Capabilities of public, voluntary and private dispensaries in basic health service provision
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A study is reported from the coastal region of the United Republic of Tanzania on the capabilities of public, voluntary and private dispensaries in the provision of peripheral health services. The implications for the future development and coordination of the different sectors are discussed.

In the implementation of its primary care programme, the United Republic of Tanzania has given special attention to the development of dispensaries and rural health centres. Medical assistants, rural medical aides, mother and child health aides and health assistants have been trained to provide services at dispensary level. However, for economic, organizational and managerial reasons there has been an overall decline in health service provision. Among the proposals that have been made for improving matters is one to increase the role of the private sector.

We investigated the actual and potential contributions made by the voluntary (not-for-profit) and private (for-profit) sectors, and found that at dispensary level in the country's coastal region the public and voluntary sectors work side by side to provide basic services that can be integrated to improve health care delivery. The study covered 18 dispensaries, six in each of three districts: Kibaha, Bagamoyo and Kisarawe. With reference to the National Health Policy of 1990, essential indicators were developed for each service and the capabilities of the three categories of dispensary were measured. Information was collected on infrastructure, health personnel, ranges of activities, and allocated resources. Capability, or the potential ability of a health facility to perform its activities by using existing resources, was calculated as the ratio of existing to expected resources, expressed as a percentage.

Findings

The buildings

The different categories of dispensary had virtually the same average numbers of essential rooms, namely 5.3 for public and voluntary dispensaries and 5.2 for private dispensaries, giving them the same capability to provide dispensary services. Whereas all the public dispensaries had delivery rooms, however, the private dispensaries had none. There was no electricity supply in any of the public dispensaries. Infrastructure quality was fair in the voluntary and private dispensaries but tended to be poor in the public ones. The capabilities were 76.1% for the public and voluntary dispensaries, and 73.8% for the private ones. However, if the complete absence of mother and child health rooms in the private sector is set aside on the grounds that no attempt was
made to provide a mother and child health service in these facilities, the capability for private dispensaries becomes 86.1%.

**Equipment for outpatients**

Two of the public dispensaries had no sphygmomanometer and one had no stethoscope. Only four of the voluntary dispensaries had otoscopes. There were too few sterilizers, especially in the private dispensaries. In so far as equipment, instruments and supplies were concerned, the voluntary dispensaries had a capability 87.8% for dealing with outpatient problems, the corresponding values for the private and public entities being 71.2% and 66.6% respectively.

**Supplies and equipment for family health**

No family planning materials were found in private dispensaries. Two voluntary dispensaries and all the public ones had at least one type of contraceptive on offer. Instruments and supplies relating to maternal and child health were found in one private, some voluntary and all public dispensaries. The capabilities for the public, voluntary and private dispensaries were 83.3%, 56.6% and 13.3% respectively.

**Equipment for childbirth**

All the public and some of the voluntary dispensaries were well equipped with delivery instruments, whereas this was true of only one private dispensary. The capabilities were 73.8%, 33.3% and 14.2% for the public, voluntary and private entities respectively.

**Immunization services**

All the public dispensaries had the equipment, instruments and supplies necessary for immunization services; only half the voluntary units and none of the private ones were satisfactory in this respect.

**Personnel**

The numbers of medical assistants and rural medical aides were adequate in both the public and the private dispensaries but not in the voluntary ones. Mother and child health aides were present in adequate numbers only in the public dispensaries. Nurse assistants and nurse attendants were present in all three categories of dispensary, but there were shortages of health assistants, cleaners, watchmen, medical officers, assistant medical officers, staff nurses, pharmaceutical assistants, laboratory auxiliaries, drivers and other staff, particularly in the public and voluntary sectors.

**Implications**

When the health activities in each facility were taken into account it was clear that the private dispensaries had a higher capability in infrastructure than did the public and voluntary dispensaries. Most private dispensaries were established relatively recently, after the amendment of the private hospital act in 1991, and consequently it was to be expected that the buildings would be newer than and superior to those of the public and voluntary dispensaries. The relatively poor quality in public sector buildings was largely attributable to lack of maintenance.
The private and public dispensaries had adequate numbers of medical assistants and rural medical aides. The voluntary sector, however, had few personnel of this type, and consequently most prescribing was done by nurse assistants or mother and child health aides, who were not adequately trained for this purpose. Nurse assistants, although not classified as core personnel at dispensary level, were the most numerous category of workers in all three types of dispensary. The private dispensaries, because of their orientation towards outpatient service, employed more medical personnel than the others.

The implementation of the standard guidelines for dispensary staff was unsatisfactory; furthermore, some of the guidelines failed to take into account the differences between the activities of voluntary and private dispensaries. The presence of non-essential personnel, especially in the voluntary and private sectors, could also influence performance.

Those in charge of public and private dispensaries were medical officers, assistant medical officers, medical assistants or rural medical aides, while those in charge of dispensaries were mother and child health aides, who, being non-medical personnel, were not authorized to prescribe drugs. A study in Dar es Salaam indicated that the technical quality of services in voluntary dispensaries was generally poor. Although the voluntary dispensaries performed better on the whole than the public ones, they were responsible for most of the practices infringing established norms (1).

The range of services provided in public dispensaries, including outpatient services, mother and child health care, immunization, family planning, delivery and health education, was in accordance with national guidelines (2). The private dispensaries had the lowest output of treated outpatients, although they were better provided with equipment and instruments. The public dispensaries had the highest output in this respect. Factors other than the availability of resources were evidently influencing output.

The highest capability for providing curative and preventive services in accordance with national guidelines was demonstrated by the public dispensaries, whose output was also superior to those of the other sectors. Clearly, therefore, it is desirable to maintain and strengthen the public dispensaries. The voluntary sector, accounting for about a third of the country’s health services, had a high capability for providing outpatient services in terms of facilities, equipment and instruments. However, shortages of medical assistants and rural medical aides led to overprescription.

The private sector is becoming a significant provider of health care at the periphery. In view of its qualified staff and capabilities it should be given responsibility for some preventive services. Remuneration for these services could perhaps take the form of basic equipment and instruments, which would attract more clients. To achieve the best possible combination of types of dispensary, district medical officers should adapt national policies and guidelines to local circumstances, coordinating negotiations between dispensary managers, supervisors and communities at village level. This could significantly improve the dispensary services available at the periphery.
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References


Is curative or preventive medicine the better buy?

The priority assigned to costly curative medicine (particularly by social insurance institutions) over low-cost preventive medicine is an inefficient way to allocate health care resources. ... In Costa Rica, the rural health program at the beginning of the 1980s did more, with a smaller budget, to reduce mortality and morbidity than the capital intensive services of social insurance. The exorbitant cost of adding sophisticated health care benefits for the few obstructs the extension of basic services for all. ... Because curative medicine treats the disease without dealing with its causes, it becomes more expensive than prevention in the long run. Consequently, shifting emphasis toward preventive medicine could cut down costs, reduce morbidity and mortality, and be more efficient over time by making curative medicine less necessary.