Informal Practices among Tanzania’s Public Sector Health Workers – Determinants and Policy Implications

By Prof. Fortunata Songora Makene and Ms. Hossana Mpango

Executive Summary
This policy brief analyses key challenges faced by government health employees as well as informal practices that have been adopted as coping mechanisms to ensure health service delivery. The practices might be negative, justifying or facilitating corrupt practices, but might also be positive, resulting in hubs of integrity and service delivery. It points out that main challenges limiting effectiveness in provision of health services are related to conditions of work and service delivery, management of human and financial resources and policy implementation. Recommendations focus on ways in which resource constraints and policy implementation challenges can be addressed to ensure that civil servants in the health sector deliver health services in an effective and efficient manner.

Introduction
The front-line of health service delivery in Tanzania encompasses public health facilities (health centres, dispensaries, district and regional hospitals) that provide basic health services to majority of the population. The responsibility for public health service delivery falls under the Ministry of Health, Community Development, Gender, Elderly and Children as well as the President’s Office-Regional Administration and Local Government. The Health Ministry deals with policy formulation, supervision and regulation of all health services throughout the country, as well as playing a direct role in the management of tertiary health services delivered by referral hospitals. PO-RALG on the other hand is in charge of policy implementation, supervision and monitoring of health services delivered by hospitals at regional and district levels as well as dispensaries and health centres that operate within areas of jurisdiction of respective regional and district councils.

Over the years, the Government of Tanzania has been making efforts to improve health service provision through formulation and implementation of health sector strategic plans including the National Community Based Health Strategy (2015–2020); Primary Health Services Development Programme (2007–2017); National Multi-Sectoral Strategy for HIV/AIDS (2015–2020); Health Sector Strategy Plan IV (2015–2020); and The Third Health Sector HIV/AIDS Strategic Plan (2013–2017).

Despite the efforts, Tanzania’s health sector still faces resource constraints particularly human and financial which impact on the availability and quality of health service delivery. In an attempt to ensure that services are delivered in the midst of resource scarcity, some health sector employees have adopted informal practices that aim at getting their jobs done. De Herdt and Olivier de Sardan (2015) define these informal regulations/regularities of routinized practices not complying, at least partly, with official norms as practical norms. They account for the numerous and diverse latent regulations which are embedded in civil servants’ practices while not complying with official (explicit) norms. The practices might be negative, justifying or facilitating corrupt practices, but might also be positive, resulting in integrity and quality of service delivery.

Practical Norms in Tanzania’s Health Sector
Health sector employees in Tanzania’s public sector face numerous challenges in the areas of conditions of work and service delivery, management of human and financial resources as well as in implementation of health policies.
Conditions of Work and Service Delivery

Challenge: Poor working conditions indicated by low salaries and delays in receiving salaries, overtime and leave allowances for health sector employees lowers working morale and impacts on the quality of health service delivered. Poor working conditions has been identified as a key factor responsible for lowering health workers morale in Tanzania’s public health facilities (Mubyazi et al, 2012). Limited salaries and financial incentives affect ability of health workers to meet their living expenses thereby making them to come up with alternative ways of getting extra income to make their ends meet.

Practical norm: Frontline health staff collecting unethical informal payments from patients and their relatives. Nurses would collect financial bribes from patients’ relatives in order to allow them to visit their patients beyond official visiting hours. The official norm is that, each health facility sets specific hours during which relatives are allowed to visit and bring meals to patients admitted in the wards. The aim is to allow health staff to be able to care for patients with limited interference from visitors and enable admitted patients to obtain enough rest. In situations where relatives arrive beyond visiting hours, the nurses would provide permission to enter the wards in exchange for financial bribes. In other instances, patients and their relatives would bribe health staff to obtain a favour of not waiting for long in the queue before receiving the service. Variation of the formal rules in this case affect quality of service delivery and enhance disturbance in service provision. Such practices also violate official government rules regarding corruption.


Management of Human and Financial Resources

Human Resources

Challenge: Shortage of human resources for health is a persistent problem in Tanzania especially in rural areas. The population density of health care workers in Tanzania is 14.5 per 10,000 people which is below the WHO recommended minimum threshold of 23 health workers per 10,000 population (URT, 2014). Severe shortage of workers in front line service points overburdens available health staff who end up working extra hours to attend many patients on daily basis. Working for many hours without enough rest increases the possibility of becoming less productive in providing health services to patients.

Practical norm: Despite the acute shortage of health staff, provision of essential health services continues being carried out with the aid of task-shifting or task-sharing practices among employees. The World Health Organisation describes task shifting as the rational redistribution of tasks among health workforce teams. Where feasible, tasks are reallocated from highly qualified health workers to those with shorter training and lower qualifications in order to maximise use of available human resources for health. Task shifting as a coping mechanism for addressing health personnel shortages has been in practice for many years in Tanzania (Munga et al, 2012) prior to official enactment of the policy in 2016. Various cadres of health workers such as medical officers, nurses, medical attendants, pharmacists would take on tasks beyond their areas of specialization, with or without prior training on how the tasks are to be performed. The practical norm of treating patients without any prior training on the best way to do so jeopardizes quality of health delivery and health outcomes of the patients.

Official rule: In recognition of the importance of task shifting in addressing the serious shortage of qualified human resources for health as well as the need to eliminate dangers posed by unofficial task sharing practices, the Government of Tanzania formally adopted the Task Sharing Policy Guidelines for Health Sector Services in 2016. By stating tasks permissible to specific cadres of health workers, the policy acts as a guiding tool to ensure that service delivered to patients via task sharing does not undermine the quality of health service delivery.
Financial Resources

Challenge: Financial resource is another crucial input for delivery of adequate and optimum quality health services. Challenges in managing financial resources for health mainly arise from delays in funds disbursement by the government. With such delays, health administrators in public facilities face significant financial shortages which limits their ability to effectively execute budgets for supporting health service delivery.

Practical norm: Some health officers divert funds from designated activities to those that need to be attended in a matter of urgency in the hope of returning to their original vote when government funds are received. For instance in case a facility has no money to purchase gas to support running of refrigerators for vaccine storage, senior officials divert funds from other health projects and use it to purchase gas. The problem with such an act is that when the expected funds are disbursed, all those who were involved in funds diversion get into trouble. If smart enough, one can defend the act of funds diversion by documenting each process of the diversion and providing justification.

Official Rule: To limit mismanagement and embezzlement of public funds, the Government prohibits diversion of funds from activities for which they were planned. If caught, the officers involved are to be reported to the Prevention and Combating of Corruption Bureau for legal action. Funds diversion violates Section 29 of the Prevention and Combating of Corruption Act of 2007 which states that an official who diverts resources for the purposes unrelated to those for which they were intended commits an offence and shall be liable on conviction to a fine or imprisonment.

Policy Implementation

Challenge: User fees in health facilities often bring undesirable impact in utilization of essential services among poor and vulnerable groups. The introduction of user fees in Tanzania’s health system in 1993 therefore raised the need to establish a protective mechanism to ensure that the fees do not limit utilisation of health services by the poor people. Responding to this, the Ministry of Health introduced waivers and exemptions in 1994 to guarantee equity, universal access and affordability of health services among poor and vulnerable groups. Nonetheless, implementation of these exemptions has been ineffective due to limited financial resources available to public health facilities (Rohregger, 2014). The growth in exemptions and waivers granted by a facility pulls down revenue collection thereby putting more pressure on available financial resources. To cushion the impact of this policy on hospital revenues, revenue forgone ought to be compensated by government resources (URT, 1994), but seldom do service providers receive those funds sufficiently and on time.

Practical norm: Facilities that are financially constrained to grant exemptions and waivers charge user fees to patients who are qualified for exemptions. Also, at times when the hospital runs out of medical supplies, patients would be asked to purchase their own medical supplies. For example pregnant women are advised to bring with them items such as gloves, cotton wool and syringes that would be used during childbirth.

Official rule: According to the government national cost-sharing policy guidelines, essential health services including maternity care during pregnancy and child birth, preventive and curative care for children under five years and treatment for certain diseases including HIV/AIDS, leprosy, tuberculosis, polio, and cancer are to be provided free of charge. Other eligible people include the elderly above 60 years old and patients who prove to be very poor and unable to pay user fees (URT, 2007).

Policy Recommendations

Improve incentives of healthcare professionals

Provide monetary and non-monetary incentives to health workers to boost their work morale in providing good quality health care so that both patients and workers do not have an excuse of resorting to bribes.

Introduce special programs to expand health workforce

Put in place a compulsory system that requires fresh graduates in the medical profession to be directly posted
in facilities with severe staff shortage to work for at least two to three years before being allowed to seek employment in other areas. That way the pool of these professionals would have been there on a continuous basis. Also conduct regular assessments on the adequacy of staff in frontline service points and make allocations and reallocations accordingly.

Elucidate provisions of the task-shifting policy guideline to implementers at all levels

Develop a standardized pre-service and in-service training program for all health workers to understand provisions of the policy and equip them with appropriate skills that will allow them to undertake the tasks assigned in an efficient manner so as to reduce medical errors and other threats to patients’ health.

Disburse fully and on time amount of public funds allocated for frontline health service points

Increase government budget allocation to health and ensure timely disbursement of the funds to facilitate purchase of medical supplies and equipment in health facilities to be able to serve all who seek medical care especially the poor and vulnerable groups. If such disbursements cannot be guaranteed than provide guidelines for reallocation of funds to mitigate delay of disbursement of funds allocated for specific votes on the understanding that refund would be made after government funds are received.

References


