

Health Sector Reforms in Tanzania: Nature, Characteristics and Outcomes

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Abstract

This paper presents the findings of the study conducted in Tanzania in 2021 to verify the effect of the nature and characteristics of health sector reforms on the realization of the reform's intended outcomes. Informed by 'the multiple stream framework', the primary assumption of the study was that the nature of the design, initiation and implementation of any reform determines the potential of the reform's intended outcomes as well as the long-term impact. The study revealed that the reform has achieved less than expected because it came along with the seed of its destruction. This is because the reform did not create a favourable implementation environment for the realization of its desired outcomes which were to improve the management and delivery of healthcare services. The reform wrongly focused on the content of the reform and neglected the main actors, the processes contingent on implementing the reform and the context within which it was developed. Thus, the study recommends that reform implementation in the future should employ community-engaged reform approaches, sustained monitoring, learning systems, and a 'faults mending' approach in dealing with recurring gaps in different aspects of the reforms to enable the reforms to achieve the intended outcomes. It also recommends for a specialized institution to coordinate the reforms.

Keywords: Health Sector Reform, Services Management, Reform Approaches, Tanzania.

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I. Introduction

This paper presents the findings of the study conducted in Tanzania to verify the effect of the nature and characteristics of the Health Sector Reforms (HSR) on the realization of the intended reform outcomes informed by the Multiple Stream Framework. The main assumption in the study was that the nature of the design, initiation and implementation of any reform determines the potential of the reform to achieve its intended outcomes as well as the long-term impact. In the study, the key analytical parameters considered when looking at the nature of the reforms included the essence of the reforms, control by the government, resources, coverage, and the pace of implementation. Using a thematic analysis approach, each of these parameters was explored to find out how its nature is connected with the failure to realize the intended reform outcome. The forthcoming sections will delve into the essence of the reforms, and the theoretical logic of the reform and, since the reforms did not achieve anticipated objectives as intended, explain the factors behind the unanticipated achievement in Tanzania. The following section provides the methodology employed to obtain the study findings.

II. Methodology

The study employed a multisite cross-sectional case study design that involved largely qualitative data gathering methods in-depth unstructured (N=48) and semi-structured interviews (N=60), facility observation, and review of official documents. The study was conducted in 18 healthcare facilities in Tanzania, namely: Amana, Temeke, Tumbi and Dodoma (regional referral hospitals); Mkuranga and Kongwa (district hospitals); Buguruni, Buza, Mkamba, Mkoani, Makole, and Mlali (health centres); and Vingunguti, Tandika, Kisiju Pwani, Kikuyu and Sejeli (Dispensaries). Interviews involved 60 respondents including Senior Public Servants from Ministries (N=5) and Councils (N=5) health workers (N=17) and facility committee members (N=8). They also included patients' representatives (N=12), local government leaders (N=10), District Health Secretaries (N=5), and representatives of NGOs that work on healthcare rights advocacy (N=3). The data generated were analysed using thematic and content analysis approaches.

III. The Origin and Rationale for the Health Sector Reform in Tanzania.

Reforms are initiated and implemented by forces that comprehend the necessity of staging the transformations. These forces may be from within or from outside the country. Ideally, internal conditions are expected to result in a more successful reform process due to the commitment of the stakeholders within the government and the broader society (Walt & Gilson, 1994). In the context of HSR in Tanzania, it was clear that the reforms were influenced by both internal and external circumstances of the 1990s (Mujinaja and Kida, 2014). It was revealed from the review of reform-related documents that foreign investors, international donors, the governing elite, and the emerging middle class were the protagonists of these reforms.

Among internal health stakeholders, the reforms were adopted as a quicker alternative to solve the previous decade's failure in healthcare improvement efforts. Evidence shows that during the 1980s, Tanzania's economy declined therefore the government's capacity to provide quality healthcare services diminished. The mentioned economic downfall was partly due to the war with Uganda and the globally increased cost of importation caused by the global oil crisis and other factors. At that time, the number of healthcare facilities had increased following 1960s-1970s expansion of healthcare services, especially in rural areas. Through the mentioned expansion programs the number of primary healthcare facilities more than doubled within the two decades after independence. These achievements were impressive but were short-lived because the government could not sustainably finance and manage these expanded public healthcare facilities to meet the expectations of the people. As a result healthcare sector and its services were characterized by poor infrastructure, shortage of staff, drugs, and medical supplies, especially in rural healthcare facilities where the majority of citizens live.

The inability of the government to provide enough quality healthcare services; forced the government to attract any stakeholder who was ready to assist in recovering the deteriorating healthcare. Adding to this pressure was also the reestablishment of the local government authorities in 1984, which failed to reverse the worsening status of healthcare services. The re-establishment was also associated with squabbles over power between the central and local government authorities that resulted in the pressures for reform in both directions, bottom-up and top-down. As a result, the reforms were grabbed as a panacea and an opportunity that the government did not want to lose regardless of what comes around. Some groups within the government also campaigned for the reforms to avoid reverting to the depressing healthcare situation of the 1980s caused by the economic slump. The study revealed that the reforms were also adopted in Tanzania as a comprehensive option to address the failed socialist informed service delivery strategies that had been in the experiment since the 1960s.

The reforms were also necessitated by the 1980s shift in the social and economic order caused by globalization that contradicted the socialist social-economy order existed in the country. It was noted during the study that the socialist policies, which were formerly guided by the Arusha Declaration of 1967 failed to withstand the emerging globalization and the thrust of the liberal movement in the world. This was also associated with the drastic economic downturn mentioned above. At the same time, the crops' income crumbled as a result of the collapse of world market prices of agricultural products, the trade deficit increased, foreign capital inflows decreased, and overall debts reached a critical level. The government could not effectively provide quality healthcare services to all free of charge because the economy was underperforming. The health sector was in pathetic conditions and thus attracted criticism not only from outside but also from within the country (Rugumyamheto, 2005). In this situation, the international community intervened. These conditions coupled with the demand for people's inclusion in the management of healthcare services and development partners' pressure for responsive governance, forced the country to adopt whatever reform proposed by donors to improve efficiency and effectiveness in the delivery of healthcare. The adoption of NPM meant the adoption of business-like culture and practices dominantly used in the private sector.

The study found out that donors' support to address the major emerging health challenges of the time, such as malaria, HIV/AIDS, tuberculosis, and others complimented the government's failure to achieve its obligation. In this sense, both donor assistance and the reform idea were received with two hands while looking at anyone disputing it as a traitor. With this dual essence, documented historical evidence indicates that the reforms were unconditionally accepted with enticement as the most reliable therapy (Semali, 2003). In this respect, the support from development partners who were willing to assist the government to improve the situation could hardly be negotiated (Mujinja & Kida, 2014). The study revealed that, in the mentioned challenging situation, it was hard for the government to grasp that improving health services management needed a reasonable time and a high degree of perseverance. Due to this, the reform was adopted hastily, and donors' power over the management of healthcare was willingly welcomed. The pressure from both internal conditions and external forces thus made the adoption of the reforms a politically celebrated endeavour. The study revealed that the reforms were initiated with applause and great hope to end up all the healthcare management and services delivery challenges of the time. However, little was done to ensure that preparations for the adoption of the reforms and the core mission, vision, and values that informed the reforms were properly internalized and cascaded down from the top government leaders' to low levels. Thus, lower levels which were one of the main implementers of the reform

following the decentralization of primary healthcare to local government authorities were to a large extent sidelined.

Practically, the transformations focused on the higher levels of healthcare services leaving the primary healthcare facilities suffering from perennial stock-outs and the lack of staff. This problem has persisted to the present. In this study, it was revealed in Mkuranga and Kongwa councils that some health facilities were established in rural areas without sufficient qualified health staff partly because of poor planning and the limited capacities of local authorities to motivate and retain them. Therefore, it was demonstrated from the existed evidence that the entrance into the reforms hardly created a favourable implementation environment for the realization of desired outcomes in the management and delivery of health services. The reform thus came along with the seed of its own destruction.

From a theoretical point of view, health sector reforms as implemented in Tanzania were 'New Public Management' based (Hussein, 2013). This paradigm was adopted as a therapy for the heart-breaking healthcare situation that existed in the country. In that period as mentioned above, there was a grave shortage of human and financial resources. The acute shortage of funds led to the scarcity of drugs, the equipment and deterioration health infrastructure especially, buildings, electricity, water, and transport. The shortage also led to the poor motivation of healthcare workers who generally received very low pay and fringe benefits. New Public Management based reform started in western countries such as United Kingdom and others and spread throughout the world to improve public services. As theory, it emerged through a bureaucratic policy process as a solution to perceived shortcomings of old public administration. Studies show that theories appear through bureaucratic policy processes and disappear through administrative reforms (Van de Walle et al, 2016). That is what has been happening in public sector concerning the shift from old public administration to new public management. New Public Management created an evolutionary path of the governance system in the public sector which has enhanced the cooperation between public and private (Shaw, 2004). It allowed the public sectors to solve social and economic problems of communities using new approaches and principles. Given the limited resources of public sectors, the growing vulnerability of people to various upheavals and challenges the need to increase the efficiency and effectiveness of governments has resulted in the real need for public sector reforms, hence the adoption of New Public Management based reforms. To what extent the reforms' have been feasible, especially for developing countries has been an issue of debate among scholars which was out of the scope of this study. However, in Tanzania studies show that New Public Management reforms has not been successful as anticipated, especially in the healthcare sector (REPOA, 2006; Piatti-Funfkierchen & Ally, 2020).

IV. Reasons for Health Sector Reforms Failure in Tanzania.

Health sector reform was introduced to improve the management and provision of healthcare services. However, though the reform has been in progress since its introduction in 1994 in the country. The study has revealed that; the achievement of the reform has been minimal in many aspects of the health sector. Factors claimed for this outcome may be many but this study identified some main factors elaborated below.

4.1. Incompatible Culture and Structures

The study revealed that the reform introduced new culture in public healthcare that hardly matched the existed setup and the old culture of the health system. Before the reform, Tanzania was a socialist country that observed socialist ethos and the healthcare services were provided free of charge by the government. The government also completely abolished private health practices save for few religious-based facilities. Thus, the rush to implement the reforms without changing the culture of the existed health system had some significant implications on the realization of the reform outcomes. Before proceeding with the analysis of how the incompatibility affected the outcome, it is important to understand the existed institutional setup of Tanzania's health system.

Tanzania has a four-level health system where healthcare service delivery points are classified in line with the political-administrative structures of the country. Level one (L-I) is a local level, which includes dispensaries, health centres and district hospitals. The lowest unit of services is a dispensary, which extends to the community through community-based healthcare services. Each village or street (Mtaa in Kiswahili) is entitled to have a dispensary. At the ward level, there is the health centre, which serves as the referral facility for patients from dispensaries and as a primary unit for villages or streets without a dispensary in the ward catchment area.

Level two (L-II) is made up of regional hospitals, which serve as referral facilities for patients from district hospitals. In some of the regions, there are both public and private referral hospitals at the regional level with L-II rank. Level three (L-III) is constituted by zonal referral hospitals. In Tanzania, zonal referral hospitals are Bugando (lake zone), Benjamin Mkapa (central zone), Mtwara (southern zone), Chato (western zone), Mbeya (southern highlands zone), and KCMC (northern zone). The highest level is level four (L-IV), which is constituted by national hospitals and specialized medical facilities such as Muhimbili National Hospital (MNH), Muhimbili Orthopaedic Institute (MOI), Jakaya Kikwete Cardiac Institute (JKCI), Muhimbili National Hospital

(Mlongazila), Ocean Road Cancer Institute (ORCI) in Dar es Salaam; Mirembe in Dodoma, and Kibong'oto Infectious Diseases Hospital (KIDH) in Kilimanjaro.

The new structure had difficulties when it comes to accommodating private service providers. For example, many districts have no district hospitals and thus are forced to use private or voluntary healthcare facilities as Designated District Hospitals (DDH). In some cases such as what the researcher noted in some districts, the limited capacity of the government is supplemented through the Public-Private Partnership (PPP) model of service delivery. The same situation also prevails in the wards and villages. To the present, some of the villages do not have dispensaries and some wards do not have health centres. This had a big implication when it comes to both enforcing accountabilities for the services being provided by private providers and responsiveness to the communities. Similarly, as pointed out by senior official interviewees from Dodoma and Dar es Salaam regions, the oversight and control autonomy of community representatives in oversight committees such as health facility governance committees was difficult to exercise in facilities under private ownership compared to the public ones. Therefore, there has been a continued crisis of accountability and responsiveness that results from the limited self-sufficiency of the government facilities in the provision of healthcare services.

Another important limitation was the failure to integrate the operationalization of the reform components across the structure of the health system. A good example was in the case of the new financing arrangements in terms of both insurance and out-of-pocket payments (OOPP). In the case of insurance, the premiums paid by members were limited to specific levels and types of services. For instance, a CHF premium could not cover treatment costs when a holder is out of the district in which the payment was made. The premium contributed at a district level could not be used at any other levels for instance regional levels and beyond. The studies also found that even the formal insurance scheme members were and are still not eligible for some of the curative services in some hospitals. Many of the interviewed respondents had a view that the mistake which was done was integrating the public health sector into the NPM and Public-Private Partnership (PPP) related culture without preliminary preparations to ensure that equity and risk pooling principles could be agreed upon and upheld by the providers including those in the private and public realm. In this situation, improvement in efficiency, availability, and accessibility of the services that the reforms anticipated to realize could not be easily seen.

4.2. Over-ambitiousness of the Reform

The analysis of Healthcare Sector Reform implementation in Tanzania indicates that the reform was comprehensive. The findings from different sources show that the HSR was very broad and encompassed many things at once (URT, 2013, 2014, 2015, 2017 & 2019). The reform tackled many issues in each phase of the reforms at once (URT, 2016 & 2018). In phase one (1999-2002), nine strategic matters were pursued. In the second phase (2003 to 2008) the mentioned nine strategic issues were consolidated into three components and implemented in all healthcare facilities. In phase three, the strategic matters to be achieved grew to eleven. In addition, more than six cross-cutting matters were executed. During the fourth phase, the strategic expectations were to reach all households with quality healthcare and four issues were addressed (The reform generally endured through the difficult social and economic contexts of the country while promising to solve a myriad of healthcare challenges that had survived for almost three decades within a compressed time. The same was the case when considering the adequacy of the resources to support the implementation of the reforms, especially locally mobilized resources. Up to this time, none of the planned strategic reform interventions can be said to have been substantially successful. The respondents who were interviewed in Dodoma, Coast, and Dar es Salaam appeared to agree that concentrating on a few issues could have resulted in more success than being too overambitious. Again, in the course of reform implementation, there was no room for questioning the performance of the reforms. The decisions focused on the continuation of the reforms and initiating new priorities to be addressed to improve service delivery. The study found that the spirit of continuation despite the resources and contextual setbacks was upheld and encouraged by national leaders in the country.

The study revealed that the reform package was quickly adopted by the government without sufficient time to conduct a deep evaluation of the feasibility of planned activities within the available time frame. Second, the big number of priority issues at focus stretched into a big network of government activities within and outside the health sector. This could have worked well if there could be a clear strategy to integrate and harmonize the pace of implementation across government activities. Third, the available resources were inadequate to implement the planned interventions. Because of the shortage, most of the reform resources were committed to the central government and hardly trickled down to solve the healthcare challenges on the service delivery levels. Because of this, many scholars such as Moyo (2009), Easterly (2007), and others have criticised the huge support from donors and development partners as ineffective and hence labelled dead aid. The respondents perceived that, the over-ambitious approach employed by the government to be connected with the need to address the pressing and complex problems in healthcare services delivery rather than making sure that the reforms were feasible and could feasibly deliver intended results. Based on these findings it was revealed that among others overambitious nature of the health sector reforms negatively affected the realization of intended reform outcomes in terms of effectiveness and efficiency in the delivery of healthcare services.

4.3. Impaired Reform Approach, Strategies, and Tactics

Implementation of any planned intervention (reform or policy) needs an evidence-informed choice of strategies and tactics. Among others, these strategies and tactics have to anticipate what should come first and what should come next, how the available resources should be deployed, who should participate in the implementation and to what extent, how to make the implementation successful, and how to mitigate the likely implementation challenges. Related to the health sector reform, the study revealed that the implementation had some imperfections that impeded the realization of the intended outcomes.

To start with, the reform hardly constituted a single and well-defined program as it is named. It was rather rolled out and implemented as a combination of various fragmented components that were subsumed into other reform programs. In this logic, various strategies and tactics were employed. First, most of the reform intervention packages were carried out by sector ministries in an ad-hoc fashion and as advised by consultants, teams, and secretariats established in the course of implementation. These actors served as advisory bodies and were engaged by various sectorial ministries. For instance, interviews with officials from the ministry responsible for public health, local government, and finance revealed that the ministries could identify the gaps relating to the implementation of healthcare-related interventions and document them, but these gaps were inadequately acted upon by responsible ministries because of poor communication and coordination among key reform implementing ministries.

It was also noted during the study that planning for adjustments in the implementation was not based on evidenced-based research, hence lacking ownership of some important stakeholders, especially lower-level healthcare service stakeholders such as the service providers within the primary healthcare facilities. The above-mentioned contracted consultants and teams acted as reform policy entrepreneurs that introduced solutions that they believed were useful in the existing situation to solve healthcare problems. As elaborated in the 'multiple stream framework' (Hoefler, 2022); these entrepreneurs proposed solutions that did not rely on evidenced-based research but proposals from academia, think tanks, and reform experts. These consultants thus, identified, prioritized, and recommended what they considered to be the best practice approaches adopted from western countries and disregarded local context. This disregard for the local contexts negatively affected the implementation of the reform in the country. For example, the interviewees from Dodoma and Coast regions observed that some of the tools used to capture information on the health condition dynamics and transmit them to the ministry did not consider the existence of remote rural areas which had limited internet connectivity and had no access to electricity which is needed for their functionality.

Related to the previous point, the study further noted that the reform relied on the application of standardized performance management tools from developed countries recommended by the main reform sponsoring donors. Some of the recommended tools included the Client Service Charters (CSC), Open Performance Review and Appraisal System (OPRAS), and Monitoring and Evaluation (M&E). Respondents from most of the visited facilities reported that these tools were introduced as a formality in the implementation process and all health facilities were required to make use of them.

The government issued directives requiring all healthcare facilities to make use of the above-mentioned tools for managing the performance of the facilities. This means that a facility, for instance, would demonstrate that it was contributing to the implementation of HSRs if it did not miss a round of OPRAS and it ensured accessibility of the CSC by service users and other health service stakeholders. However, when it came to the day-to-day operations of the healthcare facilities, there were no observed improvements that could be associated with the existence of OPRAS or CSCs. Since the tools were alien and not locally tested, they did not achieve the intended purpose and therefore healthcare facilities continued underperforming despite their existence.

Furthermore, it came out clearly during the study that the reform largely modified existing health systems and structures rather than establishing new ones. A good example of this fact was the reinstatement of the private healthcare sector in the health system that had been abolished for almost four decades. The re-establishment of private healthcare practice was allowed even before the formulation of a clear framework to guide the collaboration between the government and private healthcare providers. However, later on, mechanisms were created to facilitate collaborations between public and private sectors in healthcare provision to improve healthcare services but the collaborations were not very effective. A vivid example, in this case, was the initiation of Designated District Hospitals (DDH) that were formally owned by private sectors (mostly religious groups); that were allowed to be jointly run by the owners and the government. However, the lack of an established framework and guide caused confusion about the role of the government in these facilities. What was clear to most of the respondents was that the government stormed in with a promise to bear the burden relating to human, financial, and infrastructure resources. However, the agreed performance standards were rarely met as expected by the former owners of these facilities. As pointed out by two of the respondents in Dodoma and Coast regions, instead of improving the quality of services offered by these facilities, the arrangement largely resulted in the provision of poor-quality healthcare services.

The increased Public-private partnerships in healthcare provision were facilitated by legislation and government policies. For example, the Public-Private Policy was enacted in 2009, Public-Private Partnership Policy in 2009, Public-Private Partnership Regulations in 2011, Investment Act in 1997, and Public Procurement Act in 2012. The engagement of private providers had some significant implications on the governance of health services. The government had not thought of the strategies to ensure that the private providers quickly adopted the virtues of good governance that were an embodiment of the HSR program such as transparency, participatory planning and decision making, and responsiveness to users' interests and expectations. This is because the private providers' focus had traditionally been on making a profit. However, as admitted by the senior interviewee respondent from the ministry responsible for health, the lack of responsiveness and transparency became an emerging reality that was not expected and strategized for. This lack of transparency undermined the expectation that the reforms could make private providers responsive and accountable to the users who are required to have control over the services.

The other important point that the study noted was the employment of top-down approaches during the reform process and its related interventions. As a reform strategy, a top-down focus limits the involvement of the key stakeholders, especially those at lower levels in the process of designing, planning, and making key decisions relating to the reform. Thus, community and facility level stakeholders such as health workers were just recipients and implementers of the directives that the government identified as potential for successful implementation of the reforms. As pointed out by an old female health worker in one of the health facilities in Dodoma, the citizens who are users of the services were less informed or concerned about the reform. All they wanted was improved healthcare services.

The study revealed that, though an implied demand for improved services existed among the communities, little evidence of participation of communities in determining the design and style for implementing the reforms existed. The same was identified by respondents when it comes to the demand for reforms in health services delivery and related instruments. Thus, reform remained a prescription from above rather than a demand raised by citizens. Studies show that the top-down approach has been ineffective not only in the case of HSRs but also in many other reforms conducted in the country since independence (Lameck, 2009). As pointed out by researchers, the employment of top-down strategies and approaches in policy formulation and implementation has always negatively affected the realization of intended results in different policy interventions that were initiated by the government in Tanzania through the 1960s and 1970s in the country (Lameck, *ibid*; Aiko, 2015). The same appears to be the case for the HSRs of the 1990s to the present.

4.4. Complexity of the Reform Process

A simple program is easy to delineate and demarcate when it comes to the execution and implementation process. The more complex the program is in its logic of design, the more difficult it is when it comes to implementation. Tanzania opted to follow a unique reform process called in this study '*composite reform processes*'. The reform process merged various reform processes into complementary but independent programmes that were all substantially donors driven and funded. Even though all the reform programs sought to address issues relating to improving the management of healthcare and services provision, their efforts lacked strategic integration. The reforms that contributed to the improvement of healthcare management and services delivery are many; since they were not the focus of the study, only a few of the reforms that contributed to the governance, finance and other important improvements will be summarized. The first one is the Public Service Reform Program (PSRP) of 2000 which replaced the Civil Service Reform Program (CSRP) of 1993. The second is the Local Government Reform Program (LGRP) which started in 1998. The third is the Public Finance Management Reform Program (PFMRP) which started in 1998. The fourth is the Second Generation Financial Sector Reform (SGFSR) which started in 2003. The sixth is the Legal Sector Reform Program that started in 2000 and, the seventh is the National Anti-Corruption Strategy and Action Plan (NACSAP) of 1999. Each of these reforms had some linkages with the outcomes relating to the health sector and thus determining the success of the HSR. Let us now briefly summarise the linkage of each of these reforms with the HSR as revealed in the study.

Formerly known as the Civil Service Reform Program (CSRP) since 1993, the PSRP started in 2000. It directly embodied the aim of introducing principles, culture, and practices that could improve public services including health services. It had a focus on building a high-performing, dynamic, and meritocratic workforce, which has also been a direction of HSR (Hussein, 2013). The problems of poor service delivery and lower level of accountability reflected by corruption, embezzlement, and negligence that had been a critical concern of the PSRP (Masue & Mollel, 2015) are some of the challenges undermining the success of the HSR. It was revealed that PSRP had a special link with HSR by putting in place systems for improving institutional and individual performance in healthcare facilities. These include Client Service Charters (CSC), Open OPRAS, and Monitoring and Evaluation (M&E) systems. All these had a considerable effect on healthcare management.

In the case of the Public Financial Management Reform Programme (PFMRP), effective management of financial resources as a focus is closely linked with economic growth and stability which are needed for sustained delivery of quality public healthcare services (URT, 2015). The focus on public expenditure control systems and

ensuring fiscal discipline was expected to minimise financial leakages and improve accountability which is important for improved service delivery. As insisted by the government accountable budgets, allocations, and spending were a priority of the health sector. Efficient and effective use of public finances which was the key goal of the PFMRP necessitated the reform of MSD by decentralizing some of its functions to its zonal stores to respond to quicker clients' needs and at the same time automated more of its store management and offered some of its services online to clients. The government through TMDA stepped up control of quality, safety, and efficacy of pharmaceuticals, medical supplies, and medical equipment in the health sector. Domestic production of pharmaceuticals and the establishment of private outlets in rural areas were also promoted (Piatti-Funfkerchen & Ally, 2020). The implementation of these initiatives involved the collaboration of various reform programs.

The National Anti-Corruption Strategy and Action Plan (NACSAP) on the other hand, has been a vehicle for carrying out the intent of eliminating corruption in services including healthcare services. It specifically pledged zero tolerance for corruption-related conduct. It directly feeds into the efforts to improve transparency, integrity, ethics, accountability, and good conduct in healthcare services management and service delivery. Its implementer, the Prevention and Combating Corruption Bureau (PCCB) has a mandate to ensure integrity, accountability, and transparency in public service (Aiko, 2015; Lameck, 2009) including healthcare services delivery. Related to this is also the Second Generation Financial Sector Reform that started in 2006 that sought to improve financial inclusion as one of the factors for improved access to healthcare services.

The LGRP was an important complementary reform for transforming public health service management in Tanzania. It had an overall objective of improving the delivery of services including healthcare services through decentralization. While the central government retained its regulation and quality assurance role, LGAs under the LGRP are required to ensure the delivery of quality services and ensure effective user participation in decision-making, planning, budgeting, and priority setting. It was therefore a contributing force to the efforts to provide quality and accessible public healthcare services, especially in PHC (Mollel & Tollenaar, 2013). One of the important effects of the program was the introduction of parallel and collaborative structures for healthcare governance and management at each level of healthcare service delivery at the local level. The collaborating structure of healthcare governance structures was established to improve healthcare services and increase community ownership and participation in primary health services management and decision-making (Crook, 2010). The decentralization yielded both positive and negative outcomes. The positive accomplishments identified in the study were increased access to central government resources for people who were formerly neglected, improved supervision of health facilities, and better coordination of donor support. However, one of the main challenges faced by decentralization has been the central government's reluctance to full devolution.

The Legal Sector Reform was introduced to address the existing weaknesses of the legal system in the country. The vision, to ensure 'timely justice for all', and the mission 'the development of social justice, equity and rule of law through quality and accessible legal services' serves as a means for ensuring equity, justice, and protection for human rights. This ought to be achieved through promoting and fostering good governance and rule of law in health services delivery.

Further, the government encouraged complementarity in the management of health services and public-private partnerships. This was necessary to decongest government institutions and facilities to improve health services provision. In this endeavour, capacity building was carried out to empower peripheral institutions to take charge. Transparent standard operating procedures, management protocols, performance assessment, and auditing tools were improved to improve governance. Councils were demanded to execute primary health tasks according to government prescriptions and technical support. RHMTs concentrated on technical support to improve the quality of the council's services without assuming operational responsibilities and the central government had to create an enabling environment for the proper functioning of the health system. At the council level, service agreements between councils and private providers were concluded to increase citizens' access to healthcare services. Private health facilities with service agreements with the government were given financial support to procure medicines and medical supplies. It was noted that collaboration between public and private health workers was stimulated to make maximum use of available health professionals. Thus, various sectorial reforms, especially the above-mentioned reforms had a substantial contribution to the outcomes of HSRs.

Due to its compositeness, it was a very complex process comprising a series of detached but integrated activities in different sectors. However, the activities of each sector were organized independently and sometimes duplicated due to limited coordination. This kind of complexity undermined the realization of the results due to the competition between different implementers to emerge the winners and successful implementers against the others. The idea of the complexity of the HSR process and its effect is also revealed by one of the senior public servants from the ministry responsible for health during an interview in Dodoma.

Even though these reforms were separate and distinct, they all followed a similar process. The reform crafting was initiated by sector ministries. The drafts were then forwarded to the cabinet through the Cabinet Secretariat. The Secretariat examined the viability of each of the reforms independently before forwarding them to the Cabinet. According to the interviewed officials, the Chief Secretary who is also the secretary to the cabinet and head of public service had to circulate the draft reform papers to all Permanent Secretaries to scrutinize them

and suggest improvements before forwarding them to the cabinet. However, this did not provide a proper forum to harmonize the drafts and remove duplications something that became one of the sources of failure of the reforms to realize intended outcomes. The role of the cabinet was mainly to give final approval after the presentation by sector ministers. After that, each reform document was simply adopted as constituting a strategic direction of the government on a matter in question.

As also revealed by different respondents who were interviewed, this complexity grew out of the nature of the process of developing the reforms that limit the accommodation of the ideas of different stakeholders. For instance, neither the members of parliament who represent the will of the public nor civil society stakeholders were adequately involved or engaged in the development and review of reform proposals as confirmed by one of the senior officials from the ministry responsible for health interviewed. Such complexity undermined not only the capacity of the government to steer efficiency in the implementation, but also monitoring the implementation of a reform initiative that aimed, to improve health sector management. In this case, it was difficult to get timely feedback on how far different sectors have moved toward the intended health service management outcomes. Therefore, it is suggested that a well-coordinated and simplified reform process is essential for the better realization of intended reform outcomes.

4.5. Donor Dependency

The last theme regarding how the nature and characteristics of the reforms affected the realization of desired outcomes was the fact that the implementation of the reforms heavily relied on funding from donors. This was revealed not only for health sector reform but nearly all the reform programs that Tanzania implemented since the 1990s. Overreliance on donor funding came with prescriptions, which the government and implementers could hardly question. The effect of heavy reliance on donors as the main source for funding strategic public health initiatives and interventions in Tanzania was also admitted by the government in Health Sector Strategic Plans. For example, between 2010 and 2017, the government's spending on healthcare ranged between 32% and 40% while donor support ranged between 60% and 68% of the total expenditure as shown (Piatti-Funfkierchen and Ally, 2020).

The evidence indicates that relying on domestic sources, especially government revenue increases government control on the implementation of important programs and policy initiatives. As some of the previous studies have already observed, a government that depends on its funding sources increases the flexibility in terms of prioritizing the key components of the reform that should be implemented at different times. It is also easy to make some strategic adjustments to accommodate unforeseen events that tend to happen in the course of implementation. Therefore, having adequate domestically mobilized resources is crucial since it increases certainty during the implementation of important reforms such as the Health Sector Reforms. This was not the case for the HSR in Tanzania, hence poor achievement of intended outcomes.

4.6. Conclusion

This paper has presented the findings conducted in Tanzania to verify the effect of the nature and character of Health Sector Reform on the realization of intended healthcare management outcomes in the country. The two concepts, nature and characteristics of the reform were used to entail components such as the essence of the reforms, control by the government, resources, coverage, and the pace of implementation. The analysis centred on the identification of the themes that try to connect the nature and character of the reforms to the observed failure of the reforms to improve healthcare management outcomes in terms of efficiency, quality, access, and reliability of the services.

During the study, six themes were identified and analysed that connect the nature and character of the reforms and the failure of the reforms to realize intended outcomes as revealed in the management of the health system today. First, the reforms initiated were informed by a dual pressure from both the internal and international socio-political and economic conditions and ideologies. Second, the ideals of the reforms failed to fit well into the existing structure of the health system. For example, the role of the private sector and community authorities in the structure remains a debate. Third, the reforms were over-ambitious attempting to achieve many things at once while the possibility was logically limited. Fourth, the reform implementers employed impaired and less functioning reform approaches, strategies, and tactics. Fifth, the reform process was generally complex, and less coordinated, and outcomes were hardly confined to a single sector or ministry. Sixth, the implementation depended heavily on donor funding. This increased uncertainty and limited control of the government on the implementation of the reforms.

Previous studies have indeed indicated that public reform outcomes are highly influenced by the content and context of reform (Hinkel et al, 2015). Therefore, a proper understanding of why the reforms fail to realize the intended outcomes required examining these two interrelated aspects which relate to the nature and character of the reforms themselves. Therefore, the reforms in the health sector appear to have come with the seeds of their destruction. Implementation of future reforms requires learning from the whole process of designing and implementing the previous health sector reforms.

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