that good communication programme can facilitate mutual engagement and participation which can help to bridge gaps and create the trust that is needed for PPP to succeed [43]. Moreover, communication can pave the path for two-way dialogue on contentious issues before the public confidence and trust erode. Effective communication also helps to overcome bureaucratic hostility which, in the long run increases transparency in managing PPP related matters in the health sector [43].

Trust among partners requires significant efforts that should be invested only if, partners believe in their long-term interest [44]. Kinondoni Municipality was seen to be marred with the highest level of suspicion among PPP actors. The problem of lack of trust among PPP actors is not restricted to Kinondoni Municipality alone, but also the health sector in Tanzania in general. Itika et al, demonstrated the same results with evidence from Mpwapwa District that, PPP stakeholders do not trust each other especially on data sharing and use of funds [40]. Lack of transparency in the transaction cost is said to trigger the existence of mistrust. Itika et al, stresses further that mistrust exists among the PPP actors in regard to decision making and implementation of various agreed upon actions [40]. Mitchel, points out that although PPP actors find difficulties in cultivating trust among partners, they also understand that the need for trust in implementing PPP activities cannot be overemphasised [44]. They recognise intensely that it is through existing trust in implementing PPP which must lead to an environment of mutual cooperation for smooth PPP implementation.

Existing power relations among partners in the course of implementing PPP may trigger formidable challenges when each actor struggles to maintain power. Buse and Harmer argued that in partnership, power may be exercised on the basis of coercion, either politically or financially, in addition to the authority and legitimacy [54]. In Kinondoni Municipality, the government, by virtue of her power and authority has been influencing decisions in implementation of PPP plans. The private facility owners have been given little room to exert their view over the partnership in the course of delivering health services in the Municipality. The existing PPP institutional arrangement in Kinondoni reflects what Buse and Harmer have attested that, the central government and local government have more power to make decisions at the expense of the private health facility owners [45]. This is in line with Belt and Spierenburg argument that in implementing PPP, the distribution of benefits or outcomes reflects upon power relations [46]. Notably, the existing relations have never been a neutral tool that may realise a win-win situation for all partners involved.

Efficiency of PPP performance in health service provision would be achievable however, partners' missions, strategies and values are divergent. Whereas, the primary objective for Kinondoni Municipal Council is to improve access to health services, private health facilities are profit oriented and their core mission is profit maximisation. This therefore, compromises access to health services for the vulnerable poor. Itika et al, concurs that private health facilities maximise profits at the expense of quality of services [40]. The scholars further add that maximising profits propels lack of transparency in the transaction costs [40]. While the issue of profit maximisation by private health facilities will continue to surface,

Barnes recommends that PPP must be managed through careful crafting of agreement and negotiations throughout, to enable partners achieve their cooperate interests and goals [42].

Findings of this study contribute to the understanding of challenges under PPP in the health services delivery in developing countries and Tanzania in particular. This provides room for awareness and mechanism for resolving conflicts between partners engaged in PPP in the health sector. Health is an important factors to ensure that human resources vital for economic growth is productive, these findings also provide insights for the improvement of PPP for better health services delivery.

However, this study is without limitation. It only concentrated on PPP of health service delivery in urban centers, therefore the findings cannot be generalised to peri-urban or rural areas. Lack of focus group discussions as a methodological approach was also limited in this study. This had time and cost implication because it required organising and scheduling for the discussions. Another limitation is that in the sample of participants, health services users (communities) were not included because they were considered not conversant with different health services delivered by either government or private hospitals.

Conclusion

The existing challenges faced in the implementation of PPP in health service delivery could be attributed to institutional arrangement inadequacies, legal and policy weaknesses, as well as laxity in implementation practices. However, provision of health services through PPP in resource-poor countries like Tanzania will remain to be a viable alternative. The public sector alone cannot solve the growing need for quality health services. The public sector needs to engage private partners in all issues concerning their working contract and consider partners as equal in implementation of plans. Strengthening of communication should be mandatory, since it is a strategy through which all stakeholders get to know the success recorded, challenges experienced and the way forward. Interaction of partners should be strengthening through agreed channels of communication whether physical meetings, online communication or otherwise. This will build trust, transparency and accountability, ultimately supporting monitoring and evaluation structures.

Declarations

Ethics approval and consent to participate

Ethical approval of this study was obtained from Ardhi University on behalf of the government and Tanzania Commission for Science and Technology (COSTECH) Number ARU/ARU/HO 67/VI. Participants in this study were informed verbally and in writing. Collected data in this study were confidential and used by the research study only. Participants identify were not revealed anywhere in this study.

Not applicable

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due the reason that will still going to be used, but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors ‘contributions

SN drafted the paper and review literature. CJM review literature and conducted the secondary analysis of the data. NK collected the data and conducted initial analysis. All authors have read the final manuscript and agree all aspects and the submission process.

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Authors’ information

Not applicable.

Abbreviations

BRN: Big Result Now; CHSB: Council for Health Service Board; CHMT: Council Health Management Team; CCHP: Comprehensive Council Health Plan; DMO: District Medical Officer; HSR: Health Sector Reforms; HFGC: Health Facility Governing Committees; LGAs: Local Government Authorities; MoHSW: Ministry of Health and Social Welfare; NHIF: National Health Insurance Fund; PPP: Public Private Partnerships; SAPs: Structural Adjustment Programs; WHO: World Health Organisation;

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Figures

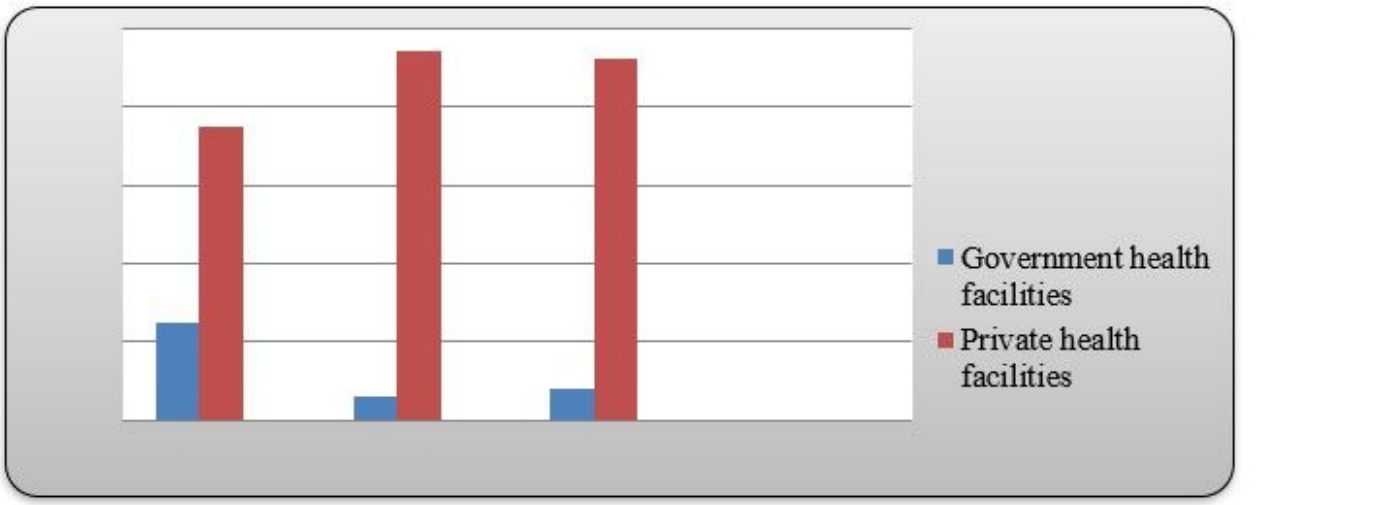

Figure 1

Distribution of Public and Private Health Facilities in the Kinondoni Municipality