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Author: Andreas Malmberg
Supervisor: Iwona Sobis
Supervisor in Field: Josephine Sundqvist
Examiner: Emma Ek Österberg

ASPECTS ON FREE PENTECOSTAL CHURCH OF TANZANIA IN HEALTH SERVICE DELIVERY

A minor field study of Public-Private Partnership in Health Care Sector in Tanzania



UNIVERSITY OF GOTHENBURG

Abstract

This Minor field study and bachelor thesis that follows will focus on the Public-private partnership (PPP) in the health care sector in Tanzania. More specifically it examines the relationship between a Faith based organization, the Free Pentecostal Church of Tanzania (FPCT), and governmental authorities from a resource dependency theory point of view. This theory stresses the dependency environment holds on organizations, interdependence between actors and strategies organizations can use to increase resources and influence. This thesis is a qualitative case study, studying two hospitals owned by FPCT. This minor field study is to describe and give a deeper understanding of: How the representatives of FPCT perceive the cooperation with the governmental authorities regarding resource exchange and dependency? What strategies FPCT uses to increase resources and influence on the government? What consequences PPP has for FPCT and their partnership, within the health care sector, with the government? This study was conducted during eight weeks in Tanzania. The main research findings concerns that the most serious problem in the cooperation between FPCT and the governmental authorities seems to be the lacking of resources and the insufficient funding of many activities. However, the actors have created an interdependent relationship between each other. This study also shows the difficulties FPCT perceive and how it is mainly concentrated to the cooperation with local government. Another finding is how FPCT consider the responsibility of providing health care as the government's responsibility.

Keywords: Public-private partnership, Health care, Faith-based organizations, Resource dependency, Minor field study, Tanzania.

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1. Introduction

In 1990 Public-Private Partnership (PPP) was introduced in the health care sector in Tanzania and was strengthened in the year 2000 (Boulenger & Criel, 2012). Now it is well established that through PPP both government, society and private sector would gain of the partnership, "if there are genuine concerted efforts to work together" (Itika, Mashindano & Kessy, 2011:8). It is a superior policy to improve health care service and as the authors put it: "Public-private partnerships is the best policy option for improving health service delivery in the country" (Itika, Mashindano & Kessy, 2011:25).

Traditionally, schools and hospitals were private driven by missionary societies and church organizations before Tanzania became independent from United Kingdom in 1961. Even after the independency, the Faith Based Organizations (FBO's) has become a big actor in the health care sector (Boulenger & Criel, 2012). The state and the church were separated a few years after their independence during the socialist period, but the state called for the churches to support and contribute to the national goals and government policy. The churches gradually changed their social mission to fit the public development policies (Boulenger & Criel, 2012). During this socialist period Tanzania made a drastic change towards socialistic politics and economy. This change meant centrally planned economy with nationalization of private owned companies and major sources of income as mines and industries. In the sectors of social services the government during this period did provide highly subsidized services, within sectors as education and health care (Ngowi, 2009). In the 1970s a decentralization of the health care system and a contracting model in Tanzania was implemented. This health care reform made some faith-based hospitals to District Designated Hospitals (DDH). DDH was implemented to cover up for shortage of public facilities and to prevent risk for duplication at places where the church already established hospitals. These type of contracts or in some cases just agreements were established between the owner of the hospital and the government (Ministry of Health) (Boulenger & Criel, 2012). From the middle of the 1980s Tanzania followed the worldwide trend of market-oriented and private sector led economy and new public management. These were reforms in opposite to the socialist period. State owned companies were once again privatized and decentralization policies were implemented (Ngowi, 2009). Public-private partnership was introduced in the health care sector with Council Designated Hospital (CDH) model and the Service Agreement (SA) model. CDH was a revision of the DDH model but these contracts were handled by the local governments

pursuant to the decentralization policy. The SA model is a more formal relationship between the state and private health organizations. In this model performance contract and monitoring and evaluation according to the performance criteria were introduced (Boulenger & Criel, 2012). Faith-based organizations are a significant actor within the health care sector today. Close to 50 % of the hospitals and about 20 % of the health care centers in Tanzania are run by FBO's (Green & Mesaki, 2010).

PPP derives from United Kingdom and USA in the 1980s and is characterized with new public management, deregulation and privatization of service. It was seen as a new form of administration of governmental activities (Jütting, 1999). Although there are many definitions of PPP it can be described in general terms as "cooperative institutional arrangements between public and private sector actors" (Hodge & Greve, 2007:545). There is a global interest in PPP reforms and there are several examples of both successes and failures all over the world. The need of evaluating the governmental standard and effectiveness is crucial since the PPP concept promises much (Hodge & Greve, 2007). The interest in PPP applies to developed as well as developing countries. Despite the global interest, the experience on a country-level is generally limited and not available. In particular, PPP-research in developing countries appears to be an area of few research publications (Christensen, 2011).

Even if the FBO's have been an important provider in the health care sector in Tanzania they have been overlooked when it comes to research and analysis of the health care sector as well as their relationship with the government has been "under-researched" (Green, Shaw, Dimmock and Conn, 2002:251). Boulenger & Criel (2012) write that the forms of public-private partnership and the contracting models have been improved. Even so, the problem with implementation remains.

One important aspect is that local authorities cooperate with the central authorities to establish laws and policies, but that local authorities directly can contract the private (for profit and nonprofit) organizations (Itika, Mashindano & Kessy, 2011). Due to Boulenger & Criel (2012) one reason for a successful collaboration is the personal contact that local level entails.

There are many FBO's in collaboration with the government in PPP related cooperation in health care sector in Tanzania. This thesis has focused on a smaller owner of private hospitals, a church organization called Free Pentecostal Church of Tanzania (FPCT). Since many years

back FPCT has connections to Sweden and Swedish aid through Swedish international development cooperation agency (Sida) and Pingstmissionens utvecklingsamarbete (PMU), hence the demarcation and choice of FBO. FPCT has two hospitals, four health centers and eight dispensaries in collaboration with the government. This study focuses on the hospitals and their partnership with local governments, both hospitals located in rural areas.

The purpose of this study is to describe and give a deeper understanding of: How the representatives of FPCT perceive the cooperation with the governmental authorities regarding resource exchange and dependency? What strategies FPCT uses to increase resources and influence on the government? What consequences PPP has for FPCT and their partnership, within the health care sector, with the government?

1.1 Disposition

This thesis is divided into five chapters with the introduction included. The second chapter presents a description of the methodology used in this study. The third chapter contains a presentation of the theoretical framework of resource dependency theory. The fourth chapter presents the results of the analysis of the interviews. Discussion of the results, answering the research questions, and drawing conclusions is presented in the fifth and last chapter.

2. Methodology

This chapter consists of the methodological choices made in this study. First a study design will be presented, then sampling, data-collection, measurement and finally ethical conduct. This field study has been carried out during eight weeks in Tanzania.

2.1 Study design

This study is based on a qualitative method and consist data sampled from interviews. During the study seven semi-structured interviews were conducted. The main focus has been on the two hospitals run by FPCT. Moreover, this study also contains interviews with representatives from FPCT headquarters and from Christian Social Services Commission (CSSC) to understand the perspectives of coordination on a national level. This minor field study is a case study studying two cases. Both hospitals are located in rural areas, one in Mchukwi, Pwani region, and the other one in Nkinga, Tabora region. The purpose of choosing

interviews as primary data is for the possibility to get a deeper understanding of how the respondents perceive their relationship with the government. Through interviews nuances in emotions and attitudes can be detected and it opens up the possibility to understand the respondents better (Kvale & Brinkman, 2014). Moreover, the method of conducting interviews can allow the respondent to give expanded and unexpected answers (Esaiaasson, Gilljam, Oscarsson & Wängnerud, 2012).

2.2 Semi-structured interviews

To be able to fulfil the purpose of this study and to answer the questions, the need of asking FPCT hospitals about their experience of cooperation with the government was crucial. The choice of conducting semi-structured interviews rests on how they allow a certain amount of flexibility. At the same time they are structured enough to be able to analyze similarities and differences. The flexibility in semi-structured interviews gives the interviewer the possibility to ask follow-up questions and the respondent opportunity to develop arguments (Kvale & Brinkman, 2014). During the eight weeks in Tanzania when this study was made, seven semi-structured interviews were performed. Interviews with an accountant, administrators and doctors in charge have been conducted at the hospitals. It was a strategic choice to interview these people since they have the overall responsible for running the hospitals. Further, the chosen respondents are also the people with the actual contact with Tanzanian government at the national and local level and possess the overall understanding and knowledge about the relationship these hospitals experience towards the governmental authorities (Ekengren & Hinnfors, 2012). On a national level an interview with FPCT headquarter, the owner of the hospitals, was performed with administrative staff to see the national perspective and their view on the partnership from the coordinating role the FPCT headquarter holds. An interview with CSSC was also carried out to see the national level perspective but outside the FPCT organization. CSSC is an interest organization of faith-based organizations running education and health service activities in Tanzania, and the main channel in which FBO-owned health facilities communicate with Ministry of Health. The conducted interviews lasted for about 30 to 60 minutes per interview and were conducted at the office of the respondent. All interviews were recorded to be able to fully reproduce what was said during the interviews and for the possibility to be completely focused on the interview when they were conducted. The seven interviews conducted during this study, have been enough, perceiving that a certain level of saturation was achieved.

2.3 The questionnaire

The questionnaire used during the interviews was structured and divided into four sections. These four sections are based on the research questions and the theoretical framework used in this study. The first section contains questions about the role of the respondents along with background and history of the hospital or organization. These questions objective was to get an overview of the respondents and the hospitals in general. The second section contains questions about the partnership and the cooperation these organizations have with the government. This section helped to give answer to how their cooperation works and how the respondents perceive the cooperation. The third part of the questionnaire includes questions about the relationship to the government. Further, the third section gives an understanding of the relationship the respondents have to governmental authorities. The final section concludes the questionnaire with questions about development and strategies. These questions aimed to get a picture about what strategies were being used to increase recourses and to see how they perceive further partnership.

After the interviews were conducted the empirical material was transcribed using the method of intelligent verbatim transcription. The use of the transcribed empirical material made it easier to analyze it and to discover patterns in the material (Kvale & Brinkman, 2014). All the empirical material have been analyzed based on the theoretical framework used in this study, in which categories of interdependence, stability vs. autonomy and power relations were found. The empirical material has also been analyzed with an inductive approach to detect patterns and draw conclusions regardless of theoretical framework, in which the category of the local level issue was found.

2.4 Ethical conduct

All respondents have been informed about purpose of this study. The participation in the conducted interviews was voluntarily and the respondents are presented anonymously due to sensitivities of talking about the relationship and request from some of the respondents. All respondents approved being recorded during the interviews (Kvale & Brinkman, 2014).

3. Theoretical framework

In this chapter the theory of resource dependency will be explained and the core parts will be described. The relationship between FPCT and the government and the concept of PPP is based on resource exchanges and on mutual dependency. Resource dependency theory according to Pfeffer & Salancik (2003) also stresses power relation and strategies of organizations, since the choice of theory is relevant to this case study.

3.1 Resource dependency theory

In this study resource dependency theory has been applied. This theory stresses the dependency on the environment organizations hold. The theory features the term loose-coupling. An organization is not totally dependent, if organizations would be completely dependent on the environment it would be on a steady course to extinction. The important perspectives of how the environment forms organizational actions depends on how the organization understand, relate and get information about the environment to contribute to it. Through cooperation and compromising with the environment in order to get the resources, the organization can manage to survive (Pfeffer & Salancik, 2003).

Interdependence between actors occurs when the actors do not control all conditions by themselves for achieving desired outcome. The authors differ between outcome interdependence and behavior interdependence. The first imply that actors are dependent on other actors achieved outcome. The second is more dependent of other actors behavior or participation to even get an outcome. Interdependence can both be competitive and symbiotic between two actors. Competitive interdependence is when an actor has a higher outcome while one automatically gets a lower outcome. When the interdependence is symbiotic both actors can have high outcome and low outcome at the same time. Interdependence does not necessary have to be balanced and can be symbiotic and competitive at the same time (Pfeffer & Salancik, 2003).

Further, this theory includes strategies for decreasing interdependence. In one way organization can try to increase its own importance to causing other actors to become more dependent on them. Another way is to decrease the other actors dependence to get resources from several actors rather than depend and rely on one single actor (Pfeffer & Salancik, 2003).

Pfeffer & Salancik (2003) also stresses the strategy and dilemma for organizations to seek stability in resource exchange and actions to avoid being controlled. To be able to adapt to the future, organizations need capability and discretion to change their actions. To stabilize resource exchange it is necessary to develop inter-organizational organizations. Due to Pfeffer & Salancik (2003) organizations also act in a contradictory way, trying to be independent at the same time as they seek certainty and stability and how that leads to certain actions. Actions as mergers and joint ventures are less flexible while coordination and cooptation are more flexible. Cooptation means the interlocking of external personal in an organizational board. Interlocking boards of direction implies, as Pfeffer & Salancik (2003:161) write, "...the practice of interlocking boards provides opportunity to evolve a stable collective structure of coordinated action through which interdependence is managed." Stable relationship is achieved through friendship, informational exchanges and understanding. An example of this is a person who attends or is committed to a board, how she is supposed to share the support for the organization and will be concerned about the problems they face and try to take action to aid the problem. On the other side external persons in a board could mean that the organization will be influenced by that person and lose its autonomy.

Williamsson (1995) means that a considerable perspective of resource dependency is power relations. Actors possessing power are the ones who hold the resource that for another actor is not easy to replace. Chen & Hubbard (2012) write that if one actor in cooperation has more resources to share, the other actor will be the more dependent part in their cooperation and there will be power inequalities between the actors. Power equality and a mutual interdependent relationship occurs when cooperating actors themselves possess valuable resources and when managing they meet mutual need. Chen & Hubbard (2012) also write that the reason for joining interactions, like exchanging resources, is in the actor's self-interest but also for the actor to attain the outcomes of the cooperation.

4. Result and analysis

In the following chapter the results of the analysis of interviews will be presented in four categories. The categories are related to the chosen resource based theory by Pfeffer & Salancik (2003). Both results and analysis of the results will be presented in this chapter.

Throughout the interviews with representatives from FPCT there are observed coherence in a number of aspects that address the cooperation and partnership with the government. The representatives seem to have similar reflections on their role in this cooperation, the government role and why they cooperate. Nevertheless, some aspects stand out, but it is most likely more of what the representatives underlines than different perceptions between the representatives within FPCT. The size of FPCT and the close connection of the representatives from FPCT may be one of the reasons for the consistent picture in their relationship and cooperation.

The relationship between the hospitals and governmental authorities is a resource exchange partnership. The financial assistance the hospitals of FPCT receive is an essential contributor when it comes to running the hospitals. The hospitals receive funding in form of salary for a certain number of staff, contribution for drugs and other funds and contributions.

4.1 Interdependence

When it comes to the extent of dependency the respondents recognize both actors as dependent on each other. No respondents from governmental authorities have been asked, accordingly this is the view of the respondents from FPCT and CSSC and not from the government. FPCT recognize the importance of the governmental funding to their hospitals, even if the response differs. To address the interdependence between the FPCT and the government there are a number of aspects that emphasize their interdependence between them according to the representatives from FPCT and CSSC. One of these aspects is how the hospital serve the poor people in rural areas and there is also a big consensus and accentuation from the representatives of FPCT and CSSC addressing they are doing something that is the government's responsibility. They help the government providing health services. Both hospitals that FPCT operates, as motioned above, are located in rural areas, implicating the financial status of the surrounding people are limited. Both hospitals are nonprofit hospitals and one thing that most of the interviewed respondents stress is how they serve the poor

people, which also make the contribution from the government important and necessary. To serve poor people that sometimes are unable to pay the patient fees, gives a loss of valuable income. One of the respondents said: "And we are just owing 26 million, I think, accumulation of unpaid patient fees for those who are not able to afford that" (Interview 2, 6 April 2015).

Hence, they stress the governmental responsibility to help the implementing actor, the FBO's, since they are doing the government's duty. As one administrator said: "[...] because the responsibility of keeping health of the Tanzanians is up to the government. We are just to helping the government to give health services to citizen" (Interview 6, 16 April 2015).

This attitude can be used as an argument for the FPCT representatives to see the government as dependent on them in regard of the hospitals fulfilling the obligation of the government toward its population. It is interesting to notice how the focus is directed. It is not unlikely to claim, as a church organization, they serve the people out of ideology, compassion and as an obligation of the church. This was mentioned, but only a few times, during the conducted interviews.

The respondents claim the hospitals could survive without the contribution from the government but it would be hard. Moreover, the respondents claim the government is absolutely dependent on them fulfilling their services. They stress the substantial part they take through the network of FBO's in CSSC, even though FPCT is a small part within that network and a small part in general within the health care service in Tanzania. But for the local community, where they are located, they are of high importance. FPCT is a small provider but being a part of CSSC and identifying themselves with this organizations gives them a feeling of being a big actor. In this regard they put a lot of faith and reliance in this network. One of the respondents said concerning CSSC and how the government is dependent on them:

As I have told you, we have more hospitals. And not only when you say hospitals, it's not only hospitals. The giant hospitals are with us. You know, if you goes for instance to KCMC, Kilimanjaro Christian Medical Center. That is a university teaching hospital (Interview 7, 27 April 2015).

It is important to notice that even if the respondents claim to be less dependent on the government than the government is on them, they also receive help from international organizations. Churches in Sweden and other aid organizations still support them, even if it is not as significant as it used to be. In this way they are dependent on other actors as well, they decrease the dependency in one actor and spread the dependency to several actors. According to the resource dependency theory, it is a strategy organizations can use to decrease interdependence on a single actor. This posture FPCT representatives hold, how they underline them being the extended governmental arm for the population of Tanzania, is a reason for them to consider themselves as partners. As one of the doctor in charge said concerning this:

So, giving service to that people, and nobody who will be giving back that money. Then we are partners with the government, within that situation. We are doing what the government should do [...] (Interview 3, 7 April 2015).

Among the respondents there is a coherence in their view on the partnership with the government. In one way the cooperation is mandatory as one of the administrators said:

The Ministry of health is the department of the government which oversees any health operator in the country. So there is no way you can conduct in health services without cooperating with the government. Actually, abiding even the laws of the government (Interview 6, 16 April 2015).

But another administrator also claims it is necessary to help the government:

For us, I can say we feel like partners. That has been our target, we are partner to the government. From our discussion when we started, I told you that it's not our obligation of FPCT to provide health care to the population. It's the obligation of the government. But, of course, it doesn't have enough resources, it doesn't have enough infrastructure, it doesn't have enough equipments we also are trying to do on our part, within the available resources we have. That's what we are trying (Interview 4, 14 April 2015).

Not as distinct as that, is how the representatives of FPCT perceive the government's view on the FPCT hospitals, as partners or not. Many of the respondents stress the spirit of partnership from the government among other things due to the financial contribution. The contributions from the government are of importance to the hospitals of FPCT, why they also see themselves as partners. The government is "doing a big part", one of the doctors in charge said (Interview 3, 7 April 2015). The respondents perceive some sort of competitive attitude

towards them from a governmental point of view. FPCT representatives stress the competitive approach is more frequent from politicians, as will be mentioned below, than from governmental hospitals. They accentuate the good relationship and cooperation with governmental hospitals and how they help each other when necessary. But in general both partners seem, according to the respondents, to gain from this partnership. However, despite the coherence of FPCT representatives being partners with the government, one aspect of competition could be detected, the competition of labour. It is not because of lower salary, FPCT follows the governmental level of salary. What could be considered as a competitive factor is the location of the hospitals in rural areas. It considers as negative when it comes to attract staff. But moreover, the conception of more secure employments within the government makes it hard for the FPCT to attract skilled staff, hence the competition of staff is a problem the respondents perceive.

4.2 Stability vs. Autonomy

Representatives of FPCT stress the opinion of them doing the duty of the government to the extent that they consider that the government should be responsible for the whole hospital, regarding all staff salaries and expenses for drugs. As one of the doctors in charge said about the cooperation and the funding from the government:

They should deal with health for their people. It's not the responsibility of the church. We are trying to show them that we are doing their job (Interview 3, 7 April 2015).

Representatives from both hospitals say they desire the government to increase the financial support. One hospital even asked the government to fully support staff and drug expenses. Through this point of view it can be implied that the understanding of the argument above can be connected to the resource dependency theory and how they rather choose stability of resources over autonomy. This even implies to suggest merges between the government and the hospital. Moreover, this approach does not give FPCT more autonomy. Furthermore, there are other reasons according to the resource dependency theory that are adverse for the autonomy which this partnership consists. The actors have relatively close contact with each other and they are members in each other's boards. For example, the doctor in charge is a member in the district medical board and the district medical officer is a member in the hospital board. Through this close and continuously relationship the representatives from

FPCT perceive they have influence in some sort of way or at least can express what they think and mean they can be critical. The possibility for FPCT to influence the government mainly goes through the board meetings and other meetings. Some of the respondents stress the informal way to influence, e.g. through personal and informal contacts with politicians. Through CSSC the influence on a national and regional level is strong, e.g. membership in various committees and groups on national level. The respondents also stress that they have a critical voice and can raise it if necessary. They know that governmental authorities may face difficulties trying to solve them, but perceive them as open and susceptible to the issue. One administrator said:

Yeah, I can say that the government is listening, but I think the capacity to help us is another thing. They want and if possible they could help us in everything, but the capacity is something else which... I can say that it's difficult (Interview 1, 6 April 2015).

Another administrator expresses the obligation to be critical:

Of course we are committed to do. But it's situational; we have to see the situation, if it allows you to do so or not. But in most cases we are using this platform, I have already mentions to you, CSSC (Interview 4, 14 April 2015).

The strategy indicated above for seeking stability in resources decreasing the autonomy may simultaneously increase the influence that follows from the close relationship. Through that influence it is a possible path to increase resources.

The FPCT hospitals also emphasize the quality and capacity their hospitals hold to obtain more resources and influences. They stress their importance, not only to their district or region but also to surrounding regions and even countries. The respondents highlight the skilled staff, the good facilities and the good standard of equipment. These arguments mentioned are used in order to increase their significance and they use their significance as a strategy to increase influence and resources.

Because, of increasing the capacity of going service that sometimes influencing the government to bring support. Like here, we have skilled personal like specialized doctors. Whom is... Like if you go to hospitals around here, they don't have this skilled personal, it's only here. So sometimes this forces the government to continue cooperation and bring more support to us (Interview 5, 16 April 2015).

The same doctor in charge extended to this opinion, mentioning the equipment standard, by saying: "Even instruments which we have here, which is of higher standards compared to nearby other units or hospitals" (Interview 5, 16 April 2015).

Thus, this approach of promoting themselves and to emphasize their importance and claim their high standard seems to be a strategy FPCT respondents frequently use. Even to use an argument as this, that the government is dependent on them, can be seen as a strategy for them to improve the influence and to get more resources. Strategy the respondents need to use, in case of problems and while trying to expand the resources, is patience. The respondents stress the importance of never giving up when it comes to issues they bring to the government. To meet with the officials over and over again and never stop asking and questioning.

We still speak and speak and we hope it will be taken care. Because it is a very long time since it was taken care for so that why we are speaking now and then for that. (Interview 3, 7 April 2015).

Another of the respondents, an administrator, said: "So we have use different strategy, we never give up." (Interview 4, 14 April 2015). This strategy is also applied in solving problems or conflicts that occur.

One important contradiction that could be discovered is how FPCT, as mentioned above, act to prioritize stability over autonomy while they simultaneously strive for autonomy and financial independency trying to implement projects for resource growth. This strategy is an opposite strategy than to claim more resources from the government. This strategy entails more independency and the aim is to self-sufficiently increase their resources. These strategies are examples of projects to create and develop activities that could provide more income. Different projects are in pipeline to start in order to increase the income of the hospitals. Both hospitals have built private wards for people who are willing to pay for extra comfort. The idea is that they will offer the same treatment but in private wards. The expenses for the treatment and the drug will remain, but higher income from patients who are able to pay for this comfort. Another project was also mentioned at one hospital in order to increase income to the hospital. Projects like these are not in order to make profit but to cover expenses and financial loss. Regarding the profit they make having patients staying in the

private wards, one administrator said: "In that way they can support even those who are not able to pay for the service..." (Interview 4, 14 April 2015).

It all indicates the goal the representatives of FPCT have to increase the stability in resource exchange over increasing their autonomy and independence, except from a few contradictions in actions implemented. In one way FPCT will never have the opportunity to seek total autonomy and most likely it is not desirable, while in that regard it seems rational to seek stability over autonomy. To seek financial stability will also be important especially when they witness the limitation of resources. The lack of autonomy appears not to be considered as an issue in other aspects. It is noticed that they claim not to disapprove but rather welcome evaluation as will be mentioned in the section below, which may indicate some trust but also indicates the power that the government holds over the FPCT hospitals.

4.3 Power relations

The power relation can be detected both in the presentation of the results above as well as below. The respondents do not proclaim to be inferior in terms of power relations. Moreover, the representatives exert a certain power over the government as well, which also has been established above. Power is related to the interdependence and most likely the conditions of interdependence will reflect the conditions of power.

According to FPCT representatives the government has big trust in them as an actor in the health care sector. Mainly, the respondents argue, this is based on the role and the status they claim to have in the society. Other surrounding hospitals and other health facilities refer their patients to the hospitals of FPCT. Further, the respondents claim to be trusted by the government in how they act and communicate with them in different ways. But when it comes to the question if FPCT trusts the government the answer is not as obvious as the issue regarding the government trusting FPCT. As one of the administrators from FPCT puts it:

Of course, because it is a matter of policy; the policy is there to be implemented but the capacity is another thing. The government doesn't have, if it doesn't have money, then what do do? It's just to wait and when they get money they will submit it (Interview 1, 6 April 2015).

It becomes a question of power. Another respondent, an accountant, also attended the question by saying: "We have no alternative. We have to trust them." (Interview 2, 6 April

2015), regarding FPCT receiving money from the government. The personal aspect on local level is something that seemingly also applies when it comes to trusting the government, and will be mentioned below.

Another part that is included in this partnership is the evaluational action governmental authorities exert. It seems the FPCT representatives welcome the evaluation from the government and how they monitor them. As a doctor in charge expresses concerning evaluation:

It's good. Because if we have weaknesses in some areas. They are giving the ways of how we can improve that. It's a good thing (Interview 5, 16 April 2015).

This was the general approach towards evaluation and monitoring. One administrator claimed the evaluation to depend on the person evaluating them, but underlines that in most cases the officials coming to evaluate is proficient. That person said:

This depends of the person who comes. Some people come knowledgeable but there are people who are not knowledgeable, who are unable to give good advices. But in most cases as far as they observe guidelines, if you go outside of that guidelines or policy, they tell. In most cases we appreciate (Interview 6, 16 April 2015).

The policies, under which the FPCT hospitals operate in the PPP-relationship and through evaluation and monitoring the power the governmental authorities have, is clearly indicated. The power is related to the funding which constitutes a significant part of the partnership as well. Apart from financial conditions a lot of surrounding circumstances are in the hand of the government and the well-being of the hospitals is closely related to how the government acts. It could be things as maintaining the road to the hospital or how the personal contact is functioning, as will be detailed below.

Besides the above presented findings of how resource exchange and dependency affects the cooperation and how the FPCT relate to the government, another aspect of the relationship was frequently recurred during the interviews. Throughout the interviews an issue that seems to be consistent for all respondents is the experience of problems occurring more often, in different matters, on the local level in comparison to the national level.

4.4 The local level issue

The interviewed persons working on national level point out differences between how different district officials cooperate with the FBOs. The representatives of the hospitals also say they meet different attitudes towards them as a FBO, depending on district officials. In some way it is natural because according to the PPP policy the local governments are the responsible ones and the one the hospitals are supposed to stay in contact with. Some of the respondents raise it like a question of religious antagonism. If a government official is a Muslim, they perceive the cooperation more difficult. As one administrator said:

And the Muslims sometimes they do not support Christian services. So there are some kind of underground resistance in term of running the hospitals. Of course, there are not documented anywhere, but you can feel it (Interview 4, 14 April 2015).

Another respondent means this is a lack of understanding of the concept of PPP on a local level:

So they come say, why are you giving money to Christians. So that is because they don't understand the concept very well. Because when you give money to any hospital, when it comes to service provision, nobody is asked whether you are a Muslim or you are Pagan or you are a Christian. You just come and get the services. I think people should know if they understand it all, then they should say: support these people so that we get the right services (Interview 7, 27 April 2015).

The same person means that this lack of understanding of the concept of PPP is not limited to religious, as in this case Muslim, reasons but a general problem on the local level. As the respondent also said: "Another challenge is that the big problem of PPP understanding. Other people, you know, they don't understand the PPP concept. So, when it comes to implementation, the actors as hinderers in the provision" (Interview 7, 27 April 2015).

One respondent meant that PPP is not fully practiced, and was referring to local politicians who would not prioritize to improve the bad and bumpy road from the main road to the hospital. A suggestion from one respondent was to implement a PPP technical working group on the local level as well as it has been established on regional level and national level, which is something they have been trying to suggest for many years to strengthen PPP on the local level. Also the political agenda and politics is something that FPCT representatives see as a problem or disturbance when it comes to the cooperation. The representatives of FPCT

believe that some politicians think of them as competitors. The respondents are questioning the act of maximizing votes from the people by promising activities that compete with the hospitals of FPCT, e.g. constructing health facilities near the FPCT hospital. At the same time some of the respondents state they apply the use of personal contacts and politicians in informal channels for strategic wins.

We do use different strategies. Sometimes we involve politicians as well, because, they are the people that have been listen much in the government. You can take maybe the member of the parliament in the district, talk to him or to her. (Interview 4, 14 April 2015).

Even if that could be the case or at least be experienced as a problem, the FPCT representatives recognize the partnership as desirable from the view of both actors. As mentioned above the dependency they perceive to each other gives relevance to claim the partnership as desirable but also for the concern for the health care sector and the people of Tanzania. As one doctor in charge said: "We need it because we want to improve this health service to our people. So, we really need it to continue with this and to improve much to areas where there are weaknesses" (Interview 5, 16 April 2015).

They also perceive the attitude of the government concerning the partnership as desirable. In one interview the administrator said:

Desirable, because of the situation. In the sense that the government is planning to improve health care in the country. It has highlighted or stipulated quit clear that they need to continue to work with other partners. That's quite clearly indicated in different governmental documentations that we still need other stakeholders in this kind cooperation, in this kind of service we provide (Interview 4, 14 April 2015).

The same person also points out documented policies as a perspective of sustainability in the partnership, but at the same time questions the sustainability: "But I consider it to be sustainable in the sense that, it's already in the policies, government policies. So, when we talk of implementation of the policy and evaluation, that's another part of the issue" (Interview 4, 14 April 2015).

5. Discussion

The purpose of this study is to describe and give a deeper understanding of: How the representatives of FPCT perceive the cooperation with the governmental authorities regarding resource exchange and dependency? What strategies FPCT uses to increase resources and influence on the government? What consequences PPP has for FPCT and their partnership, within the health care sector, with the government?

Regarding answers on the first research question, from this research appears that the different dimensions of the relationship and cooperation between FPCT representatives and the government can be identified. One dimension of the cooperation is how they mutually relate to and communicate with each other. Another dimension is the action and implementation, while a third dimension is the question of responsibility. Many of the respondents highlight the open attitude the government keeps towards the FPCT, how FPCT is free to come with questions and concerns. The representatives of FPCT feel that most of the time the government listens and understands issues they bring up and how they have a responsive approach. According to Resource dependency theory by Pfeffer & Salancik (2003) that can be considered as natural. The actors are interlocking each other's boards, friendship through close connections is achieved and they are expecting to share the concerns together. When it comes to the problems in the cooperation, FPCT representatives have a mutual attitude that the lack of money and resources in the government is a big problem, although they recognize and understand the problem. The lack of money and the limitations of resources affect the relationship in some ways. Even if the trust and responsibility are solid, it is damaged by the limitations of resources which hinder the implementation. It seems to be a mutual understanding between the government and FPCT of issues being raised in many of the cases. However, the problem is implementation rather than understanding of the problem. Due to that, the FPCT hospital representatives express their concerns and problems in their relationship with the government. When the FPCT representatives address the question of responsibility it can be considered as an obvious opinion that they are helping the government and are doing what the government should do. To some extent the people of Tanzania is the responsibility of the government, just as the respondents stress. Though, it is interesting how it is being emphasized that since they are ideology driven hospitals based on a religious faith. If the hospitals would have been constructed for making profit it could be seen as a natural argument to put the responsibility on the government. The FBOs on the other hand claim to,

and maybe even are supposed to, have a deeper meaning concerning what they do, which also was mentioned. However, this deeper purpose of helping people was not a main argument and a distinguished opinion as it can be considered to expect from a FBO.

The representatives from the FPCT hospitals address the problem with the local level of the government. They perceive the cooperation on the local level as more difficult than on the national level. Some of the respondents address the lack of understanding of PPP and others on personal interests. The reason for problems occurring more frequently at the local level could be considered as natural since the local governmental officials are the point of contact in accordance to the decentralization policy and the PPP policy. But in another way, regardless of that, the problem seems to be deeper than just limitation of resources and problems with implementation. The perception about the governmental officials at the local level, not understanding the PPP policy and relating to the FPCT hospitals from their personal views, may point to failure in the system. A system that in some way is not legally certain when it entails arbitrarily decisions and personal perception. That is what the representatives of FPCT and CSSC in some way experience.

5.1 Strategy

The approach to underline the dependency FPCT representatives argue the government has on them is a strategy they use to acquire more resources and influence. The representatives know their value and FPCT also identifies themselves with CSSC, which gives them argument to increase their importance. As specified above the organizations within the network of CSSC have more hospitals together, in number, than the government, which gives them a certain power to use for strategic purpose. Not exclusively do they use the importance in number as a factor for strategic matters, but stress the quality of their hospitals. The strategy aims to emphasize the high quality of staff and compare to the quality of the governmental hospital. Even facilities and equipment is something they mean is of high standard in comparison to the governmental hospitals. All this has given the hospitals good reputation and contributed to increase their status. In itself, the increasing of cooperation and importance, can be seen as a strategy to increase resources and influence, e.g. gain authority by being referral hospitals or regional referral hospitals. Furthermore, it is interesting how some highlight the skilled staff as a strategy and almost as advertisement, but at the same time address the competition they perceive towards the government regarding skilled staff and how it is hard for them to attract

these skilled personnel to their context and hospitals. When underlining the impotence in number and quality of the hospitals it includes the dependency argument they perceive. Accentuating their importance for the population of Tanzania is used as an argument and strategy for the representatives to continuing and increasing the partnership and resource exchange.

The FPCT representatives claim to use persistence as a strategy and they consider it to be necessary. If it can be considered as a strategy it requires never giving up. To increase resources they have to ask over and over again. Of course it can be seen as a strategy and maybe applicable when it comes to problems and promises not fulfilled. In order to increase resources and influence the hospitals most likely need something more that indicates their qualification. To increase resources and influence just by asking the government over and over again could be seen as a complement to a strategy but not a strategy in itself.

In a contra-dictionary way a strategy that also is being used is through a channel they complain at. They use politicians to get response for their wishes, complains and suggestions. A relative coherent view is on politicians and the problem occurring when they interfere, just to win votes. But in the same way the hospitals try to use political contacts and personal relationship with people who have the power or authority to speak for them.

5.2 The Consequence

For the FPCT hospitals there are multilayered consequences to be in PPP with the government. In one way it makes them a legitimate actor within the health care sector in Tanzania, it gives them recognition and relevance. The representatives of FPCT hospitals consider the partnership important for the long-term security and stability running the hospitals. They also claim the partnership to be mostly desirable. The desirability they perceive is one way for them to adapt to the environment and to seek stability in receiving resources as Pfeffer & Salancik (2003) explain. The economic argument behind that statement is not hard to see or accept as a reason to emphasize the desirability in the cooperation. From an economic point of view the partnership is important. It is no doubt that the respondents put a lot of interest in and highlight the money from the government. To them the partnership seems to be more of a financial reason than any other reason. Through the partnership the FPCT hospitals receive important funding and contributions. One reason for that could be

because of the concrete nature funding and money implies, but also because, in the end, that may be the actual thing that matters. Despite the interest in funding and money is bigger than the interest in having influence, influence can be seen mostly as a mean for getting more money. When they seek stability of resource assets another consequence will occur. The theory of resource dependency by Pfeffer & Salancik (2003) stresses the conflict between stability and autonomy. When the representatives from FPCT claim to seek stability, they do it on behalf of autonomy. It is in no way an irrational choice. Better to be safe than sorry, better to survive with stability and lesser autonomy than facing economical problems risking being bankrupted. However, it is hard to believe it would be allowed from Swedish interest and stakeholders. Furthermore, in another way the request they express towards the government, to fully support the hospitals in financial terms, points not only to stability, it could almost be seen as absence of inspiration and future vision to run and develop the hospital organizations and mission. They have some projects that imply development but the reason for those projects seems to be more of financial intentions since they currently may be tired of the absence of resources and chasing money.

From a strategic point of view the consequences of PPP make it possible for them to be a part of the decision-making process and they will have access and the opportunity to influence and advocate for their interests and further, use that arena to influence matters out of their control. They are also given the opportunity to contribute with their approach and view regarding aspects in the health care sector.

6. Conclusion

It is relatively clearly revealed how the local government became an area widely spoken of and a key function in PPP, both in earlier research as well as in this case study and the two cases it includes. Through the decentralization policy and how PPP is organized, the responsibility is located on the local governments. This is however not unproblematic. The problems FPCT representatives perceive with the local government are in some way problems that could be discovered in every level of public administration. The most serious problem seems to be the lacking of resources and the insufficient funding of many activities. Tanzania is a poor country and problems occur when allocating money. That is in no way a problem more revealing on a local level than on a national level. But when the issue comes to the

problem of understanding the concept of PPP and personal vendettas, in this case it seems to be quite more common on the local level than on a national level. It does not mean that the national level is totally free from these types of problems, but the higher up in the government it is relevant to argue a higher level of professionalism, which also have been insinuated in this study. In one way you can try to strengthen the knowledge and understanding for PPP on the local level. Another way may be to leave it for the national level to deal with PPP related partnerships.

The relationship seems to be in some regards an open and honest relationship when it comes to communication and in some aspects how they relate to each other. Apart from the above mentioned relational issues with a few of the governmental or political people on a personal level. But one reason for the hospital to not be fully satisfied is the understanding and sometimes promises they get from the government but rarely implemented, delayed or how because of the lack of resources never even considered to be completed. Although the relationship is weak in that aspect there is not much to do than to accept the problems. They respectfully understand the problem, but at the same time they are frustrated because of their own situation, with what they are trying to do in the context they are located, with a poor population that has limitations paying their patient fee. They can return and ask again and they can hope for the problems to be solved sometimes in the future, but some of the aspects in the relationship they are not, and will probably not be, in control of. The fact that it seem not to be even a goal in itself for them to try to be more self-dependent and autonomous points to that as well.

The actors this study focuses on is both in need of each other. They are highly dependent on the partnership and exchanges of resources it consists. It is in another way also important, at least in a short term run, what these two hospitals mean for the population in the rural area in which they are located. The network of CSSC, with more hospitals than the government national wide, is an important actor for FPCT, with which they also relate and identify themselves. This network makes them strong and towards the government dependent. Even though the problem of lacking resources, the financial help FPCT hospitals get from the government is very important.

The hospitals' self-esteem and self-image are, in some way well deserved, very good. They know their position in the society and what they contribute with and that they are an important

actor for both the government and the population, in particular the poor. The hospitals know their value and they believe they do fulfill their purpose and responsibility.

Further research can be conducted with the other FBOs in Tanzania to give a broader and deeper understanding on how the relationship between FBOs and the Tanzanian government works. Research about how the other FBOs relate to the responsibility of the government to provide health care to its population and if the FBOs should mantle that role. Moreover, further research can be conducted on the local level of the government concerning the understanding of PPP and how it is implemented.

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Appendix A

Questionnaire

The role of the respondent and Background

- Name, job title, years on present position
- Can you tell me about the history of this hospital?
 - History of cooperation with the mission

The partnership and the cooperation with the government

- Why do you cooperate with local government?
- Why do you cooperate with Ministry of health?
- How are the resources distributed?
 - Labor
 - Money
- Responsibilities
 - What is your responsibility within this cooperation?
 - Do you think you fulfill your responsibility?
 - What is the government's responsibility?
 - According to you, does the government fulfill their responsibility?
- Can you describe for me how your cooperation with the government is organized today
 - What is the most difficult in the cooperation? Why do you think so?
 - How do you solve eventually problems you face in this cooperation?
 - How do you communicate?
 - What are the arenas for the cooperation?
 - How often?

Relationship with government

- What is your opinion about your relationship with the government?
 - What works good/what doesn't?
 - Do you have any form of influences?
 - Can you raise critical voices if needed?
 - Have any problems/conflicts occurred? Solution?

- Is the government evaluating you? How? How often? Feelings about that?
 - Do you feel like they trust you? What gives you this confirmation?
 - Do you trust them?
- Do you consider yourself as partners or competitors and why?
- To what extent would you say that you are dependent of the cooperation with the government?
- To what extent would you say that the governments are dependent on you?

Development and Strategy

- Do you consider your partnership as desirable? Why?
- Do you consider your partnership as sustainable? Why?
- Do you have any strategies to get more resources and influences?