



BEST PUBLIC VALUE FOR PUBLIC MONEY?

THE CASE OF MATCH-FUNDED MULTI-HOSPITAL INFRASTRUCTURE DEVELOPMENT IN TANZANIA

DISCUSSION PAPER

Triggered by concerns raised by several civil society organisations (CSOs) in our networks in East Africa, about public support for profit making business in their healthcare systems, Wemos made an analysis of the application of Dutch Official Development Assistance (ODA) policy instruments for business strengthening in the healthcare context through multiple case studies.

One of the case studies looked into the case of a multi-hospital infrastructure development project (2010-2024), including medical equipment for diagnostic and surgical services, currently carried out by Royal Philips in Tanzania. The project follows an earlier hospital infrastructure development project (1999-2005). It has a considerable budget of approximately 23 million euros and is match-funded – i.e. the governments of the Netherlands and Tanzania contribute equal shares.

With the case study we aimed to get answers to the questions: 1) *How does this type of development project (potentially) impact on health system goals, including Universal Health Coverage (UHC), and 2) to what extent does it respect general aid effectiveness principles.* The case study was carried out end of 2018, and is based on desk research and interviews with key informants in Tanzania and The Netherlands. Discussions about its preliminary findings took place in 2019 with CSOs in Tanzania and other stakeholders.

This paper presents the main themes of interest that emerged from both the case study and following stakeholder discussions. These are:

- Sustainability of infrastructural improvements
- Strengthening local private sector
- Universal access to public health services
- Financing arrangement and its impact on fiscal space for health
- Public procurement and the untying of aid
- Social accountability and transparency.

The paper concludes with recommendations directed towards the Dutch government.

This discussion paper aims to contribute to the public debate on finance for health and quality of aid, in both recipient and donor countries, and multilateral institutions. It is part of Wemos' *Public Return on Public Investment: Aid for Trade in Healthcare* project (2018/2019), realised with the support of Open Society Foundations.

Wemos is a Dutch civil society organisation that advocates the right to health for all. Together with civil society organisations in the South and in global networks, we analyse policies that affect health and propose policy changes to government and multilateral organisations. We also raise general awareness on urgent health or health system issues, and aim to strengthen cross-border civil society learning and collaboration.

BACKGROUND INFORMATION

This section of the discussion paper describes the case study, summarises facts about the current and previous hospital infrastructure development projects based on information in the public domain, and provides relevant background about Tanzanian healthcare.

CASE STUDY: DESCRIPTION AND RATIONALE

The Netherlands used to be among the few donor countries providing ODA over the threshold of 0.7% of Gross National Income (GNI) for many years, but Dutch ODA is on a downward trend¹. Since 2010, Dutch ODA as proportion of GNI has gradually gone down, dropped below 0.7% of GNI in 2012, and is at its lowest point since 1973². Bilateral aid to countries to support sector wide approach (SWAP) baskets has been reduced, while at the same time it gradually increased ODA expenditure to strengthen and engage the private for-profit sector through so-called Business Strengthening Instruments (BSIs)³ in both absolute and relative terms⁴. The latest OECD Development Co-operation review (2017) praised a shift in the Netherlands to more innovative funding models but cautioned this could lead to a lesser focus on recipient country systems and could weaken mutual accountability between the Netherlands and recipient countries. It recommends a review of new instruments and tenders, particularly in private sector development¹.

Through our interactions in our [Finance for Health](#) work with health professional organisations and CSOs in East-Africa (in 2017-2018), we learned that the Dutch government's ODA expenditure for business strengthening – especially when applied in the context of the healthcare sector - is a concerning yet opaque 'black box' area for them. They were concerned that profit making instead of a human rights approach in healthcare is fueled by this type of donor support, they were questioning access to health impacts. They were also concerned about accountability and cost-effective spending of tax payers' money in the public interest in their country, and wished to be better informed.

Sharing the concerns and wishes, we embarked on the project *Public Return on Public Investment* which included a mapping exercise and multiple case studies. The mapping exercise was carried out in Q1 of 2018 and comprised of an inventory of Dutch ODA expenditure through BSIs in the health care sector in sub-Saharan Africa. It showed that a variety of BSIs were being applied in this sector and region, including the so-called ORIO⁵ ODA-grants for Infrastructure Development.

Case study selection

The case study that informed this discussion paper, on ORIO hospital infrastructure development in Tanzania, was selected for two main reasons.

¹ OECD Development Co-operation Peer Reviews: The Netherlands 2017 [\[LINK\]](#)

² OECD database query on Net ODA as % of GNI 1960-2017 [\[LINK\]](#) (visited September 2019)

³ ODA-based Business Strengthening Instruments (BSIs) is our unauthorized translation of the Dutch term *OS-bedrijfsleveninstrumentarium (BLI)*, a term that is used for the group of ODA-policy instruments for Private Sector Development (PSD) and for the engagement of private sector partners in development projects, e.g. in public-private partnerships (PPPs) or PP-collaborations.

⁴ Oxfam Novib (2017): 'Zaken eerst: BV Nederland in ontwikkelingssamenwerking' is a publication in Dutch [\[LINK\]](#)

⁵ ORIO is the Dutch acronym that literally stands for 'developmentally relevant infrastructure development', and is internationally known as the Facility for Infrastructure Development [\[LINK\]](#).

- 1) The inventory showed that ORIO projects in health involve relatively large public budgets from both the Dutch government's side *and* the recipient countries' side, and this was a special concern to the organisations we had spoken to in East Africa.
- 2) We chose to look at the application in Tanzania because this was the only country with an ORIO project in health where we had close CSO contacts who had already shown special interest and concern.

For transparency sake, it must be noted that Wemos had already done a case study in 1999-2000⁶ on the application of ORET in the export of medical devices in Gujarat (India). ORET⁷ is a former Dutch ODA grant facility for *Development Related Export Transactions* and forerunner of ORIO. This was not a decisive factor in the selection of our case study however.

Approach

Our case study assessed the quality of the design choices of the ORIO multi-hospital infrastructure development project and its preparatory steps. It is not an evaluation study. It explored the questions '*who pays for, who benefits from, and who owns the project?*' from the perspective of international rights, goals and principles: the right to health, the Sustainable Development Goal of Universal Health Coverage⁸ (UHC), and aid effectiveness. The study took into account lessons learnt in its predecessor project under ORET (1999-2005), based on experiences of stakeholders interviewed and a formal evaluation report⁹.

The case study was carried out in Q4 of 2018 by Oxford Policy Management (OPM)¹⁰ in Tanzania¹¹, and complemented by Wemos in the Netherlands. It encompassed desk review and interviews with key informants to elicit both factual information and opinions or reflections. Interviews included the following stakeholder categories: Dutch government staff (former and current), Tanzanian government staff (former), main companies involved in the hospital infrastructure project, health professionals, and academics in Tanzania. Interviews were systematically documented and analysed.

The insights from the case study were described in a draft discussion paper 'Best Value for Public Money?' (21 March 2019). This draft paper was used to inform health, public finance and/or development CSOs in Tanzania, and again most of the stakeholders interviewed in the case study, to stimulate discussions and obtain additional information (March-April 2019). The information that flowed from the discussions was processed in a revised version of this discussion paper. This version was presented for feedback to representatives of the companies involved, the Dutch government, and Tanzanian and international CSOs in August and September 2019. Insights and additional information gained from this round of feedback was processed into the final version of the discussion paper at hand. Table 1 shows a complete overview of stakeholder categories, and the number of organisations and individuals interviewed during the case study and/or consulted during the discussion round. Each organization and individual is only counted once, even though they may have been spoken to more than once.

⁶ Wemos' findings were published in a newspaper article, *Trouw* 23 May 2000 [\[LINK\]](#)

⁷ ORET is the Dutch acronym for Development-Related Export Transactions; see brochure [\[LINK\]](#) and website [\[LINK\]](#)

⁸ Universal Health Coverage (UHC) means equitable access to essential health services, without financial hazard, for all. See key facts on the World Health Organisation (WHO) website: [\[LINK\]](#)

⁹ Severens et al, Evaluation of ORET Transaction TZ000030, 2015 [\[LINK\]](#)

¹⁰ Oxford Policy Management Tanzania [\[LINK\]](#)

¹¹ Saith and Sokile: '*Dutch ODA for Medical Equipment in Tanzania. A qualitative assessment of its impact on the health system*'. November 2018. Not published; available from Wemos upon request via info@wemos.nl

Stakeholders interviewed or consulted by OPM and/or Wemos	Tanzania		The Netherlands (or international)	
	Nr. of organisations	Nr. of individuals	Nr. of organisations	Nr. of individuals
Government representatives (current)	0	0	4	9
Government representatives (former)	1	4	1	2
Companies involved (Philips and AMPC)	1	2	2	3
Health professionals (different cadres)	5	16	0	0
Academics/ Researchers	3	4	3	3
CSOs (in health, public finance and/or development)	8	20	3	6
Miscellaneous (CSO networks, banks, insurance companies, individual experts, local equipment companies)	2	3	5	7
TOTAL	20	49	18	30

Table 1: Overview of stakeholders interviewed or consulted

Limitations

While some basic information about the ORIO project could be obtained from the public domain, i.e. through the [IATI](#) website of the Netherlands Enterprise Agency (RVO)¹² and a joint press release by the Governments of Tanzania and the Netherlands (2012)¹³, the case study was hampered by a lack of access to documentation. We did not get access to requested documents such as the feasibility study, hospital needs assessment, project plan and project contract. We obtained additional pieces of factual information about the ORIO project through personal communications with representatives of the Dutch government and the companies involved, mostly during the discussion and review rounds that followed the case study. This method of fact retrieval was suboptimal, because many facts could not be verified (with written documents). Also, it was time consuming and oftentimes confusing because the pieces of information gathered over time were not always clear until complemented by other pieces of information.

Another limitation of this study is that neither OPM nor Wemos were able to speak to Tanzanian government staff currently in office, mainly due to bureaucratic constraints.

¹² The Netherlands Enterprise Agency, or *Rijksdienst voor Ondernemend Nederland* in Dutch, is a Dutch government agency to support business enterprises and is also known by its acronym RVO or RVO.NL [\[LINK\]](#)

¹³ Joint Government of Tanzania and Government of the Netherlands Press Release on the ORIO grant agreement for the multi hospital infrastructure development project, 2012 [\[LINK\]](#)

THE CURRENT HOSPITAL INFRASTRUCTURE PROJECT AND ITS PREDECESSOR

For the purpose of this paper, we refer to the current hospital infrastructure project in Tanzania as the 'ORIO project' and to its predecessor as the 'ORET project'.

The 'ORIO' project

In Tanzania, a multi-hospital infrastructure development project entered into its implementation phase in 2018. The project is co-funded by a Dutch government grant through the ORIO infrastructure development facility⁵. The project is officially registered under the title '*Extension of the project of the rehabilitation of diagnostic services in Tanzania Mainland*'. The project equips 37 public hospitals – at municipal, regional and tertiary (referral and specialized) level - to improve diagnostic and surgical services, with a special focus on maternal and neonatal care services¹⁴.

The Government of Tanzania (GoT) officially applied for the project in 2010. The ORIO grant arrangement for the project was signed between the Government of the Netherlands (GoN) and the GoT in 2012. According to the joint GoT and GoN press release¹³, the project would cost approximately EUR 23 million for which the two governments would match funds, i.e. pay equal shares (50% - 50%) of EUR 11.5 million each. The press release also draws attention to the fact that through ORIO, the Netherlands continues "to support the Health Sector in Tanzania", even though it was phasing out its bi-lateral ODA support. And it ends by emphasizing the ORIO project's contribution to UHC: "*Health systems (including rehabilitation and maintenance) to ensure increased and improved services delivery need to be strengthened to help achieve Universal Health Coverage in Tanzania*".¹³

Between 2010 and 2014 the Dutch consultancy firm AMPC provided technical assistance (TA) to the GoT/Ministry of Health (MOH)¹⁵, in order to prepare for the project including its procurement. See section *Public Procurement and the Untying of Aid* for more information.

In 2013, the GoT published a tender to procure a defined package of goods, works and services for the project¹⁶, including:

- Delivery and installment of medical equipment, including guaranteed maintenance, and defined related infrastructural improvements including (non-medical) equipment.
- TA to hospitals on efficient and effective use of equipment and technology, and training of hospital staff.

In September 2014, the GoT signed a contract¹⁷ with the winning bidder: multinational company Royal Philips, which is headquartered in the Netherlands and has a local distributor in Tanzania, named Mokasi Ltd.

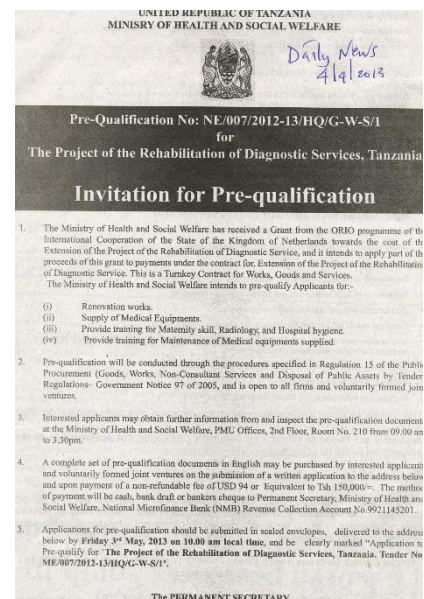


Photo: Daily News 4-4-2013 (Credits: AMPC)

¹⁴ The project is coded ORIO09TZ05 and is described on the [IATI](#) website [\[LINK\]](#) of the RVO (the Netherlands Enterprise Agency) [\[LINK\]](#)

¹⁵ In Tanzania, the Ministry of Health's official title is the Ministry of Health, Community Development, Gender, Elderly and Children. Before it was the Ministry of Health and Social Welfare. It is also called 'Ministry of Health' for short, and abbreviated as MOH. For the purpose of this paper we use the short name and abbreviation [\[LINK\]](#)

¹⁶ Project was published in e.g. the Daily News (4 April 2013) and the Tanzania Procurement Journal of in 9 April 2013 [\[LINK\]](#)

¹⁷ We do not have access to the contract between GoT and Philips, and thus the exact project details, as it falls under corporate privacy rules and was not shared by the involved parties. Philips, however, shared some information verbally and through emails. This information could unfortunately not be verified with the GoT/MOH or other authoritative sources.

The implementation of the project could not start until four years later, because the GoT could not provide sufficient funding for its own 50% share of the budget. In 2018 the GoT succeeded to ensure its share, mainly through debt financing: a supplier's credit with Philips. This credit was insured for a maximum liability of over EUR 15 million¹⁸ by Atradius Dutch State Business (DSB)¹⁹, the official Export Credit Agency (ECA) for the Netherlands. For more details about the Tanzanian finance of the project, see *Financing Arrangement and its Impact on Fiscal Space for Health* on pages 14-16.

The GoN funds the other 50% of the project budget with ODA funds through the ORIO grant facility, which falls under the Dutch ODA budget for Private Sector Development (PSD)²⁰. ORIO supports work to improve developing countries' public infrastructure in diverse sectors including Social Services (Health Care and Education). In health care, ORIO is usually applied for medical equipment and/or hospital construction. It is government-to-government (G2G) support. While ORIO originally aimed to contribute explicitly to "the poorer segments of society" (see policy rules²¹), the pro-poor focus was abandoned after a revision of the instrument in 2013²². According to the revised ORIO manual²³, the objective is to have a positive impact on private sector development as well as human development. A third objective is to stimulate the involvement of international business in the development and implementation of projects in order to benefit from the private sector's expertise²⁴. ORIO grants are reported as untied aid.

The grant is managed by RVO, the government agency that is responsible for supporting Dutch business abroad. It also handles all projects supported by ODA grant instruments for business strengthening. The project at hand is published on the RVO IATI website¹⁴, with information such as a description of the project and its objectives, the ORIO budget(s)²⁵ and the disbursement of funds from the ORIO grant. It reports results on general output indicators, used for all programmes managed by RVO, such as: the number of companies awarded a contract and the amount of co-investment generated from the recipient country. Since April 2019, project specific output indicators and targets are added, including numbers of facilities upgraded, [medical] equipment installed and staff trained. In principle, reporting on results proceeds as the project proceeds.

As to the governance of the ORIO project:

- In the development phase, the Dutch government's ORIO team at RVO and the GoT (Ministries of Health and of Finance) make decisions together.
- From the implementation phase onwards the ORIO team is involved from a more distant position. It uses so-called Statements of No Objection (SoNO) to respond to decisions by the project's Steering Committee in Tanzania, which is made up of the GoT/MOH and Philips.

¹⁸ See page 43 of the insurance policies issued in 2018 [[LINK](#)]

¹⁹ Atradius Dutch State Business (Atradius DSB) [[LINK](#)].

²⁰ PSD evaluation protocol, annexed to Letter DDE-436/2011 of the Ministry of Foreign Affairs 2012 [[LINK](#)] (in Dutch)

For least developed countries (LDCs), including Tanzania, the ratio grant versus own contribution is 50:50, in non-LDCs the ratio grant versus own contribution is different (35:65)

²¹ ORIO Policy Rules 2009 [[LINK](#)]

²² 2014 Letter of the Minister for Foreign Trade and Development Cooperation to Parliament [[LINK](#)]

²³ ORIO Manual 2013 [[LINK](#)]

²⁴ See presentation for 2012 ORIO call [[LINK](#)]

²⁵ *Note:* before 12 April 2019 the project was reported as 1 project with 1 budget of EUR 12,047,585 for the Dutch government (not including the Tanzanian co-finance). Since 12 April 2019 the project is reported in 3 separate, complementary entries with separate budgets with the respective extensions '05' [[LINK](#)], '05I' [[LINK](#)], and '05O' [[LINK](#)], total budget amounting to EUR 12,747,585. The 3 budgets relate to respectively the Development, Implementation and Operation&Maintenance phases of the ORIO project, RVO explained. We assume the total budget's difference is caused by the last payment that was disbursed from ORIO in 2018: the premium for the credit insurance. This assumption was not confirmed by RVO. RVO had no alternative explanation and promised to look into the matter.

Predecessor: the 'ORET' project

The ORIO project is a follow-up to an earlier project (1999-2005)⁹, titled *'The rehabilitation of diagnostic services in Tanzania Mainland'*. This was an ORET⁷ project, entailed a similar development package though it lacked the special focus on maternal and neonatal care and surgical equipment. The budget of approximately EUR 27 million was also co-funded; 60% by the GoN (EUR 17 million) and 40% by the GoT (EUR 10 million). The Netherlands then funded with a grant through the former and fully phased out ORET facility. For the ORET project the Dutch government contracted Philips. It concerned *tied aid*, as this facility subsidised developmentally relevant export transactions of Dutch companies to developing countries without an open international tender procedure.

TANZANIA'S HEALTHCARE AMBITIONS AND CHALLENGES

"Challenges (...) require change to the way financial access to health care is organized, greater efforts on resource mobilization, transparency and social accountability, as well as more determined measures to strengthen the health system as a whole." (Tanzanian Health Sector Strategy Plan 2015-2020)²⁶

Tanzania has a population of 56 million, 44% of which is under 15 years old. While the Gross Domestic Product (GDP) has been growing, poverty has not decreased in par. Still, nearly 50% of the population lives below the USD 1.90/day poverty line²⁷. The government has a significant external debt, at 26% of its GDP²⁸.

There have been improvements in maternal and child health. Yet the maternal mortality rate is estimated at an average of 556 deaths per 100,000 live births²⁹, while the SDG goal is to get below 70 deaths by the year 2030. Healthcare in Tanzania – from primary healthcare up to tertiary care - is mainly provided through the public sector (74%), followed by the private (14%) and faith-based (13%) sector providers. Tanzania faces a major shortfall in public finance for the health system, in number of health workers, and in essential medicines and commodities.

With regard to human resources for health (HRH), according to current national staffing norms, the government indicates to have a critical shortage of 52%³⁰. Compared to the SDG threshold of a minimum of 45 core medical cadres (doctors, nurses and midwives) per 10,000 inhabitants, the HRH gap is worse. Tanzania currently employs only 10% of that minimum target: 4.4 per 10,000³¹.

According to 2016 data³², total health expenditure is USD 35 per capita. According to the same database, the Tanzanian government allocates nearly 7% of its government budget, or 2% of its GDP as government health expenditure, equalling USD 14 per capita. These figures are far less than the recommended minimum thresholds of 15% of government budget (Abuja Declaration), 5% of GDP and USD 86 per capita for government spending on health³³. The per capita amount from domestic government resources is complemented by USD 13 through external funding for health, and by

²⁶ Tanzanian Health Sector Strategic Plan IV (2015 -2020) [[LINK](#)]

²⁷ World Bank Data, accessed March 2019 [[LINK](#)]

²⁸ Jubilee Debt Campaign 2018 publication [[LINK](#)]

²⁹ Demographic and Health Surveys 2015-16 [[LINK](#)]

³⁰ HRH and Social Welfare Strategic Plan 2014-2019, 2014 [[LINK](#)]

³¹ Based on the latest available World Health Observatory statistics [[LINK](#)], visited March 2019.

³² WHO (2018) – Global Health Expenditure Database [[LINK](#)]

³³ Africa Score Card 2018 [[LINK](#)]

people's out-of-pocket health spending (OOPS) of USD 8. OOPS of USD 8 per capita is relatively high, mostly due to user fees introduced from 1993³⁴ onwards. There is no single national social health insurance covering the entire population, although the government aims to create one. Different insurance schemes now cover about 32% of the population³⁵.

Government funds used to be transferred to districts, and then to facilities. It has just changed to Direct Health Facility Financing (DHFF), to allow funds to be transferred directly to facilities³⁶.

Medical equipment is mentioned in the current Health Sector Strategy Plan (HSSP) IV, for the period 2015-2020³⁷. Earlier, when the ORIO project was developed, the MOH (in HSSP II/2005-2009) had planned for regional hospitals' upgrade to regional referral hospitals. Over the past decades the number of suppliers of medical equipment active on Tanzania's market has grown. And every year Tanzania hosts a regional exhibition dedicated to hospital infrastructure and equipment³⁸.

The main objective of the current Plan (HSSP IV)³⁷, however, is to improve primary health care services and achieve equitable access for all. There is a strong focus on reducing child and maternal mortality and increasing life expectancy at birth, which require health system strengthening efforts.



Photo: Nurse in Tanzania (Source: Flickr creative commons)

³⁴ Mubyazi et al 2005 [[LINK](#)]

³⁵ Health Budget Brief 2018, UNICEF [[LINK](#)]

³⁶ Kapologwe et al 2019 [[LINK](#)]

³⁷ Tanzania HSSP IV [[LINK](#)]

³⁸ See MEDEXPO Africa website [[LINK](#)]

KEY DISCUSSION POINTS

This section describes the main themes that emerged from our case study as discussion points, fed by commentary from the CSOs and other stakeholders that were interviewed or consulted (see Table 1), and the fact finding efforts we carried out to complement the information available in the public domain. For general clarification of the relevance of the themes we added citations drawn from well-known international sources (in blue directly below each main theme).

SUSTAINABILITY OF INFRASTRUCTURAL IMPROVEMENTS

Low-resource settings present a design challenge not only for device manufacturers but also for governments responsible for setting and applying health technology policies aimed at improving or maintaining the health of their populations. (...) Inadequate maintenance is the main reason why so much medical equipment is lying idle in developing countries. Proper maintenance requires a budget, industry technicians for specific maintenance, and ready access to spare parts. But most of all, adequate maintenance requires properly trained staff (WHO, 2010, [Medical Devices](#))

According to the various stakeholders interviewed and consulted, medical equipment such as devices for medical imaging and surgery in the higher level public hospitals, will certainly fulfil a need in the health referral system. In particular, the fact that the upgrades in medical equipment are accompanied by necessary general infrastructural improvements, training of personnel and a guarantee period for maintenance, will improve functional usability, as was the case in ORET.

The earlier mentioned official evaluation⁹ of the ORET project stated that in the 20 facilities that were visited, the equipment was working and used for patient care throughout the project, and the project was overall evaluated as successful. However, there were some challenges to the proper functioning of the equipment including: 1) shortage of trained health personnel to effectively use the equipment, 2) inability of hospitals to purchase consumables, and 3) lack of capacity to do or commission the necessary maintenance and repair beyond the 5-year period. As we wanted to know whether the current ORIO project is better designed or less vulnerable to these sort of challenges, we discussed these with the companies involved and in the discussions with CSOs and health professional organisations in Tanzania.

Human resources for health (HRH)

During ORET, the health system and the project suffered from the shortage of health staff in all cadres, and inability to retain personnel that had received additional training in the project. According to the companies involved, the feasibility study and needs assessment for the ORIO project included a full HRH assessment per hospital – both in terms of numbers required and training needs – relevant to the project's aims regarding the provision of improved health services. The companies commented that the GoT committed itself to meeting the HRH needs in terms of required staff numbers, though not explaining how exactly that would happen. Many stakeholders commented that fulfilling HRH needs in the overall health system – and especially at primary level - is a higher goal (see Tanzania's most recent HRH Strategy)³⁰, that shouldn't be dependent on and risk being skewed by a project like this ORIO project.

The training needs are to be met by the ORIO project. According to Philips, training needs of clinical, para-medical and biomedical personnel and a train-the-trainers element are included. We did not obtain or read any details on this HRH training plan.

Consumables

In the ORET project the supply of consumables (such as X-ray films) from the MOH through the Medical Stores Department proved relatively unreliable⁹. Hospitals had to purchase them from their own budgets, which were limited and often suffered from irregular funding flows. In ORIO, there is less reliance on consumables as the new equipment will generally be digitalised. Moreover, most stakeholders expect funding flows to hospitals to improve significantly with the new DHFF system.

Maintenance and repair

The ORET evaluation and consulted CSOs and health professionals mentioned that technical issues with the equipment often did not get fixed after the end of the 5-year guarantee period.

Soon after the ORET project finished, the GoT floated a tender for another period of equipment maintenance. The subsequent contract was awarded to Philips, to be financed by GoT/MOH and covered the period 2006–2011. There was no co-finance from the Netherlands in this contract. In practice, there were many problems with the payments by the GoT for the contracted services.⁹

According to health professionals it was hard for hospitals to pay for Philips' maintenance services due to unexpectedly high bills and due to problems in the payment arrangement between Philips and the government. *"We were shocked and said there is no way we can pay – as this has not been accounted for in our budget"* (health professionals representative). Philips added that it often provided maintenance services despite problems in payments.

Acting on the persisting situation of equipment sitting idle in public hospitals, a Presidential Decree was issued in 2015 demanding that hospitals would realise any necessary maintenance and repair. According to health professionals this Decree had an effect in at least a few hospitals, that shuffled around resources to be able to fix equipment and ask medical personnel to use it instead of referring patients to private clinics with diagnostic services.

In ORIO, the guaranteed maintenance period has in fact been decreased from 5 years to a 1-year standard warranty period plus 3-years guaranteed maintenance after installation of the last piece of equipment. The majority of supplied equipment will be maintained for more than 4 years, Philips commented. In response to the question how the ORIO project is going to tackle this bottleneck of maintenance and repair beyond the guarantee period, Philips clarified that it raises awareness in the MOH to allocate sufficient budget: *"ORET and ORIO projects include a substantial maintenance component to make the Ministry of Health aware that with proper maintenance budgets, equipment can remain operational at a very high level for longer period"*.

In short, it looks like the ORIO project will contribute to Tanzania's health referral system with useful and functional medical equipment. Practice will show whether over time the project proves less susceptible to problems related to human and budgetary constraints than the ORET project was. As to the bottleneck of maintenance and repair beyond the guarantee period, the ORIO project does not show it is better prepared than the ORET project.

STRENGTHENING LOCAL PRIVATE SECTOR

Private Sector Development is defined as the range of strategies that aim to establish markets that function vibrantly and fairly, providing economic opportunities of quality to poor people at scale. (Donor Committee for Enterprise Development, 2019, [Private Sector Development Synthesis Note](#))

Although there are limitations to the role that private for-profit actors can or should play in healthcare³⁹, because healthcare cannot be regarded as a standard commercial market for numerous reasons⁴⁰, most stakeholders stressed that appropriate roles for local businesses can be defined and strengthened accordingly. Roles for technical companies in relation to the challenges of maintenance and repair, for instance.

Dutch and Tanzanian policy on private sector strengthening in international cooperation

As ORIO is part of the Dutch ODA Private Sector Development (PSD) budget, it promotes⁴¹ that ‘the programme is designed to encourage the involvement of local and international businesses in developing and implementing infrastructure projects, so as to benefit from the private sector’s knowledge, know-how and development skills’. In that same line, Tanzania’s policy stresses ‘Local Content’ (2014)⁴², to promote optimal gains for the local private sector in projects with foreign enterprises. The policy, which was originally meant for activities in the extractives industry but is now expanded to other sectors, aims at ensuring local jobs, skills transfer and in-country development of value chains.

Although ORET was part of the PSD budget too, during the ORET project (early 2000s) there was no apparent emphasis on strengthening local technical or medical equipment enterprises. This is understandable given that there were only few of such enterprises in Tanzania at that time. On the flip side, there is a paragraph in the ORET project’s evaluation⁹ on ‘Policy Coherence’ that suggests that strengthening Dutch business and trade in the export of medical equipment was regarded a higher aim in itself. This quote illustrates that the evaluators sought for policy coherence of this development project with general export promotion policies: “(...) Sector-wise it [the project] was less coherent with export promotion policies. Although it is worth noting that PMS [Philips Medical Services] is very successful in East African countries. And this might also have positive consequences for other exports of medical equipment from the Netherlands.”⁹ As of 2013, Dutch policy on Foreign Trade and Development Cooperation in general combines development goals with the goal of success for Dutch companies abroad⁴³ - also called the ‘win-win’ goals - although it does not explicitly define which ODA-policy instrument should combine those two different wins.

The suggestion of a higher aim of ‘successful Dutch business abroad’ is also reflected in the current ORIO project. The PSD *output* indicator that has been attached to this project at RVO’s IATI website⁴⁴ was described as: ‘number of Dutch firms awarded a contract’, or after April 2019: ‘number of companies with supported plans to invest or trade - Dutch companies’. No reference to the number of *local* companies supported or awarded a contract accompanied this indicator in this project. While this

³⁹ Refer for instance to De Wolf and Toebes, 2016, *Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health*, *Health Hum Rights*, 18(2): 79–92. [\[LINK\]](#)

⁴⁰ Refer for instance to Harvard, 2017, *The Economics of Healthcare* [\[LINK\]](#)

⁴¹ ORIO Policy Rules 2012 [\[LINK\]](#)

⁴² Kinyondo and Villanger (2016). *Local content requirements in the petroleum sector in Tanzania* [\[LINK\]](#)

⁴³ Ministry of Foreign Affairs Netherlands, *A World to Gain. A New Agenda for Aid, Trade and Investment* (2013) [\[LINK\]](#)

⁴⁴ We checked this website in multiple instances between January 2018 and August 2019

is simply a reporting issue according to RVO, it also suggests that contracting local firms was not an explicit goal of the project, since indicators for success are usually set before they are reported on. In any case, the two companies that were awarded contracts in this ORIO development project are in fact Dutch: AMPC for technical assistance (TA) in the development of the project, and Philips for project implementation and maintenance. Philips commented in the discussion round that the goal for them in working with ODA [projects] is opening markets for their products and services.

Options for appropriate capacity strengthening of local private sector

Most stakeholders questioned why the PSD/ORIO project's grant arrangement or description on the RVO IATI website does not explicitly mention how it is designed to strengthen the local private sector in the area of medical devices. Nowadays, Tanzania has more technical and equipment companies than during the ORET project. *"The ORIO project could do better on building local capacity"*, said one of the consulted researchers. Based on first-hand observations in hospitals, a representative of health professional organisations commented: *"Not only our in-hospital staff, also local enterprises should be capacitated to do the technical work of installment, maintenance and repair of medical equipment. If anybody is to be flown in from Europe, it should be for really complicated issues. Not to fix a configuration error."*

Dutch government representatives commented that as the ORIO project was procured by the GoT, it was entirely up to the GoT to define in its contract with Philips whether or what type of business should be done with local companies. OPM suggested that the main company involved in this project should help build capacity by developing local plants for assembly, thus reducing procurement costs for replacements and spare parts. The ideas that consulted stakeholders in Tanzania brought to the table included: involve Tanzanian/local companies in electronics and the installment of medical equipment, and train and capacitate them in maintenance and problem fixing that is additional to the training for hospital (technical support) staff.

Representatives of Dutch government and the involved companies questioned whether these suggestions are at all viable, legally possible and safe to do. They added that it is not normal practice for a company to capacitate other companies for products or services that compete with their own.

In a more recent email communication in response to a draft of this paper (August 2019), Philips shared with us that in ORIO not only Philips' local distributor Mokasi will be subcontracted to provide installation and maintenance services for medical equipment, but also other Tanzanian private companies. They wrote: *"All maintenance is done locally, and expertise is transferred to local companies to provide all necessary services, only in very complicated cases the Philips regional office in Nairobi can and will support"*. This does not take away the fact that there has been no mention of local content or transfer of knowledge to local companies in the ORIO project's communications in the public domain (GoT and GoN joint press release¹³ and RVO IATI website¹⁴). Practice will demonstrate to what extent Philips' promise works out.

In short, we conclude that the explicit attention that has been given to relevant and appropriate development of local private sector in medical or hospital infrastructure – at least as we understand from information in the public domain - has been quite minimal.

UNIVERSAL ACCESS TO PUBLIC HEALTH SERVICES

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, (...). UHC enables everyone to access the services. (WHO, 2019, fact sheet [Universal health coverage](#))

Apart from delivering functional health services in the designated hospitals, the project also aims to ameliorate mother and child health and ‘to help achieve UHC in Tanzania’¹³. The fact that this project concerns an investment in public hospitals, and not private hospitals, is positive in light of the general population’s access to (improved) services. ‘Access’, defined as the number of people with access to improved health facilities with a proxy measure being the number of people in the catchment population of the hospital, with specific attention to women and poor people, is considered an outcome indicator according to an early draft version of a monitoring sheet⁴⁵. This aim of ‘access’ would relate to the so-called *human development* dimension of the project which is described next to its *infrastructure development* dimension, as described in the ORIO Manual²³.

UHC: the wider policy context

Greater availability of services relates to one of three dimensions⁴⁶ of UHC: service coverage. The other two are population coverage and affordability. People’s actual access to services is greatly determined by affordability of services. The way to improve affordability of essential health services *for all*, is to move away from out-of-pocket spending (OOPS) at point of service, and towards progressive (equitable), mandatory pre-payment, whether in a tax-based or insurance based national health financing system. UHC is built on the notion of equity, which requires that resources and services be allocated according to needs rather than ability to pay⁸.

Achieving UHC through a new health financing strategy is a larger aim for the GoT²⁶. A contribution to these two other dimensions of UHC, however, is not explicitly part of the ORIO project, even though the project’s draft indicator on access – counting people in the hospital’s catchment area – may suggest so. Yet, from our perspective it is still important to be critically aware of these other dimensions. This way one can maximize synergy towards reaching Tanzania’s national goals, prevent any unintended harm, and create greater policy coherence. The majority of interviewed and consulted stakeholders in Tanzania wanted to include this discussion point because they are concerned about the way user fees affect the poor disproportionately.

User fees and other obstacles to access

The MOH had already introduced user fees for selected services in the 1990s. In the ORET project, facilities charged fees for services with newly installed diagnostic equipment to cover costs for their use. The evaluation described that this was applauded by the project’s steering committee in the project’s progress reports, for it contributed to ‘income generation’ for the facilities and thus to financial sustainability⁹. In light of equitable financial access to services as described above, though, this should be regarded a regressive form of income generation. User fees impede access of the poor⁴⁷.

According to the stakeholders interviewed by OPM, hospitals will likely charge fees again for the use of newly installed diagnostic equipment supplied under the ORIO project. What would the fees be? As we have no access to project information on this issue, OPM provided an example. For ultrasounds, a

⁴⁵ This draft monitoring sheet was sent to us as an excel document by email (February 2019). It is an internal document, and not published in the public domain, and the mentioned indicator is not part of the set of indicators that are published on the RVO IATI website. The latter only contains output indicators, and no outcome indicators as yet.

⁴⁶ Refer to the well-known ‘UHC cube’ on WHO’s website [\[LINK\]](#)

⁴⁷ Medecins sans Frontieres (MSF), 2017, *Taxing the Ill* [\[LINK\]](#)

national hospital now charges TZS 25,000 (USD 11) for referred patients, and TZS 30,000 (USD 13)⁴⁸ for patients without referral. We are not aware of the prices charged at smaller and lower level hospitals. There are waivers and exemptions to user fees for those aged below 5 years and those above 60 years. These do not apply to all services though. Diagnostic services are often not waived for instance. Moreover, the waiver system doesn't always work well. Thus, user fees for needed services can pose a real access barrier for those who belong to the nearly 50% of the population living below the poverty line of USD 1.90 per capita a day²⁷, as well as for those living just above that – already very low - threshold. In Tanzania, still 22% of total health expenditure comes from OOPS (2016)⁴⁹. As to catastrophic health expenditure 2.5% of population spends more than 25% of their income on health, and 9.8% spends more than 10% of their income on health (2012)⁵⁰. OOPS, including user fees, need to be reduced in Tanzania in order to improve access for the poor.

Pro-poor measures

Consulted CSOs were of the opinion that if the ORIO project truly aims to contribute to the reduction of mother and child mortality and morbidity, and UHC, one would expect it to somehow contribute to measures that increase access of especially the poor, women and those in remote communities. Or at least that it should refrain from measures that disproportionately affect these groups by using user fees for needed diagnostic or other medical services at the point of use. UHC is primarily the responsibility of the Tanzanian government - all stakeholders stressed - and it requires sufficient and well-channelled public resources for health (see next discussion point). Most CSOs commented that an official development project like this therefore, could and should make clear how it contributes to such pro-poor measures, or at the very least, how it avoids the potential harm of an increase in access barriers through additional user fees.

Impact evaluation

A number of CSOs in Tanzania stated that people's actual access – differentiated to relevant sub populations - could and should be measured properly. It cannot be measured by merely noting down the number of poor people in the catchment area of a hospital that gets an upgrade.

Concluding, as long as there are no specific measures to remove barriers to service access for the poor or other vulnerable populations, it is less likely that the ORIO project will significantly contribute to the reduction of mother and child mortality and morbidity, and UHC including financial protection.

FINANCING ARRANGEMENT AND ITS IMPACT ON FISCAL SPACE FOR HEALTH

Fiscal space or public resources for health (pooled government revenue and external funding), prove to be important to achieve UHC. Health systems that rely more on public spending offer people better financial protection and are associated with better coverage of essential services. (WHO, 2018, [Public Spending on Health](#)).

According to all stakeholders, the Dutch grant helps the GoT to purchase and finance medical equipment and infrastructural development for public hospitals that otherwise could not have been financed. And Philips would not have been able to sell the package of goods, works and services to the Tanzanian government without the Dutch government's support. The financial additionality of this project was not disputed.

⁴⁸ TZS 25,000 - TZS 30,000 equaled approximately USD 10 – USD 13, according to XE.com accessed in July 2019.

⁴⁹ As to the latest available data (2016) in current USD in the Global Health Expenditure Database, WHO [\[LINK\]](#), accessed August 2019

⁵⁰ As to the latest available data (2012) , UHC data portal of WHO Global Health Observatory, section financial protection [\[LINK\]](#), accessed August 2019.

However, serious questions were asked about the type of impact this project's financial arrangement will have on Tanzania's longer term fiscal space for health. In our view, this question is indeed important because a steady and sufficiently large pool of public resources is crucial to progress towards equitable access to essential health services. While strengthening the public purse for health is clearly outside the scope of this ORIO project, any undue impact on Tanzania's current or future resources for health should be avoided. Before going into the question of impact, we need to answer the question how much financing is involved and how the financing is arranged.

Financing arrangement and money flows

The question of how the financing is arranged, was not easy to answer, as information showing the full picture, i.e. including the Tanzanian part, is not in the public domain. Initially, different sources within the Dutch government informed us that the required funding from the GoT in this ORIO project was arranged through a commercial loan with a specific Dutch commercial bank in 2018, and that co-investment through a loan is very common in similar infrastructure development projects. As to the total amount of the investment: we did not have direct access to information from the Tanzanian government. The RVO IATI website¹⁴ shows the Dutch part of the funding, but not the part of the GoT or its contract with Philips. Instead, there were only indirect and differing pieces of information about Tanzania's contribution, ranging from EUR 8.6 million to a little over EUR 15 million (see box 1).

Indirect information about Tanzania's financial share of the ORIO project budget

- The original grant agreement (2012) mentioned the amount of **EUR 11.5 million**, namely 50% of then foreseen total budget of EUR 23 million.
- RVO informed Wemos (February 2019)⁵¹ that the total project cost was EUR 22.8 million, and that the Netherlands (through ORIO) would contribute EUR 12.75 million. Deducting the Dutch share from the total cost produces an estimate of just over **EUR 10 million**.
- Information published in the public domain (between April-August 2019) included these:
 - The insurance for a credit that GoT MOH owed to Philips for medical equipment (without any mention of ORIO), defining an amount of **EUR 15,086,154** for the credit's maximum liability (checked in August 2019)¹⁸.
 - Since the update of 12 April 2019, the RVO IATI website shows 3 budgets for the ORIO project, for development, implementation, operation & maintenance. Each of the budgets shows a 'Detailed Report' section, which mentions the 'Commitment' of the Tanzanian government (MOH) under the heading of 'Transactions'. The sum of the commitments equals **EUR 12,737,585** – an amount that exactly matches the ORIO grant (website visited in July 2019)¹⁴.
 - Information on the same website, under the 'Results' section, shows two output indicators related to the implementation budget (ORIO09TZ05I) to be reached by 2021, of EUR 5.8 million and EUR 2.8 million. These targets are respectively the 'Amount of co-investment generated by ODA in EUR - by (local) government' and the 'Amount of co-investment generated by ODA in EUR - by private sector/financial institutions', that possibly indicate what the Tanzanian government contributes to the project's implementation, according to RVO staff. This amount equals **EUR 8.6 million**. The budgets for project development and operation & maintenance do not mention any targets for co-investment (website visited in July 2019)¹⁴.
- Philips informed Wemos (August 2019)⁵² that the transaction value of the contract is EUR 22,419,509, and that the Tanzanian government will pay half: **EUR 11,209,755**.

Box 1: Indirect information about Tanzania's financial share of the ORIO project budget

⁵¹ Through an email to Wemos, in response to questions, dated 19 February 2019

⁵² Through an email to Wemos, in response to our request for feedback on a final draft of this Discussion Paper, dated 7 August 2019.

Thanks to recent consultations and correspondence with Philips, we learnt that the amount that Philips should get paid for the comprehensive project is EUR 22,419,509, that the GoT/MOH will pay half - just over EUR 11 million – for which money was not raised through a commercial loan - but mainly through a zero-interest supplier's credit. We put the following pieces of information together about the actual money flows and the financing arrangement of this match-funded project, and depicted them in a flow chart (see box 2) ⁵³.

- The Tanzanian government did not pay for the development phase or any preparatory steps in the project. The GoT pays for its contribution to the project, which it had tendered and contracted Philips for in 2014, in two complementary ways:
 - **Deposit:** the Tanzanian government paid a first deposit of EUR 2.9 million in 2018, through an escrow agent⁵⁴. It is not known to us what the source of the money for this deposit was; whether it was paid from government budget (which budget line), or whether the GoT borrowed money for this deposit. The escrow agent subsequently paid a first down payment of just over half a million euros to Philips. The deposit will be depleted for the first upcoming payment(s), upon delivery of specified parts of the project's package of goods and services. We don't know whether the escrow agent charges any costs.
 - **Debt servicing:** Philips structured a 'supplier's credit' for the remainder of Tanzania's financial contribution: an amount of about EUR 8.3 million.
This is a credit for deferred payment of Philips' package of goods and services. For the collection of payments from GoT/MOH, Philips involves banks: it will sell parts of the credit – through 10 bills of exchange (BOE)⁵⁵ – spread over a period of 5 years to discounting banks⁵⁶. A bank that buys a BOE pays an agreed amount (lower than the amount on the BOE) and will collect the money from GoT/MOH when it reaches its final payment date. Note: this credit could be supplied with virtually no risks for Philips or banks because it got a state insurance through Atradius DSB¹⁹.
The GoT will repay the credit, via the 10 bills of exchange to the discounting banks evenly spread over a tenor of 5 years. Importantly, Philips stressed that GoT pays the credit *without* additional financing costs; i.e. there is no interest and no insurance premium for Tanzania. The insurance premium has been paid for by the GoN (see below).
Again, it is not known to us what the source of the money for the BoE payments will be; whether the GoT intends to do the payments from a defined government budget, or whether the GoT will borrow money for this deposit (on what terms).
We also do not know what actions the discounting banks or Atradius DSB would take in case the GoT defaults on its debt, and whether this would pose any additional financial costs to the GoT.
- The Dutch government (Ministry of Foreign Affairs) pays its contribution from the ORIO ODA grant facility, through the designated government agency RVO, for both the preparatory steps and for the project implementation and maintenance phases:
 - Preparatory steps: RVO sent seven separate disbursements of money (about EUR 0.6 million in total) to AMPC for TA between 2010 and 2014, and disbursed nearly EUR 0.7 million to Atradius DSB for Philips' credit insurance in 2018. According to RVO, all disbursements from ORIO were done 'on behalf of the GoT/MOH'.

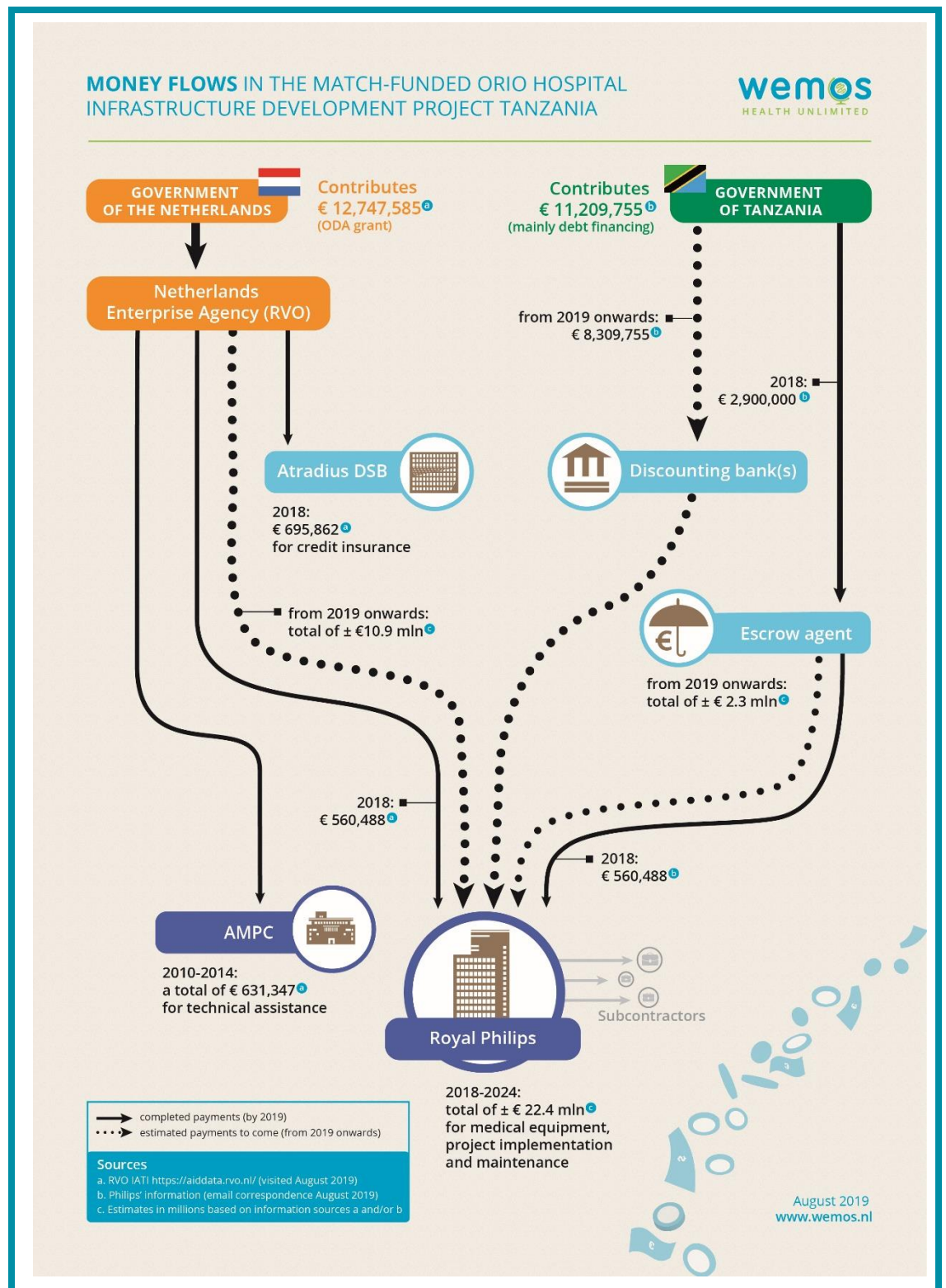
⁵³ We did not get access to any document that describes the full picture and details of the match-funding in the ORIO project. Therefore we created the picture ourselves while relying on a combination of sources: the ORIO grant's financial reports on RVO's IATI website (last checked in August 2019), and – where it concerns the Tanzanian side of the funding - correspondence from Philips Eindhoven office (8 August 2019). The information was clarified verbally by senior staff from respectively RVO and Philips Eindhoven office.

⁵⁴ An escrow agent is a person or entity that holds property in trust for third parties while a transaction is finalized [[LINK](#)]

⁵⁵ A bill of exchange is similar to a check or promissory note [[LINK](#)]

⁵⁶ A discounting bank "cashes a bill of exchange (after discounting it) before it becomes payable (matures), or uses it as collateral for advancing a short-term loan". [[LINK](#)]

- Implementation and Maintenance: RVO sent a down payment of just over half a million euros – matching the down payment from Tanzanian side – in 2018. It will continue disbursing to Philips from 2019 until the end of the project, ‘on behalf of the GoT/MOH’ and based on a payment system agreed with the MOH.



Box 2: Flow chart 'Money flows' (2019)

Potential impact on fiscal space for health

The information depicted in the flow chart shows that although all payments in the ORIO project are done by or on behalf of the GoT/MOH, no external money (grant or loan) is added to Tanzania's health budget in real terms. The primary recipients of the nearly EUR 24 million are the companies involved. Through the ORIO grant facility, resources are certainly added to the Tanzanian health system, though they are added 'in-kind'. Had it been the case that the costs for this project had already been budgeted by the MOH before the financing arrangement came about, the ORIO grant could have been regarded as a contribution to Tanzania's fiscal space for health. We did not find evidence of a specific budget line for this project within the MOH budget. We were, however, unable to check this matter with MOH staff. For now, this leaves the question how the project contributes to Tanzania's public purse for health unanswered.

In the stakeholder discussions other critical questions came up about the project's (potential) effect on fiscal space for health, which we will touch upon one by one:

- *How come the Tanzanian government could not ensure their contribution of over EUR 11 million (equaling roughly USD 12 million) after signing the project contract?*

The reason is unclear, but Tanzanian CSOs and researchers assume that there was simply not enough space in the health budget for a major expenditure like this. A representative of a CSO said this about the amount of approx. 10 million euros [the estimated amount we used in March 2019]: *"It is not a small amount, considering the severe limitations of Tanzania's fiscal space for health and other sectors of social services"*. In 2015 (the year after it signed the ORIO contract with Philips) the GoT's health expenditure from domestic resources totaled nearly USD 600 million⁵⁷. Compared to that, the project contribution of USD 12 million would represent 2%. Whether that is a significant percentage in itself is up for debate. CSOs and professional organisations argued that the government could also invest this amount in the priority area of primary health care or other reforms needed towards UHC.

- *Is a debt of this magnitude sustainable?*

The January 2018 Debt Sustainability Assessment (DSA), a check that is done every year by the International Monetary Fund (IMF) for LICs, shows Tanzania had a 'low risk' to debt distress in the year (2018) that the GoT committed to debt repayment for the ORIO project. Thus, officially there seem to be no problems in relation to this debt. Yet, CSOs monitoring Tanzania's debt say this ORIO debt is adding to an already problematic debt burden. These CSOs do assessments according to a more comprehensive set of indicators⁵⁸, and state that Tanzania is at risk of an external debt crisis marked by increasing dependency on commercial lending⁵⁹. Moreover, they point at the fact that Tanzania's current risk rating is officially unknown, as the 2019 DSA was not published or open for the public until this date⁶⁰.

⁵⁷ According to data of the year 2015 in current USD in the Global Health Expenditure Database, WHO [[LINK](#)], accessed in August 2019

⁵⁸ See Jubilee Debt Campaign 2018 publication [[LINK](#)]: countries are classified as in debt crisis if they have a large financial imbalance with the rest of the world and high government payments on external debt as a proportion of revenue.

⁵⁹ Jubilee Debt Campaign 2015 'The new debt trap' [[LINK](#)]

⁶⁰ Jubilee Debt Campaign 2019 blog on transparency about debt sustainability [[LINK](#)]

- *Couldn't the Dutch government contribute more through the ORIO grant facility, considering the limited fiscal space for health?*

When discussing with representatives of the Dutch government whether a loan from any commercial bank⁶¹ would not weigh too much on Tanzania's public purse, it was emphasised that the total package of finance is already concessional because of the 50% grant that is involved. They also said that a project should not be more concessional than this, because then it would show too little commitment on the recipient country's side. Other consulted stakeholders tended to agree with this, although they feared that the grant had in fact induced financial commitment from the Tanzanian government towards this project.

- *Future resources have to be mobilised to repay the debt, and to finance maintenance after the guaranteed maintenance period of 4 years. How will this be done?*

None of the interviewed and consulted CSOs and other researchers had seen information about debt repayment, not even those who closely analyse the government's budgets, track expenditure or participate regularly in technical working groups of the MOH. It is not clear how the money for the payments will be mobilised. Based on how earlier debts for medical equipment and medical supplies were handled, some CSOs expect that repayment will show on the health budget.

The companies involved agreed that future reservations for maintenance and repair could be a challenge. As one representative explained: *"The need to make budgets available for maintenance of equipment, but also all other infrastructure, is a bottleneck in several African countries, including Tanzania. This has been addressed with the Ministry of Health and Social Welfare several times, but still one sees that budgets are inadequate."*

- *Does the ORIO project contribute to Tanzania's fiscal space through taxes?*

No, in fact the project was granted exemption from various taxes by the GoT, when Philips was contracted in 2015. According to representatives of the companies involved and the Dutch government, Philips – for this particular project - is exempted from paying import duties, VAT⁶² and profit tax. Also Philips' subcontractors are VAT exempted for this project. A natural decision, as Philips representative phrased it: *"Donor funded projects are generally tax exempted, as it does not make sense to tax a donation."* However, only half of the project is funded from Dutch ODA⁶³. The question here is still why any profits in this project should be tax exempted; who benefits from this tax exemption and who doesn't? More detailed information is needed to answer these questions.

In short, the resources via the ORIO grant facility are added 'in-kind', but it is not clear how it affects Tanzania's fiscal space for health. The amount that the GoT contributes through debt financing is significant yet officially not unsustainable. However, it is worrisome in light of the larger debt problem that threatens Tanzania's fiscal space for public expenditure in general. It is unfortunately unclear how resources will be mobilised to repay the debt, whether additional debt financing costs are involved, and how it will affect Tanzania's future health budget and priority health expenditures.

⁶¹ At the time of these discussions the representatives of GoN were talking about a loan from a commercial bank. We did not know as yet that a supplier's credit from Philips was involved instead of a direct loan from a commercial bank to the GoT.

⁶² VAT: Value Added Tax

⁶³ Nowadays, The Netherlands is among donors that do not seek tax exemptions on goods, works and services in development assistance. See e.g. Overseas Development Institute (ODI) (2018): *'Should donors pay taxes in the countries they support?'* [\[LINK\]](#)

PUBLIC PROCUREMENT AND THE UNTYING OF AID

All countries can do something (...) to improve the efficiency of their health systems, thereby releasing resources that could be used to cover more people, more services and/or more of the costs. Public procurement, or the purchase of goods and services by governments through a contracting process, is an important part of health financing (WHO, 2010, [Health Systems Financing](#))

In the 1990s, when the ORET project was initiated, the GoN contracted Philips after a pre-qualification and bidding procedure in the Netherlands. Aid through ORET was reported as ‘tied aid’ (see box 3). At the time it seemed like a natural choice to work with Philips for both governments: the company had a strong presence in Tanzania and a reputation for good quality. Nowadays, a range of other providers in medical equipment - both multinational companies and smaller companies - are active on the Tanzanian market. According to all consulted CSOs and researchers in Tanzania, Philips equipment is still known for good quality, but also regarded as ‘top segment’ in terms of price. Private clinics in Tanzania often work with medical equipment from other suppliers, allegedly for much lower prices and still sufficient quality. According to a large private hospital interviewed by OPM, better value for money deals require diversified tendering. Diversified procurement can lead to cost savings in the long term. It entails inviting separate bids for different categories of equipment (like X-rays or ultrasound) rather than combining all in a single tender (OPM). Other stakeholders stressed that having to manage multiple contracts in a project also has disadvantages, for instance in terms of overhead costs and liability for equipment.

Initiation of the project

In 2010, the GoT’s application for this hospital infrastructure project was among the first applications for the newly installed ORIO grant facility (following ORET). In fact, the Dutch consultancy firm AMPC explained that it assisted the Tanzanian government’s MOH and submitted the application on its behalf. AMPC comments *“The [first] ORIO call was almost like a beauty contest, as during a defined time slot proposals were allowed to be submitted by governments.”* After a number of evaluation rounds the application was approved, and a budget for the feasibility study was set after a detailed price check by SGS⁶⁴. AMPC conducted and completed this study, developed the plan and guided the process until it got approval from ORIO and the grant arrangement was signed by the GoN and GoT in 2012.

Public procurement via an international tender

Representatives of the Dutch government and the companies involved explained that in 2013 the GoT published⁶⁵ an open tender according to International Competitive Bidding (ICB) procedures and Tanzanian procurement guidelines, to attract bidders for the (ORIO) hospital infrastructure development project. The whole, comprehensive project was put out in one tender. Most probably these lie in the wish for standardisation, economies of scale and efficiency. Perhaps it was done because the predecessor project (ORET) was one big comprehensive project too and evaluated positively on this characteristic: *“(...) partly because of the successful implementation of this project, Philips Medical Systems was awarded another contract with the Government of Tanzania for a project co-financed by the successor of ORET: ORIO.”*⁹

On the downside, having a single foreign company in a large hospital infrastructure project, also limits the possibility to negotiate differential prices and terms. In that light, a former Tanzanian government staff member stated in relation to ORET: *“Philips is holding the government to ransom”*, referring to

⁶⁴ SGS Netherlands [\[LINK\]](#)

⁶⁵ According to AMPC the tender was in fact published twice: in April 2013 and July 2013. In Newspapers Daily News, Guardian, East African Business Week, GoT websites [www.moh.go.tz](#) and [ppra.go.tz](#) (tender portal), and the UNDP website [DGMarket](#)

the high maintenance and repair bills that were produced after having introduced so much of its medical equipment subsidised by the Dutch government (OPM). Philips, in response, emphasises that there are always alternative suppliers and that it is not in the position to monopolise the market.

From the Dutch side, there was ORIO guidance: contracting and/or procurement were to be done by the recipient country and aid was to be untied according to the recommendation of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) (see box 3). AMPC explained that, although not written down in the ORIO policy rules or manuals, the GoN expected that ORIO applicants would develop comprehensive projects for *one* turnkey partner as was the case in ORET (which had closed down new applications in 2007): the GoN expressed its preference for procurement of turnkey projects through a single contractor. Philips commented on reasons for this: *“taking an integral approach (single supplier) has the absolute preference of the Donor [the Netherlands] and the company [Philips] for a number of good reasons, in particular full accountability for implementation”*.

AMPC provided technical assistance to the GoT to write the tender and secure a systematic and transparent tender process. According to AMPC, this type of TA had not been foreseen in the ORIO budget. And that the GoT/MOH requested GoN for TA support for the tender process, mentioning that it preferred to have direct negotiations with AMPC due to the complexity of the tender process, their knowledge of the project and ORIO regulations that may apply to the tender documents. This request was accepted by RVO, after which AMPC was allowed to offer. This offer was subject to a market conformity check, and eventually AMPC was contracted by the MOH. The GoN paid for it on behalf of the GoT/MOH.

Price

The evaluation⁸ of the ORET hospital infrastructure project in Tanzania was among the case studies that were part of a larger evaluation of ORET as a programme (2015)⁶⁶. It appeared that in the majority of the case studies, recipient governments regarded the supplied works, equipment and services (in ORET projects) as relatively expensive but of better quality than those from alternative suppliers. As in the ORET project the original price had been judged too high by an independent price consultant⁸, recommending an overall reduction by 15%, we were interested to know the pricing of the tendered ORIO project.

AMPC explained that pricing of the project goods and works in ORIO were assessed by SGS⁶⁴. Goods were priced against international prices, according to what was common in the international market. Goods were defined as A-quality products with long lifetimes. Works were priced against local construction costs multiplied with project management costs. Philips stresses that the reference pricing for equipment and services are the same everywhere in the world, but that the cost of (remote) implementation can be higher.

In the opinion of AMPC, this type of infrastructure development project is expensive in its execution due to the turn-key nature, which limits the number of competitors and increases the costs for project management and profit margins.

The price was also relatively high because of the Export Credit Agency (ECA) insurance costs that were involved in the supplier's credit (see the earlier notes on the Financing arrangement), paid from ORIO. Due to lack information, we cannot say how the GoT mobilises funds for their payments in the ORIO project and whether any financing costs are involved that would raise the cost even more.

⁶⁶ IOB (2015) Work in Progress. Evaluation of the ORET programme: Investing in Public Infrastructure in Developing Countries [\[LINK\]](#)

The untying of aid: a grey area

In ORIO, aid assistance is officially *untied*. However, the difference between tied and untied aid is not black and white in the hospital infrastructure project at hand. Current and former representatives of the Dutch government and the companies involved pointed out the following:

- The fact that the procurement was not done independent of Dutch companies' influence: *"The ORIO tender was fully set up and guided by Dutch consultants" and "International Bilateral Development Aid is predominantly allocated by the (OECD) donor countries to national businesses in preferred sectors (e.g. Logistics, Agriculture, Water, Energy and Health in the Netherlands) with "Aid and Trade" impact potential and right capabilities to actually develop and realize projects."*
- The way ORIO influenced the nature of the hospital infrastructure project tender: *"The consequence was that only big and strong companies, a company like Philips, really met the requirements."*
- The observed practice that big companies give way to each other in tenders when donor funding is involved: *"(...) as if there's a gentlemen's agreement. (...) like, when the Dutch government gives support or is involved, then GE or Siemens won't react to the tender."*

Even when ODA is formally untied there is a risk that donors 'informally tie' their ODA, as Eurodad describes it in its 2018 report 'Development, untied'⁶⁷.

Notes on the OECD-DAC Untying of Aid agenda

Tied aid is generally known to be relatively expensive and sub-optimal in terms of development effectiveness:

- Evidence has shown that 'tied' aid - offering aid on the condition that it be used to procure goods or services from the provider of the aid - can increase the costs of a development project by 15 to 30%.
- The untying of aid – which is about removing the legal and regulatory barriers to open competition for ODA funded procurement – increases aid effectiveness by reducing transaction costs and improving recipient countries ownership.

In 2018 the OECD-DAC reports that *"most members report as untied all or almost all of their ODA covered by the Recommendation."* However, *"In 2015 and 2016, 65% of contracts were awarded to companies in the donor country."*

Source: OECD-DAC Untying Aid Recommendation 2018 report⁶⁸

Based on the percentage range of 15-30% increasing costs when aid is 'tied', Eurodad⁶⁷ calculated a conservative estimate that the immediate cost of tying – that is, the cost of being unable to shop around for the best price – was between USD 1.95 billion and USD 5.43 billion in 2016. Eurodad adds that a far greater cost of missed opportunities to catalyse local economic, social and environmental development over the long term should also be factored in, which is hard to quantify in an estimate.

Box 3: Notes on the OECD-DAC Untying of Aid agenda

In short, the price of the ORIO project seems to be relatively high due to the fact that it was set up as a big comprehensive project for one turnkey partner, was largely based on high international rates and tariffs, and required an ECA credit insurance. Capacity strengthening in public procurement in Tanzania was thorough, but decision making about the project seems to have been influenced by large (Dutch) companies' interests. Therefore, formally the ORIO funding for the project may be untied, informally it is tied.

⁶⁷ Meeks, Eurodad 2018. *Development, Untied*. [LINK]

⁶⁸ OECD-DAC 2018 report on the Untying of Aid Recommendation [LINK]

SOCIAL ACCOUNTABILITY AND TRANSPARENCY

Mutual accountability and accountability to the intended beneficiaries of development co-operation, as well as to respective citizens, organisations, constituents and shareholders, are critical to delivering results. Transparent practices form the basis for enhanced accountability. (Global Partnership for Effective Development Co-operation)⁶⁹

Oversight

In ORET, the Dutch Embassy in Tanzania was closely involved in the design of the project and in the oversight of all subsequent phases. This was regarded normal practice. The Dutch government even considered it a necessary measure to protect the Tanzanians against the vested interests of a big company like Philips. As a former embassy staff member explained: *“don’t trust them blindly, but stay close and on top of it and have experts who can say ‘this is too expensive, this is hot air’ or the like”*. Reportedly, there have been multiple interactions between Philips and staff members of the Tanzanian Ministries of Health and Finance during ORET and the initiation of the ORIO project.

The Steering Committee (SC) overseeing the implementation of the ORIO project is lean and consists of representatives of the MOH Tanzania and Philips. The MOH is the first responsible for oversight. The GoN is not represented in the SC, although the SC reports to RVO for approval on general terms through so-called statements of no objections (SoNOs), and to the Dutch Embassy for information only. Due to the delay in the project, a reassessment of the hospital needs was required, conducted by the project implementer Philips in 2018-2019 in co-operation with the MOH, within the limits of the agreed on budget, and contractually documented.

It is a common option to add a third party, such as an independent expert advisor, to the SC. However, the GoN did not consider this necessary because it is a relatively small infrastructure project. It is not clear why it wasn’t considered necessary by the GoT. It seems natural that the GoN stepped back to a more distant role, respecting that ownership lies with the recipient country, especially since the Paris Declaration on Aid Effectiveness (2005). However, the omission of independent oversight carries a risk. For instance, the needs assessment of the hospitals risks to be more ‘supply driven’ than ‘needs driven’ when done by [foreign] companies. A CSO commented this, while being aware of the fact that it was done in cooperation with the MOH as accountable partner. Discussions with multiple CSOs revealed that their concern is rooted in the apparent lack of local civil society representation in the development of the hospital infrastructure development plan, of which – in their view - the assessment and reassessment of hospitals’ needs are or should be a part.

Social accountability

In development projects, the principles of ‘inclusiveness and democratic ownership’ should be taken more seriously, as was affirmed in the Busan Partnership (2011)⁷⁰. Until recently, however, the ORIO project seems to have been quite outside the public eye. This investment was not discussed with civil society, among others, through designated accountability structures like the relevant MOH technical working groups or at the Health SWAp⁷¹ meetings. This is not appreciated by CSOs we spoke to in Tanzania. *“We don’t want to have any hidden projects that burden us as taxpayers”*, one CSO representative commented.

⁶⁹ Global Partnership for Effective Development Co-operation [[LINK](#)], website visited August 2019

⁷⁰ See comments *Reality of Aid Africa* on the Busan Partnership resulting from the 4th High Level Forum for Aid Effectiveness (2011) [[LINK](#)]

⁷¹ Technical Committee Health of the Sector Wide Approach (SWAp), chaired by the MoH’s Chief Medical Officer, is the government’s main discussion forum with development partners and civil society on health sector issues [[LINK](#)]

According to the same CSOs, the intended expenditure for this match-funded ORIO project was not discussed in Parliament or parliamentary committees at the time the GoT committed itself.

Recently, the Minister of Health spoke about hospital equipment upgrades to be delivered soon, and financial resources for medical equipment were mentioned in the most recent Budget Speech⁷², although there was no explicit mention of the match-funded ORIO project or Philips.

Transparency

Transparency and access to information for the public are key in social accountability. We were only able to obtain basic information about the ORIO project through RVO's IATI website. We did not get hold of documents such as the feasibility study, the hospitals initial needs assessment, or the project plan. Even though there is a Freedom of Information Act (FOIA)⁷³ in the Netherlands, we didn't obtain documents upon request⁷⁴. The reason for this, according to representatives of the Dutch government, is that these documents belong to the GoT and it is therefore inappropriate for the ORIO team in The Hague to share these. It is up to the GoT to decide whether or not to share this information. Is the consequence of the good principle of recipient country's 'ownership' of a development project, that the taxpayer in the donor country cannot ask for the documents related to ODA expenditure? Only a FOIA request would probably provide a definite answer.

In Tanzania, on the other hand, the local OPM researchers didn't get access to documents or to government staff. There is limited transparency, and restriction in the use and interpretation of information in Tanzania⁷⁵. Most CSOs in Tanzania stressed that for this reason it is important that civil society organisations share information across borders, so this can be used for monitoring and advocacy work.

Commercial contracts are confidential, and thus normally without reach of the public eye. A concerning observation is that as public (ODA or non-ODA) expenditure is increasingly used to support commercial partners - working through commercial contracts – transparency is not secured anymore and social accountability becomes severely complicated. It is up to the partners in the contract to share information voluntarily. It is because of Philips' willingness to share some details, that we have been able to understand more about the Tanzanian part of the financial arrangement of this match-funded project. Still, we don't have official documents with such details, and we could not verify information with Tanzanian authorities.

The above shows the public is informed in a minimal way about the ORIO project through the RVO IATI website. And, thus far, civil society in Tanzania has not been informed or included in any substantive ways in this hospital infrastructure development project.

⁷² President of Tanzania Budget Speech 2018-2019 [\[LINK\]](#) and the Minister of Health's Budget Speech (May 2019) [\[LINK\]](#)

⁷³ Freedom of Information Act Netherlands [\[LINK\]](#)

⁷⁴ Note: we did not actually resort to formal FOIA requests, when requesting information.

⁷⁵ See discussions on the application of Tanzania's Statistics Act [\[LINK\]](#)

CONCLUSIONS AND RECOMMENDATIONS

Progress towards UHC will require not just more money for health, but more value for money, (...) allocating resources in such a way as to provide the optimal mix of goods and services to maximize the benefits to society. (WHO, 2015, [Improving Health System Efficiency](#))

Conclusions

Information in the public domain about the currently running ORIO hospital infrastructure development project in Tanzania is relatively superficial, as it lacks details about the project's package of goods, works and services, the feasibility study and assessments it is based on, the TA that took place, the project's intended outcomes and impacts, any measures to promote (or avoid harm in) pro-poor development, equity or local content (or to avoid harm), the financing arrangement and in particular the recipient country's co-funding. Through our case study we were able to retrieve additional information and uncover some of the 'black box' that CSOs in East Africa were concerned about, though not nearly as exhaustive as we had hoped for (also see conclusion 4). This additional information was helpful in the discussions about our case study's main questions about the potential impact on health system goals, including UHC and adherence to aid effectiveness principles. Our conclusions are the following.

1. The current Dutch/Tanzanian match-funded, comprehensive multi-hospital infrastructure development project will likely **improve the quality of diagnostic and surgical services, particularly in maternal and neonatal health, through better medical equipment in the higher levels of Tanzania's health referral system**, which is a tangible contribution to an area of need. There will also likely be positive contributions to health staff knowledge and skills, work (and skills) of local technical enterprises, and access to improved services in general. Practice will teach to what extent and how exactly.
2. This hospital infrastructure development project would likely not be realised without donor support. **Financial additionality from a donor point of view is undisputed.**
3. There are critical questions about development additionality, however. **Both the cost of the project and its contribution to longer-term health goals (including UHC) in Tanzania are debated.**
 - a) **Public cost:** This type of project seems relatively expensive, in particular for Tanzania's limited public purse and despite the open tender procedure, due to:
 - the design of the project as a big comprehensive project for one turnkey partner, largely based on high international rates and tariffs;
 - the informal influence that ties aid to large companies' interests, automatically affecting the Tanzanian co-finance too, despite the fact that ODA in this project is formally untied;
 - the negative effect on Tanzania's future fiscal space because it increases its debt burden, while tax exemptions were granted for the project;
 - costs involved in debt financing (i.e. the ECA insurance)
 - and possibly other costs involved in debt repayment.
 - b) **Public value:** The contribution of this type of project to long-term health (system) development goals is limited, due to:
 - the fact that there is no explicit support or negotiation for 'pro-poor' measures, like support for measures to improve (financial) access to these health services for poor and vulnerable populations;
 - the lack of an ex ante assessment of future effects on Tanzania's fiscal space for health, which needs expansion in order to make progress towards UHC;
 - and the fact that capacity strengthening in public procurement towards the Tanzanian government was influenced by donor guidelines to tender as one comprehensive project.

4. There are **concerns about social accountability and transparency** that should secure best public value for public expenditure, especially when money from a severely limited public purse is involved. More specifically:
- The project design, implementation and related expenditure lack structural independent civil society and/or expert input and monitoring;
 - Access to written information about the project in Tanzania and the Netherlands is very limited, even though public funding from both countries is involved.

Recommendations

The discussion round in Tanzania with (health) CSOs, health professionals and researchers brought recommendations for both the Tanzanian government and the Dutch government.

Wemos, as Dutch CSO, regards itself only in the position to formulate recommendations towards its own (Dutch) government.

Related to the *currently* running ORIO hospital infrastructure development project, we recommend the Dutch government to collaborate with the Tanzanian government on the following:

- **Access to services:** add monitoring and evaluation indicators that measure the project's impact on actual access to improved diagnostic and surgical services, when needed and indicated, for different sub-populations including the poor (and other vulnerable groups), with special attention to the user fees or out-of-pocket health spending mechanisms.
- **Fiscal space for health:** evaluate the impact of the financing arrangement of this project on Tanzania's fiscal space, with particular attention to the sources and conditions of funding for payments that have been used and will be used in the remaining 5 years, and related health budget choices.
- **HRH:** take measures to avoid unwanted effects on Tanzania's HRH strategy in line with public health priorities.
- **Social accountability and transparency:**
 - involve independent, local organisations with health system expertise to play substantive roles in project oversight, monitoring, and – in time – also in evaluation;
 - and make available in the public domain (e.g. in RVO's IATI website) past and upcoming documents, including project plans, needs assessments, evaluations or other documents that underlie this project and are (co-)funded with public funding.
- **Sustainability of improved services:**
 - elaborate on the technical sustainability strategy beyond the project period, taking into account lessons learned from the earlier ORET project;
 - and make clear how this project will contribute to strengthening local companies in the area of the maintenance and repair of medical equipment and monitor / evaluate this.

Related to (*future*) bilateral ODA expenditure for business strengthening whenever applied in the health sector, whether for public infrastructure development or not, we have the following recommendations to the Dutch government:

- **Health system strengthening and access to health services for all:**
 - Do ex ante assessments against crucial health sector specific criteria, including any positive impacts on or avoidance of negative impacts on equitable access to health services (including reduction of OOPS), the health workforce and public resources for health, with certain thresholds needing to be met before projects can go ahead.

- Do ex post evaluations according to the same health sector specific criteria.
- **Fiscal space for health:**
 - Ensure that projects contribute to strengthening of recipient countries' public resources for health, and do not lead to an erosion of (future) public resources for health by steering for more debts and financing risks or granting of tax exemptions.
- **Policy coherence for sustainable development:**
 - Ensure that output, outcome and impact indicators are most relevant to health and development in the recipient country, and aligned with the health SDGs. Success for Dutch enterprises – whether in terms of contracts awarded or transactions made – should not be considered relevant for development.
 - Prioritise capacity strengthening that first and foremost meets the interest of the recipient country's health system, free from companies' vested interests, whether it concerns technical assistance or transfer of knowledge to policy makers and government agencies, health sector staff or other key responsible actors in health.
 - Address known barriers that impede (smaller) firms in medical equipment - active in the global south - from participating in public procurement.⁷⁶
- **Social accountability and transparency:**
 - Make available to the public any significant project related documents paid for with public (tax payers') money.
 - Call for publicly available information from the recipient government on their funding commitments, and appropriate forms of public consultation in line with the principle of democratic ownership of development priorities.
 - Publicly disclose any new loans or credits to governments the moment they are given (and not afterwards), as to better enable parliamentarians and civil society to hold their governments to account on public spending.⁷⁷
 - Systematically register companies awarded with contracts in (wholly or partly) ODA-supported projects in the designated contract database of the OECD-DAC.

We realise that above mentioned recommendations may not always lie fully within the Dutch government's sphere of influence. In those cases we call on active collaboration with governments of recipient countries and/or with multilateral (donor) organisations the Netherlands is part of (including the World Bank Group, the OECD-DAC and the European Commission) for measures in ODA expenditure that protect the right to health.

In this discussion paper Wemos takes full responsibility for the conclusions and recommendations addressed to the Dutch government.

Wemos is grateful for the generous collaboration of all organisations and individuals in the case study, the discussion round and the feedback round.

⁷⁶ This recommendation is based on a recommendation by EURODAD, 2018 [[LINK](#)]

⁷⁷ This recommendation is based on a recommendation by Jubilee Debt Campaign, 2016 [[LINK](#)]