Community Health Funds (CHFs) in Tanzania: Innovations Study
Draft Report

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Disclaimer

The views and ideas expressed herein are those of the author(s) and do not necessarily imply or reflect the opinion of the Institute.
## Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CCHP</td>
<td>Comprehensive Council Health Plan</td>
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<td>CHF</td>
<td>Community Health Funds</td>
</tr>
<tr>
<td>CHIC</td>
<td>Comprehensive Health insurance competence</td>
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<td>CHSB</td>
<td>Council Health Service Board</td>
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<tr>
<td>EHCS</td>
<td>Essential Health Care Services</td>
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<tr>
<td>ED</td>
<td>Essential Drug</td>
</tr>
<tr>
<td>DCCC</td>
<td>District CHF competence centre</td>
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<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DP</td>
<td>Development Partners</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organizations</td>
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<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) GmbH</td>
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<tr>
<td>GoT</td>
<td>Government of Tanzania</td>
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<tr>
<td>HF</td>
<td>Health Facility</td>
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<tr>
<td>HFGC</td>
<td>Health Facility Governing Committee</td>
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<tr>
<td>HH</td>
<td>Household</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MIS</td>
<td>Micro Insurance Schemes</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MSD</td>
<td>Medical Store Department</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>PMO-RALG</td>
<td>Prime Minister’s Office for Regional Administration and Local Government</td>
</tr>
<tr>
<td>P4H</td>
<td>“Providing for Health” Initiative</td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of reference</td>
</tr>
<tr>
<td>RCCC</td>
<td>Regional CHF competence centre</td>
</tr>
<tr>
<td>SCIH</td>
<td>Swiss Centre for International Health (at the Swiss TPH)</td>
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<tr>
<td>TGPSH</td>
<td>Tanzanian German Programme to Support Health</td>
</tr>
<tr>
<td>TNCHF</td>
<td>Tanzanian Network of Community Health Funds</td>
</tr>
<tr>
<td>Swiss TPH</td>
<td>Swiss Tropical and Public Health Institute</td>
</tr>
<tr>
<td>WDC</td>
<td>Ward Development Committee</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>ZCCC</td>
<td>Zonal CHF competence centre</td>
</tr>
</tbody>
</table>
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1 Executive Summary

Purpose of the Study
The Community Health Fund (CHF) innovations study was commissioned by the German Development Cooperation Agency (GIZ) in order to explore the innovations and best practices which have allowed some district CHF schemes to perform relatively better than others. This was done with a view to furthering the national discussion for improving the schemes generally and to provide creative impulses to districts where the schemes are performing relatively less successfully.

Results of the study
The study revealed primarily numerous innovative refinements to enrolment, and health service quality improvements financed by the CHF. There were no clearly successful innovative "re-designs" of the scheme, though one attempt in Kyela district (where the scheme membership management was outsourced to an NGO) was on-going. All of the actual "innovations" could be classified as "tinkering" with the business process rather than "re-tooling" it.

The majority of these relatively more successful districts visited were able to point to the following main elements for their success:

- the "CHF-motivation" of the RMO, the DMO, and the various local authorities who were mostly responsible for the successful sensitization of the communities to the benefits of the CHF (social marketing: scope and frequency)
- a district employee dedicated (rather more than less full-time CHF coordinator) to ensure needed CHF coordination between health facilities and the district executive director's accountant (financial control of CHF enrolment premiums and data collection for matching grant applications)
- well-functioning Council Health Service Boards (CHSB), District Health Management Teams (DHMT) and Health Facility Governing Councils (HFGC) all doing their best to supervise and support the CHF scheme AND the quality of health services in the health facilities.
- use of CHF and other financial resources to ensure quality improvements of the health services being offered at the health facilities, especially the availability of medicines and supplies

Conclusions and Recommendations
The study team, based on the results of the literature review and the surveys of selected districts, concludes that the potential for realizing the most benefit from the existing CHF scheme is greatest when:

- the overall district health and local government structures within which the scheme is operating are functioning well. This is also a pre-requisite for improving the quality of health services being offered to CHF members and the served communities.
- A focus on ensuring a continuous and adequate supply of needed medicines and supplies at all health facilities is the single most important factor for improving the quality of services being offered at health facilities, making it more attractive to become a CHF member
The study recommends further that to maximize the potential of the CHF scheme to benefit the communities most as a (partial) protection from catastrophic health risks and to pool the most resources in the CHF:

- the focus needs to be placed on a more systematic approach to enrolment and CHF membership management.

The capacity and appropriateness of the in-charges of health facilities to manage this process at community level is extremely limited, therefore it is recommended that:

- CHF social marketing (sensitization), member enrolments, control of membership premiums, and member data management right through to regular successful applications for matching grants should be made the responsibility of the local authorities at district, ward and village levels.

2 Study Methodology

The study was designed and lead by the Swiss Tropical and Public Health Institute with support and collaboration from key stakeholders and development partners: GIZ (Tanzania), the Swiss Agency for Development and Cooperation (SDC), Tanzania Network for Community Health Funds (TNCHF), National Health Insurance Fund (NHIF) and the Ministry of Health and Social Welfare (MOHSW) and the Ifakara Health Institute (IHI). The study team included the Swiss TPH health economists Manfred Stoermer (Principle Investigator) and Patrick Hanlon, Mr. Meramba Tawa of the TNCHF, Mr. Deogratius Mosha of the NHIF and Ms. Jane Macha from IHI. The study team was voluntarily supported through data collection in Dodoma Region by the team of the Health Promotion and System Strengthening / Tuimarishe Afya project (HPSS)

2.1 Selection of Districts

A pragmatic selection of better performing districts was made based on available data (source: NHIF) of relatively high enrolment rates and also relative success in receiving matching grants. Key stakeholders and informants were also consulted for anecdotal references to known best practice or innovations concerning the CHF scheme and health services quality improvements funded with CHF resources.

The following table outlines the districts chosen and the criteria used for their selection:

Table 1: Selected districts and selection criteria
<table>
<thead>
<tr>
<th>No.</th>
<th>District/ Region</th>
<th>% CHF HHs/ total HHs</th>
<th>District rank % CHF HHs</th>
<th>Matching grant: from-to / 12 month average TZS</th>
<th>Reported features of innovation / best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bariadi District, Shinyanga</td>
<td>40.9%</td>
<td>2</td>
<td>none</td>
<td></td>
</tr>
</tbody>
</table>
| 2   | Iramba District, Singida               | 28.1%                | 3                       | Jan. 2008 - June 2010 / 42'723'600            | • Group enrolment of students of primary and secondary schools  
• Drug management through drug audit |
| 3   | Singida Rural District, Singida        | 27.2%                | 4                       | Jan. 2008 - Oct. 2010 / 46'662'400            | • Referral system: FBO hospital services are included  
• Buffer stock of medicines at district level  
• Referral arrangements: hospital services included |
| 4   | Mpwapwa District Dodoma                | 25.5%                | 7                       | Apr. 2008 (est.) - Sept. 2010 / 73'086'923    | • Buffer stock of medicines at district level  
• formula for the fund distribution of CHF funds |
| 5   | Lushoto District, Tanga                | 23.4%                | 8                       | Oct. 2008 - Sept. 2010 / 22'512'500           | • CHF scheme includes access to Huruma CDH (faith-based hospital) |
| 6   | Rombo District, Kilimanjaro            | 20.7%                | 9                       | Apr. 2006 - Nov. 2010 / 53'162'143            | • each member of the CHMT has been assigned a ward to be the CHF contact person  
• Referral system: FBO hospital services are included (Nkinga Hospital) |
| 7   | Chamwino District, Dodoma              | 15.0%                | 11                      | Jan. 2009 - Oct. 2010 / 25'123'636            | • Utilisation of CHF resources: bought an ambulance, and solar panels  
• Group enrolments: |
<p>| 8   | Igunga District, Tabora                | 12.8%                | 15                      | Jan. 2006 - Aug. 2010 / 23'305'862            |                                                |
| 9   | Kahama District, Shinyanga             | 12.1%                | 16                      | Oct. 2008 - Feb. 2010 / 204'854'118           |                                                |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>District/ Region</th>
<th>% CHF HHs/ total HHs</th>
<th>District rank % CHF HHs</th>
<th>Matching grant: from-to / 12 month average TZS</th>
<th>Reported features of innovation / best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Pangani District, Tanga</td>
<td>11.3%</td>
<td>17</td>
<td>July 2008 - June 2010 / 5'402'000</td>
<td>Village enrolment of all residents (Mkwaja)</td>
</tr>
<tr>
<td>11</td>
<td>Kyela District, Mbeya</td>
<td>9.6%</td>
<td>18</td>
<td>none</td>
<td>Group enrolment of cocoa growers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CHIF management took over the representation of CHFs from CHSB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>group enrolment of farmers</td>
</tr>
<tr>
<td>12</td>
<td>Liwale district, Lindi</td>
<td>8.0%</td>
<td>25</td>
<td>Nov. 2005 - Feb. 2010 / 3'834'231</td>
<td>CHF have a claiming mechanism (like NHIF)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Group enrolment of tea growers association, secondary school students</td>
</tr>
<tr>
<td>13</td>
<td>Rungwe District, Mbeya</td>
<td>6.5%</td>
<td>28</td>
<td>April 2008 - March 2010 / 42'930'000</td>
<td>CHF have a claiming mechanism (like NHIF)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Group enrolment of tea growers association, secondary school students</td>
</tr>
<tr>
<td>14</td>
<td>Kilwa District, Lindi</td>
<td>3.8%</td>
<td>45</td>
<td>none</td>
<td>group enrolments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NHIF contributions for poor children</td>
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### 2.2 Literature review

#### 2.2.1 Literature review methodology

The methodology included a desk review of the available document and literature related to CHF/TIKA success stories and different innovations. Published and grey literature were compiled from different sources. Major national and international websites were referred to in order to gather the available and relevant policy documents, health financing reports, district specific research studies on CHF/TIKA etc. Relevant articles were searched through the Google and Pubmed search engines, where a variety of key words were used, some of which were *community health fund, community based health insurance schemes, community health insurance and mutual health insurance*.

Other relevant materials were obtained from other team members of this study and from the informal discussion. A lot of literature and documents were collected that related to the topic, however the focus remained to those providing success stories, challenges and different innovations that have been implemented to improve the performance of the community health fund/community based insurance schemes.
2.2.2 Definition of Innovation

Innovations in theory have been defined as a break from the past, new structures or new skills required for implementation (Osborne and Browne, 2005)\(^1\). They are different from the idea of ‘change’ which can happen within existing paradigms or systems. Innovation implies a shift in the existing paradigm. Individuals working in systems usually are responsible for the implementation of different changes or innovations. Often, innovations inform revisions of policy of the country or of a particular sector in the system once there is enough evidence for success. This study aimed to understand different innovations that intended to improve the implementation or to solve different problems that have so far being identified by different studies regarding the implementation of CHF.

2.2.3 Innovation areas found in the literature review

Group enrolment

The problem of low enrolment rates in most of the community based health insurance schemes in many countries and Tanzania in particular has resulted in the introduction of the group enrolment (Musau, 1999)\(^2\). In Tanzania, group enrolments were to scale up the CHF membership, encourage the remaining population to enrol into the scheme and improve the quality of health care services (Sheuya, 2006)\(^3\). These were also introduced as a means to empower members to take influence on health care related issues. In places where group enrolment was introduced, positive results were found. The approach of group enrolment was supported with technical assistance by GIZ, through sensitization of groups in the informal sector. A study conducted by Sheuya (2006)\(^3\) in Rungwe, showed a joint public private partnership (PPP) initiative between the Rungwe CHF and Rungwe Smallholder Tea Growers Association (RSTGA) and the Wakulima Tea Company helped to increase membership substantially. RSTGA/Wakulima agreed to pay the CHF contributions for their members. At that time they paid 50 million Tsh to the CHF to cover 5000 member households (Mtei and Mulligan, 2007a)\(^4\).

Introduction of Buffer stock

Buffer stocks have been introduced to a number of districts in the country to tackle the problem of drug shortage and frequent stock outs. In most of the districts where they have initiated this innovation, the enrolment rate has been increasing. One example is Mpwapwa district, where at the district hospital a buffer stock of drugs was built up which also attracts people to join CHF, as drug availability has been one of the main barriers for people to join the CHF scheme (Stoermer and Macha, 2009)\(^5\). The introduction of the buffer stock has been a mechanism to avoid drug stock-out at the health facility. Another example is described in the study of Stoermer et al. 2008\(^6\) for Lushoto District. There the District Pharmacist buys drugs at MSD on behalf of first level health facilities and builds a buffer stock using the district hospital. The District Pharmacist is empowered by the DMO to validate and authorize requests for drugs of the health facilities and dispenses the drugs to them in a fast and efficient way. Presently GIZ is heavily engaged in the development of buffer stocks, as well as in the better inclusion of alternative drug suppliers for preventing stock-outs.

Pro-poor funding

The poor have greater health care needs than people who are better off. However, financial barriers are reasons for poor people, in particular, for not seeking care when sick. Income has also been reported to be influencing enrolment to health insurance and studies done in
China and Uganda have found income to be playing a greater role in community based insurance enrolment (Wang et al., 2005\textsuperscript{7}, Basaza et al., 2008\textsuperscript{8}). Thus the situation continues to exclude poor people from joining the insurance schemes or accessing care through direct payment, despite having exemption and waiver policies. The implementation of the exemption and waiver has been reported by different studies to be not very effective nationally (Manzi, 2005\textsuperscript{9}, Burns, 2006\textsuperscript{10}). However, in some districts success has been observed, whereby the councils managed to plan and set a budget for the poor within their annual health plans and others managed to organise a number of Non-Government Organisations (NGOs) to pay for the poor annually.

The pro-poor funding mechanisms have been implemented differently from one district to another. The literature review conducted by Mtei and Mulligan, 2007\textsuperscript{4} reported success stories on ensuring access to the poor, whereby some districts have made efforts to both identify the poor and make the waiver system work. In Mwanga district, officials have been able to identify the poor and maintain lists of the poor in all health facilities, so that the application of waivers is straightforward (Burns, 2006)\textsuperscript{10}. Other districts have consolidated all forms of cost sharing into the CHF and households who cannot afford to pay are identified and provided with a CHF card (Burns, 2006)\textsuperscript{10}. In Muheza district the council released Tsh 3,000,000 for the year 2005/06 and secured additional funding to provide CHF membership cards for the poor, which was estimated to be 733 families (Siegert, 2005)\textsuperscript{11}. Some of the criteria that are used to identify the poor in Muheza include elders and widows who have no means of support; physically/mentally handicapped persons; orphans less than 18 years; and those with poor housing and no access to safe drinking water (Ndangala and Kalimalwendo, 2005)\textsuperscript{12}.

The review by Stoermer and Macha, 2009\textsuperscript{5} showed Dodoma Municipality, Kondoa and Kongwa conducted fundraising, which involved officials from various sectors during the CHF opening ceremony. The money collected was used to pay for poor households. In addition, Dodoma Municipality and Mpwapwa put aside some money in the FY2009/2010 district comprehensive health budget to cater for poor households.

Some of the development partners have also been contributing some funds to pay for the poor: for instance, Mpwapwa has budgeted 3 Mio in 2009/10 for pro-poor support, Compassion (NGO) paid for 39 groups of students, and Africare (NGO) had a plan to pay for 180 households. Similarly, Dodoma Urban budgeted for 4 Mio in 2009/10 for pro-poor funds. Despite these efforts, key resource persons indicated that many poor and vulnerable groups are still required to pay directly in order to access health care. Looking at the quantities of households covered by pro-poor funding it is obvious that the objective of ensuring equitable access to health services is far from achieved.

**Inclusion of hospital care within the CHF package**

In principle, any facility can enter into a service agreement with the Council Health Service Board (CHSB) for provision of services to CHF/TIKA members (United Republic of Tanzania, 2001)\textsuperscript{13}. In practice, in rural districts, public providers have been used exclusively for primary care, with some districts having arrangements with mission hospitals for referral care. With TIKA, councils are encouraged to offer greater flexibility in the choice of providers for primary care (including non-governmental facilities).

Inclusion of hospital care within the benefit package emerged as a result of the complaints from members on the restriction to only one primary facility and also hospital care has been reported to be the cause of catastrophic health expenditure and impoverishment. This been the case in some of the districts such as Hanang, Igunga, Mwanga and Rombo which decided to include hospital care within the CHF benefit package, which has then been reported to be among the reasons for joining the scheme among the majority of households (Mtei 2007)\textsuperscript{4}.  

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\textsuperscript{8} It is obvious that the objective of ensuring equitable access to health services is far from achieved.


Mechanism to increase user fees

The cost of health care has been reported to be among the most acute health care problems of the poor and the vulnerable. The study by Laterveer, 2004 on the equity implication of the user fees concludes that presently, user fees in Tanzania are regressive and contribute to substantial exclusion, self-exclusion and increased marginalization. It was also found that poor people often cannot afford to pay the CHF premium because it is too high and has to be paid at once.

However, in some districts where CHF is in operation they have increased the user fees as a mechanism to make it financially more attractive for the population to join CHFs instead of paying fees. In Mpwapwa district, user fees were raised to TSH 4,000/= for hospitals, TSH 3,000/= for health centres and Tshs 2,500/- for dispensaries. This mechanism has a critical implication to equity as it can easily create financial barriers for the poor, and lead to unintended results. As a consequence, this approach of promoting a pre-payment scheme acts contrary to its original objective: instead of improving accessibility and social protection for the population, especially those most at risk may be left without accessibility, not being able to pay either the enrolment premium or the user fees. (Stoermer and Macha, 2009)

District managers’ commitment to support CHF implementation

CHF is a district council based pre-payment scheme and the council officials are responsible for implementing the fund successfully. However, studies show that lack of commitment of some of the top managers at the district has affected the implementation of the fund. On the other hand, there are examples where the commitment and support of district managers resulted in the success of the fund. The Kongwa, Kondoa and Dodoma urban districts' success has been seen to be due in part to the improved cooperation between the district health board, councillors and other leaders who together mobilize the community to join CHF, as well as through community groups supported by the Community Based Health Initiative project (CBHI) and village health workers (VHW) (Stoermer and Macha, 2009).

In the review of the SDC project “Health insurance for rural population” (Stoermer and Macha, 2009) examples were identified on the positive commitment of the district managers to support CHF. In Mpwapwa district, the personality of the DMO was mentioned as one of the factors leading to the high enrolment rate. The DMO in Mpwapwa had long experience with CHF since serving in Mwanga District, which was also very successful. Trainings on roles and responsibilities on CHF implementation at the level of Council Health Service Boards and Health Facility Governing Committees have been numerous supported by development partners such as GIZ and SDC.
2.3 Survey methodology

2.3.1 Survey tools used

A survey form covering the main parameters was designed for both the district and the health facility level:

The parameters included:

- management and use of CHF funds
- matching grants
- benefit package
- portability
- pro-poor enrolment
- governance and administration
- innovations

These survey tools were based on a categorisation of major problem areas used in the Health Promotion and System Strengthening (HPSS) project’s CHF situation analysis in Dodoma region conducted the same year. The survey forms were field tested in two districts leading to some minor refinements for use in the remaining districts.

The field study team, lead by Swiss TPH health economist Patrick Hanlon, also included Mr. Meramba Tawa of the TNCHF and Mr. Deogratius Mosha (NHIF research). The team visited 12 districts (5 with Patrick Hanlon, the remainder without) meeting with RMOs, DMOs, DED accountants, CHF coordinators, and health facility in-charges and conducted semi-structured interviews and site visits to numerous health facilities. Additional data was provided by the team of the SDC funded “Health Promotion and System Strengthening” project in Dodoma for two additional districts.

The survey results of the visits to each district were summarised by the study team into one document per district, which were then collated in a master table summarising the key points across all surveyed districts.

3 Results of the study

Collection of qualitative data

The study team collected large amounts of qualitative data and oral report evidence of CHF best-practice and innovation, and discussed ways of improving the quality of health services at the health facilities using CHF and other sources of funds.

Scarcity of quantitative data

The ability of the team to confirm and augment quantitative data such as current enrolment (absolute and as a percentage of total households), renewal rates, requested and received matching grants was generally restricted by lack of up-to-date data or the willingness to share this. This is an important finding of the study, that the quality of data management is
generally very poor and is a serious impediment to maximizing the potential of the CHF scheme. This seriously affects the management of members, especially renewals and also the ability of the district to apply successfully and routinely for available matching grants.

3.1 Analysis of collected data

3.1.1 Summary of selected indicators

Below is a summary of selected indicators and their status within the district CHF scheme and health service organisation.

Table 2: Status of CHF schemes along selected indicators

<table>
<thead>
<tr>
<th>Selected indicator</th>
<th>Dedicated district CHF coordinator</th>
<th>Functioning CHSB</th>
<th>Buffer stock / CHF funding of medicines and supplies</th>
<th>Group enrolments</th>
<th>Health facility (HF) discretionary funds</th>
<th>HF own bank account</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariadi</td>
<td>25%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Iramba</td>
<td>80%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Singida Rural</td>
<td>100%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Mpwapwa</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lushoto</td>
<td>150%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Rombo</td>
<td>25%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Chamwino</td>
<td>50%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Igunga</td>
<td>200%</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Kahama</td>
<td>50%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pangani</td>
<td>50%</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kyela</td>
<td>50%</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Liwale</td>
<td>25%</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Rungwe</td>
<td>50%</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Kilwa</td>
<td>90%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td># Districts/Total</td>
<td>11/14</td>
<td>12/14</td>
<td>10/12</td>
<td>12/13</td>
<td>8/12</td>
<td></td>
</tr>
<tr>
<td>per cent %</td>
<td>68%</td>
<td>79%</td>
<td>86%</td>
<td>83%</td>
<td>92%</td>
<td>67%</td>
</tr>
</tbody>
</table>

3.1.2 Problem areas addressed

The survey forms used were based on a problem analysis of four major problem areas of CHFs. This methodology is based on a categorisation for the CHF organisational characteristics developed in the HPSS project (Stoermer et al 2010).
The parameters for CHF problem areas are:

- design
- enrolment,
- servicing, and
- sustainability.

The table below summarises which problem areas were addressed by the innovations and best-practices recorded by the survey team.

**Table 3: Problem areas addressed by CHF innovations and best-practices**

<table>
<thead>
<tr>
<th>Problem areas addressed</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESIGN 1.1 No separation of purchaser-provider roles</td>
<td>40</td>
</tr>
<tr>
<td>1.2 Overburdening of current office bearers</td>
<td>60</td>
</tr>
<tr>
<td>1.3 Line of command conflict between the NHIF and MOHSW</td>
<td>80</td>
</tr>
<tr>
<td>1.4 Limited/inappropriate benefit package</td>
<td>80</td>
</tr>
<tr>
<td>1.5 Contribution level setting</td>
<td>60</td>
</tr>
<tr>
<td>1.6 Limited space for competition amongst health providers</td>
<td>20</td>
</tr>
<tr>
<td>1.7 Insufficient Insurance Management Information System (IMIS)</td>
<td>10</td>
</tr>
<tr>
<td>ENROLMENT 2.1 Access for the poor</td>
<td>70</td>
</tr>
<tr>
<td>2.2 Low trust in service provision promise</td>
<td>50</td>
</tr>
<tr>
<td>2.3 Adverse Selection (No waiting time)</td>
<td>30</td>
</tr>
<tr>
<td>2.4 Weak Sales Force, Process and Monitoring</td>
<td>80</td>
</tr>
<tr>
<td>SERVICING 3.1 Unstructured payment system to health care providers</td>
<td>40</td>
</tr>
<tr>
<td>3.2 Low quality of service provision</td>
<td>70</td>
</tr>
<tr>
<td>3.3 Insufficient feedback mechanism</td>
<td>20</td>
</tr>
<tr>
<td>3.4 Insured Identification</td>
<td>60</td>
</tr>
<tr>
<td>SUSTAINABILITY 4.1 Organizational Sustainability</td>
<td>30</td>
</tr>
<tr>
<td>4.2 Financial Sustainability</td>
<td>40</td>
</tr>
</tbody>
</table>

Categorisation based on Stoermer et al 2010
From this summary one can see that some problem areas were seldom addressed, but at the same time are very pertinent to the success of the CHF scheme, notably:

- the insufficient insurance management information system and
- insufficient feedback mechanism

On the other hand, there were many attempts to deal with the quality and accessibility of health services, such as:

- the benefit package
- the contribution levels for enrolment premiums compared to user fee levels and ability to pay
- access for the poor
- trust in the promise of adequate service provision and
- the quality of service provision

### 3.2 Main findings

#### 3.2.1 Dedicated people

The study revealed that the districts surveyed repeatedly confirmed the dependence for success on dedicated people in key positions. This dedication was evidenced by:

- **convinced CHF scheme advocates**: government officers and politicians dedicating their time to sensitization in the communities of the CHF scheme in a concerted and sustained social marketing effort.

- **functioning decision-making bodies**: CHSB, DHMT, HFGCs - all of which are essential for supporting and supervising the CHF operations, and the improvement of health service quality in the health facilities (HFs) which may be partly or solely funded by the CHF account of the district. (Most of these bodies were successfully motivated simply through normal sitting allowances for meetings.)

- **a dedicated district CHF-coordinator**: the willingness and ability of the district to fund (as full-time as possible) the position of CHF-coordinator bears fruits in terms of better CHF membership data management and financial control leading directly to routinely successful matching grant applications.

#### 3.2.2 Quality health services

The study confirmed the well-documented requirement for quality health service provision. The absence of a basic level of quality at a health facility will doom any CHF scheme there to failure. The provision of good quality health services will guarantee a "busy" health facility and the ability of the HF to collect more user fees and CHF enrolment premiums.

The main drivers for improvement and maintenance of health service quality were:

- First and foremost, the continuous availability of required medicines and supplies. (This was realized through supplementary procurement using CHF funds and other sources, as well as through improvements in the control and management of drugs within the facility.)
Further, the ability of the HF to:
- make minor repairs and improvements to the facility
- pay for continuous power supply, etc.
- pay for small staff incentives
- pay for additional medical (contract retired medical officers) and support staff (watchmen and cleaners)

The health facilities in the “well-performing” districts reviewed in this study were able to access the CHF and other sources for the needed funds for these quality improvements. This finding is in line with the findings of previous studies showing that less well performing districts had problems accessing these CHF funds (and other supplementary health financing funds such as NHIF reimbursements and user fees) as the fund flow was structurally blocked at district level (Stoermer et al. 2008) at the example of Muheza District, and (Stoermer et al. 2009) at the example of Kyela and Ileje Districts. Of less relevance was the issue of whether the HF had an own bank account.

In one district, the formula for allocating CHF funds to health facilities was not based on how much the health facility had collected in enrolment premiums in a given period, as was the usual approach (to reward health facilities for active enrolment of CHF members). Rather, the allocation was based on a flat amount per patient treated in the previous quarter (rewarding HFs for treating patients - a novel incentive!)

Further factors contributing to the quality of care were found to be:
- referrals to FBO health facilities or the district hospital were often realized through a variety of agreements using multiple sources of funds including the CHF and some form of user fees above certain limits
- "dedicated" registration, waiting rooms and treatment of "pre-paid" patients: CHF, NHIF, and other schemes
- improvements to the portability of CHF membership to other HFs in the district (though there were very mixed opinions about the advantages and disadvantages of a rigid "home" health facility practice)

3.2.3 Missed opportunities:

Social marketing and enrolment:

There is enormous potential for improvement in the marketing of the CHF, which was found to be limited to sporadic CHF sensitizations by prominent authorities and politicians. The driving force was usually reported to be the efforts of a single district CHF-coordinator and the DMO. However, they are spread too thin for capitalizing on block enrolment opportunities. A big role is played by chance enrolments in health facilities by patients seeking health care.

There were many novel attempts to make enrolment more efficient:
- Mkwaja village (Pangani) council decision to enrol every household by paying for pictures and enrolment fees from the council account (- a very elegant solution for pro-poor enrolment!)
- block enrolment of pupils in schools: schools were convinced to make it a requirement that all pupils are enrolled (as households of 5 pupils) in the CHF scheme using part of the deposit made in case of sickness
- enrolment of exempted elderly in novel households of 5 with enrolment premiums paid for by the community (also a way of promoting pro-poor enrolment despite the recognition that many elderly are not poor) as well as the opportunity to secure
"additional" matching grants. However, obviously this approach of building new groups on voluntary basis increases the risk of adverse selection as mainly persons of high health risk will be motivated to join, and thus may create additional costs for the health services. In the present det-up of the CHFs this does not matter, however, as elderly people are exempted anyway and the costs of their treatment are fully born by the health care providers.

- enrolments of association members as a way to reduce their health care costs, which may be partly paid by the association or employers (tea growers associations, etc.) This approach has much been supported by GIZ.
- some efforts were being made to time the enrolments to correspond to annual harvest periods in order to capitalize on the households' seasonal liquidity
- in Rombo district, there is a provision for a waiting period of 14 days, (which is planned to be extended to 30 days) before a member can access health services for free. This was the only attempt seen to address the structural flaw of the CHF which enables a person to choose the least expensive between user fees and CHF premiums at point of service in the HFs, in the absence of any incentive mechanism to enrol before requiring health care.

Renewals

The issue of renewals was found to be almost a non-issue as this was seldom being addressed, and if it was, it was not systematic. There was very little pro-active follow-up of expiring memberships. Sometimes there were efforts made to pass on expired membership cards held at the HF to the village council at meetings in an attempt to inform village leaders of expired memberships of the village inhabitants. Generally, however, such efforts were not very successful. The reasons are not the lack of motivation, but rather structural ones: on the one hand, the absence of a well working Management Information System makes it enormous difficulty for the persons involved in CHF management to keep track of the membership data and get adequate information on forthcoming expiries of cards. On the other hand, the few staff members involved in these activities (DMO, CHF coordinator) have to do this part time next to their main responsibilities of ensuring (DMO) and contributing to (CHF coordinator) the quality of health care provision.

Matching grants

The less than optimal CHF membership data management found even in the best districts leads to excessive efforts to collect the information and documentation required for a successful matching grant application. This results at best in delays and matching grants which are less than they could be if all of the data and documentation for each CHF member were available. For example, one of the more successful CHF districts (Bariadi) had not yet received any matching grants at the point of this study despite very high enrolment rates.

The following table illustrates the great potential by CHF for generating funds for improving district health services in addition to the yearly health basket allocations. Pre-conditions are systematic enrolment and routine matching grant applications, which again requires a structural reform in the organisation of CHFs, with a functioning management information system and more human resources in the form of dedicated full time staff.

The table illustrates both the actual situation of CHF funds, and projects a future situation, which obviously would be very ambitious. In the first case CHF funds, both from enrolled members and from the matching grant allocation, are calculated for their estimated yearly average (because time periods of collections and matching grants requests are not applied on a yearly base). This average estimated yearly income for CHF is then expressed as a percentage of the basket fund allocation in the respective district.
Results show that in the present situation the CHF funds have considerably less weight for district health funding than the basket fund, in most cases remaining at around or below 20%.

In a projection where enrolment of 50% of the population would be reached, at given enrolment prices, the weight of CHF funds could significantly be increased and could reach a value of between 20% and 80% of the health basket funds.

**Table 4:** Weight of actual and potentially increased CHF funds compared to current health basket

| Estimated current and potential CHF funds as % of current Health Basket allocation |
|---------------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Percent                        | Estimated yearly average % of CHF funds / current Health Basket | Potential % of CHF funds / current Health Basket at 50% CHF HHs of total HHs |
| Paired, Tanga                  | Lushoto, Tanganyi   | Rombo, Kilimanjaro  | Iringa, Singida     | Kahama, Shinyanga   | Lwandle, Lindi      | Mwagwawa, Dodoma   | Chamwino, Dodoma   |
| 0%                             | 20%                 | 40%                 | 60%                 | 80%                 | 100%                | 120%                | 140%                |

Please note that Bariadi, Kilwa and Kyela were excluded from this analysis as they did not report the receipt of any matching grants.

**Pro-poor enrolment**

In almost all of the districts surveyed, there were funds for pro poor enrolment foreseen in the CCHP at district level, but these were rarely accessed. This is due to the difficult process of identifying the "poor" at local level and submitting a request for the funds to pay for the enrolment premiums from the district. The classic "exemption" procedure was quoted to function on a person-by-person, illness-by illness basis with a letter of exemption being issued on written request of the local authorities by the office of the DED.

Some districts had success in engaging NGOs (or other institutions including the NHIF) to pay for the enrolment of orphaned or poor children. These initiatives rarely proved to be sustainable and were of short-term benefit.
4 Conclusions, Recommendations and Discussion

4.1 Conclusions and recommendations

The study team, based on the results of the literature review and the surveys of selected districts, concludes that within the present CHF set-up some impressive increase of enrolment may be realized.

Preconditions, however, seem to be:

- The active engagement of the structures of Local Government Authorities for awareness raising and enrolment. If the overall district health and local government structures within which the scheme is operating are functioning well and impressive effort for mobilisation can be mobilized.

- active engagement of health and generally local government authorities also is a prerequisite for improving the quality of health services being offered to CHF members and the served communities.

- However, this needs to go along with a focus on ensuring a continuous and adequate supply of needed medicines and supplies at all health facilities. This is the single most important factor for improving the quality of services being offered at health facilities, making it more attractive to become a CHF member.

The study has revealed a number of promising approaches for addressing principle problems areas of Community Health Funds. However, all the positive achievements seem to remain rather fragile and short lived, depending on the personal motivation and engagement of key persons (DMO, CHF coordinator), as long as two structural problems are not addressed. As there is no solid organisational system specifically for CHF administration is put in place, but rather the management of CHFs is done as a “side-job” of health care providers, the personal engagement of these individuals are hampered by:

- the lack of a supportive Management Information System, and

- the lack of specialized, dedicated full-time staff working on the CHF issues.

All other problems so frequently observed in studies in Tanzania are the consequence of these shortcomings of not having a professionalized structure with professionalized information management and skilled staff at hand. The non-ability to monitor and pro-actively manage re-enrollments of members, the difficulty and partly inability to apply for matching grants from the central government, the lack of provisions against adverse selection, the non-existing overview on fund balances available for individual health facilities, the non-existing overview on the degree of cost-recovery achieved by the CHF schemes, they all are a consequence of a weak and fragile organisational structure without own fully dedicated professional staff, and without a functional management information system. It becomes obvious that focus needs to be placed on a more systematic approach to enrolment and CHF membership management.

That said, it should also be clear that it is the will and ambition of the individuals and decision-making bodies within the district health care structures which are the deciding factors. Without will and the capacity, the largest amount of money will not help solve the problems.

The capacity and appropriateness of the in-charges of health facilities to manage this process at community level is extremely limited. Indeed, the CHF scheme has traditionally been the responsibility of the district health services and where the scheme in this
framework succeeds the most is in the effective use of the health structures for improving the supply-side provision of health services.

Where these structures fare much less favourably is on the demand-side of the scheme: social marketing, efficient enrolment and renewals management, financial control of enrolment premiums, and establishment of routinely successful matching grant applications. This is not very surprising when one considers that these are not classic duties for mostly medically trained personnel and decision-makers.

Apart from organisational weaknesses, which lead to a loss of potential income due to weak enrolment successes in the less well performing districts, the present structure therefore results in a second shortcoming. Even if the organisational management issues would be strengthened with deploying more full-time staff to the CHF structure and developing a management information system for them, the model of the health care providers operating a prepayment scheme themselves has a decisive shortcoming.

Without the classical purchaser-provider split the system has only very limited potentials for building up “voice” mechanisms for the population / clients towards the health care providers. Complaints of dissatisfaction with the quality of services offered in the present set-up cannot effectively be raised. A classical health insurance scheme would demand such quality on behalf of their members, and would be in a position even to negotiate quality improvement measures, if the membership base is large enough. In the present set-up, the DMO, however, represents both the insured clients, who would demand better quality services (e.g. regular drug availability), and at the same time would be the responsible person for exactly providing this quality, in the government facilities. This would put him / her in a dual position of representing both interests, and obviously would leave him / her in a position of conflict of interest.

The same is true for the Council Health Service Boards (CHSB), who oversee the CHF schemes. As their prime interest, however, is to oversee the quality of health services within their council area, they are put in the same position of conflict of interest. For instance, if the option of raising the enrolment premiums are discussed in the CHSB, the board cannot easily take the perspective of an insurance board fighting for the interests of the insured members (affordable fees, and rather voicing demands on increase of quality to the DMO), but would be in a position to also advocate for a raise of fees for improving the health service quality, even if this is conflicting with the interest of the CHF members.

In the conclusion of the study team therefore the deeper structural problems hindering the CHF schemes to capitalize on their strengths and become fully successful needs to be addressed. A professionalized structure, with dedicated full-time staff, supported by an adequate management insurance system, and organised in provider-purchaser split independent from the District Medical Office, seems to be a way forward. Then the innovative approaches described in this study can be taken up and more fully implemented within a strengthened organisational structure.

The SDC supported HPSS project presently follows such an approach in Dodoma Region, strengthening in a systems approach the CHF within the overall health system. The approach in Dodoma is based strongly on the creation of an independent CHF office, managed by the districts, and supported by NHIF. Experiences on this way of professionalizing CHF structures should be shared among stakeholders, and learning from successful cases in the districts described in this study should be incorporated in such efforts.
4.2 Discussion: next steps and open questions

The feasibility and scalability of this separation of the supply-side from the demand-side of the health care provision needs to be explored through operational research. Further, there has been an observed lack of evidence to establish the cost-effectiveness of the CHF schemes to generate additional funds for improving the quality and accessibility of health care services. A study to determine the cost-effectiveness of the current (supply-side) and proposed (demand-side) CHF membership management should be conducted to inform the debate as to the utility of the CHF schemes to generate additional funds.

A further issue which should be explored is whether the trade-off between CHF enrolment fees plus matching grants against user fees results in a net positive balance of funds. This of course will also depend on the degree to which pro-poor funds may be provided by local government (at village and/or district level), to which degree a re-allocation of existing supply-side funding through government budgets to a demand-side funding by paying CHF membership cards (e.g. for exempted population categories) may be implemented by the local governments. It is clear that with the present level of premiums of TZS 5000/= to 10000/= per year for a whole family for all inclusive services at primary level full cost recovery would not be a realistic objective. As in the present system, CHFs will have to continue to be a cost-sharing mechanism, where the government health budgets play a more decisive role, until such a re-orientation to partial demand-side financing would be taken up by the local governments.
5 References:


14 LATERVEER, L., M. MUNGA, AND P. SCHWERZEL. 2004. Equity implications of health sector user fees in Tanzania - Do we retain the user fee or do we set the user f(r)ee? Analysis of Literature and Stakeholder Views. Leusden: ETC Crystal.


References: 18