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## Development of the Tanzania Health Financing Strategy

### Options paper nr. 6

## REFORM OPTIONS FOR THE CHF SYSTEMS

### Final Report

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## Abbreviations

CBHI	Community Based Health Insurance
CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
CHIF	Community Health Insurance Fund
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CIDR	Centre International de Developpement et de Recherche (France)
DMO	District medical officer
HFGC	Health facility governing committee
HSSP	Health Sector Support Program (Swiss)
ICT	Information and communication technology
ISC	Inter ministerial Steering Committee
LGA	Local Government Authority
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (a Primary Health Care Investment Program)
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
NHIF	National Health Insurance Fund
NHSSP	National Health Sector Strategic Plan
PMORALG	Prime Minister's Office for Regional and Local Government
SHIB	Social Health Insurance Benefit
SSRA	Social Security Regulatory Authority
TIKA	Tiba kwa Kadi (CHF in Urban Councils)
TOR	Terms of reference
VEO	Village Executive Officer

## Executive Summary

### Background and objective

The government is developing a new National Health Financing Strategy to address limitations in the financing of the health system. The process will be informed by nine options papers in key reform areas. The objective of the present paper is to develop 3-5 options for comprehensive, adequate and feasible reform of the Community Health Fund (CHF).

### Presentation of options

Taking point of departure in current challenges with CHF and existing experience from variations in implementation in Tanzania and abroad, five options for development of CHF are presented. The key strategic decisions relate to increasing the risk pools and further development of a purchaser-provider split. The five options could be regarded as a possible stepwise approach, choosing two to three steps to a national system, which may even in the end include one single risk pool not just for the informal sector, but for all Tanzanians.

In **Option 1 – From passive to active enrolment** the present „Cost sharing“ model will continue with minor amendments. The point of enrolment will change from the health facility to the community level and membership will be portable across all accredited facilities within a district. Contributions may increase to allow for increased demand for services and inclusion of inpatient services at the level of district hospital upon referral from the primary care level within a strictly enforced referral system. The management of CHF would clearly lie under PMORALG and NHIF would have only a minor role in providing technical assistance upon request.

**Option 2 - Moving towards insurance**, on top of the shift from passive to active enrolment, introduces a purchaser provider split as the administration of the CHF/TIKA is undertaken by a CHF Office separated from the District Health Office and overseen by an independent CHF Board. Under this option the CHF Office will reimburse health facilities for services to members, so payment will be linked to demand. The CHF Board will enter into service agreement with relevant public and private providers based on rates, quality of services and accessibility for members. The LGA will only have minimal direct involvement in the management of CHF. Technical support will be provided by NHIF.

In **Option 3 - Expanding risk sharing** the focus is on moving the risk sharing beyond the district. A risk equalisation mechanism is introduced in which fund transfers (e.g. matching grants) are adjusted for *expected* differences in CHF expenditures due to different distribution of members along risk factors (demographic, socio-economic and epidemiological). Benefit packages and contribution rates will have to be harmonised between the risk sharing districts - initially at regional level. Risk factors for which information is available can only predict some amount of variation in health expenditures. Therefore a reinsurance function may be introduced to cope with random variation resulting in abnormal *actual* expenditures. These functions are administratively complex and would lie with NHIF.

In **Option 4 - Establishing a regional CHF** the purchaser functions of a regional CHF will be clearly split from the provider functions of the district health services. The point of enrolment will be at the community level, but the risk pooling will be at regional level governed by an independent Regional CHF Board. The package of health services may include referrals for inpatient care as well as more elaborate diagnostic

services at the regional referral hospital and membership is portable within the regional health system. This option is more practical for a big city like Dar es Salaam in which people continuously cross district boundaries as they live, work and do business. The Regional CHF office might function jointly with the regional NHIF structures.

In **Option 5 - Bringing all together** the CHF is operating as a national scheme (one single CHF- risk pool) providing coverage for the informal sector. The community base is maintained in the sense that the point of enrolment will be at the community level, and there is a district level CHF coordinator, possibly joint with NSSF and NHIF at a 'district health insurance office'. The benefits will be portable across Tanzania, but the package is (initially) more restricted for CHF members than for NSSF and NHIF members as CHF contribution rates are relatively low. Some cross-subsidization from NHIF/NSSF members will, however, allow for gradual improvement of the package. Office administration will be shared with NHIF.

Option 1 to 5 is increasingly complex to implement. It is estimated that Option 1 can be implemented in the short term, option 2 in the short to medium term, option 3 and 4 in the medium term, and option 5 in the long term.

### **Cross – cutting issues**

Voluntary membership creates problems with adverse selection into CHF, i.e. only those in high risk of needing services enroll. To achieve universal coverage through a CHF system mandatory membership should be pursued – initially as a moral obligation and later more strictly enforced.

Some degree of voluntary enrolment will continue for some time. Group enrolment (e.g. household) helps reduce adverse selection and should be encouraged. In urban areas identification of households may be difficult and individual membership could be considered. It could be considered to set the premium at a pro-person contribution rate with rebates for group enrolment.

As contribution rates increase to allow inclusion of more services in the benefit package, contribution rates would still be affordable to most people; but unaffordable to some. Achievement of universal health coverage (and enforcement of mandatory membership) would require that a mechanism for inclusion of the poor be in place.

Enrolment and acceptance of higher contribution rates is linked to expectations regarding access to quality health services. Shift to a more demand-side oriented financing in which funds follow the patient (more or less strongly through reimbursement by capitation, fee for service or a mixed system) and allowing patients to choose between health facilities ('voting by feet') will stimulate the provision of best possible quality services. To further stimulate this at local level it should be considered to allow more flexibility in the use of funds at facility level. A uniform reimbursement system across funding sources would ensure a harmonized approach to patients irrespective of membership status and ease the administrative burden on the staff.

Defining the benefit package that members are entitled to is one side; the functional accessibility to that benefit package is another. In a rural environments service availability is often a major challenge; in urban areas facilities are often already over-crowded. Expansion of services is crucial for the ability of the health system to meet expectations regarding availability of quality health services. To a large extent this is a function that goes beyond the CHF as purchaser of health services and requires commitment by the

government to provide the needed resources and to focus on using resources more efficiently for improvements in quality service delivery.

### Effects on overall health care financing objectives

The Table below summarises the authors' assessment of the likely effects on overall health care financing objectives of adopting each option.

**Table 9: Summary assessment of effects on overall financing objectives.**

	Resource mobilisation	Financial protection	Efficiency	Access & quality	Equity
<b>Option 1: From passive to active enrolment, expanding the package</b>	++	+ (members)	0 (+)	0 (+)	+
<b>Option 2: Introducing purchaser-provider split</b>	+++	+ (members)	+	+	+
<b>Option 3: Expanding risk sharing</b>	+++	++ (members)	+	+	++
<b>Option 4: Insurance for regional health services</b>	++++	+++ (members)	++	++	++
<b>Option 5: Bringing all together in a national pool</b>	++++	+++ (members)	++	++?	+++

Note: 0 – no effect; + indicate a positive effect; number of +'s indicate relative magnitude of effect.

It is important to emphasize that unless membership is subsidized for the poor, then the financial protection through CHF/TIKA is likely to decrease for the poor as contribution rates increase and user fees most likely also increase. This effect is lowest for option 1 and highest for option 5 as more services are included in the benefit package and contribution rates are correspondingly higher.

### Strengths, weaknesses, opportunities and threats<sup>1</sup>

A general strength for the development of any of the CHF reform options is that CHF is embedded in a functioning decentralized governance structure and tradition which provides a solid basis for development of CHF reforms. With increasing 'centralisation' of the management through option 1 to 5, it will be a challenge to maintain the local base, but it is suggested to do so through continued close-to-client responsibilities in relation to enrolment. The reforms also rely on local civil society engagement through the Health Facility Governing Committees and the Council Health Services Board in the general improvement of health services and response to client needs.

<sup>1</sup> Overview of the main specific strengths, weaknesses, opportunities and threats for each option is presented in Table 10 p.52.

General weaknesses that cuts across all options is the voluntary nature of the scheme and the fact that the scheme in itself does not provide financial protection for the poor. These weaknesses can be addressed by introducing (morally) mandatory membership and subsidization mechanisms for the poor.

General external opportunities include the recent decision to establish bank accounts for health facilities, thereby placing more (visible) management authority at the health facility level, which may also open for harmonization of the way funds generated at facility level (user fees, NHIF reimbursements, CHF funding) is treated. The fact that the NHIF has already been operating for a number of years and has contributed to public awareness, development of structures and mechanisms for provider payment and an organizational set up, may also be perceived as a general advantage that can be built on. Also a number of on-going pilot interventions are contributing to the experience.

General threats to any of the options are that sufficient funding for matching grants, for enrolment of the poor and for increased service delivery cost cannot be mobilised. This could result in deterioration in quality of services and lack of financial protection of the poor, as well as decreasing interest in enrolment. Focus in general on fraud and cost containment in the use of public funds is very important, but could also result in very detailed documentation requirement and lengthy and (costly) procedures for disbursements, causing unpredictable delays, which may in the end make contracting with CHF and service provision to CHF members less attractive.

#### **Financial sustainability issues**

With increasing complexity also come increasing economic costs, although it is hard to assess the exact implications without much more detailed analysis. There is, however, likely to be economies of scale, e.g. instead of having all district CHF organisations negotiate a regional CHF organization may negotiate for all districts. Also efficiency gains on handling of claims and reimbursements and management of cost containment measures by a more professional administration may outweigh the additional costs of administration and may result in better services. Investment in the development of the organization is, however, needed before the benefits can be realized.

It should be emphasized that where scale up of community-based insurance has been relatively successful, it has been accompanied by increases in need for funding for service delivery. As the calculations suggest the total cost of providing comprehensive care for the whole targeted population outweighs the amount of total revenue contributed by all able to pay members. More subsidies will be needed from the government to cover premium contribution for the poor, matching funds and costs beyond what the total CHF revenue can cover.

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## 1. Introduction

For the past 20 years Tanzania has been making efforts to reform its health system financing structure for the purpose of increasing resources to the health sector and ensuring availability of needed health services to the wider population. In 1993, user fees were introduced to replace the free health care policy adopted immediately after independence. The introduction of user fees was a response to constraints in the ability of the government to generate enough revenue to fund free health care needs for the whole population. The introduction of user fees was followed by the establishment of prepayment schemes, starting with the Community Health Fund (CHF), formally enacted in 2001 (piloted in 1997 in Igunga district) and the National Health Insurance Fund (NHIF) in 1999. Most recently, the Social Health Insurance Benefit (SHIB) package of the National Social Security Fund (although in principle introduced in 1997) has been operationalized. Despite these various initiatives, population coverage through prepayment schemes, however, remains low at about 15%.

At the same time Tanzania is committed to moving towards Universal Health Coverage, ensuring that all citizens have access to needed quality health services and are protected against financial risks as a result of paying for health care services. This commitment is stipulated in various policy documents including the National Health Policy (2007) and National Health Sector Strategic Plan (NHSSP III 2009-2015). In order to succeed in this, Tanzania is embarking on a new round of health sector reforms, among them being strengthening primary health care provision system through the MMAM (Mpango wa Maendeleo wa Afya ya Msingi) primary health care investment program, encouragement of public private partnership and increasing revenue available to public facilities through the opening of facility bank account.

Recently, the government through the Ministry of Health and Social Welfare (MOHSW) has launched another major reform of developing the National Health Financing Strategy to address limitations in the health system financing. The process of developing the National Health Financing Strategy is overseen by the Interministerial Steering Committee (ISC) bringing together a team from various Ministries. The ISC has identified a number of key reform areas (option papers) that need to be addressed to inform the development of the Health Financing Strategy. These are:

- 1) Minimum Benefit Package(s): options to sustainably structure access to benefits;
- 2) Insurance Market Structure: options for the Social and Private Health Insurance architecture;
- 3) Performance financing: options for linking allocations to performance of service providers;
- 4) Equity-based financing: options for improving the equity targeting of (esp. budget) resources;
- 5) Inclusion of poor & vulnerable: options for identification and financing of services for this group;
- 6) CHF reforms: options for the re-design of the CHF system;**
- 7) Private sector resources: options strengthening equitable funding from the private sector;
- 8) Financial management: options for improving accountability and timely availability of funds;
- 9) Innovative financing and fiscal space: options for increasing public financing for health;



This is the Report for the development of Options Paper number six focusing on CHF reform, cf. Terms of reference (TOR) in Annex 1. The team worked in Tanzania May 13-20 and June 14-24 and met with various stakeholders.

## 2. Objectives

The overall objective of the assignment is to develop comprehensive, adequate and feasible reform options for the Community Health Fund system that can feed into the process of development of the Health Financing Strategy for Tanzania Mainland.

The specific objectives for this Options Paper are

- to discuss CHF reform options with an emphasis on the CHF as a tool for achieving Universal Health Coverage
- to develop 3-5 options for future development of CHF including
  - o status quo with some improvements
  - o 2-4 specific options for implementation of CHF as an insurance model
- to analyse the advantages and disadvantages of the specific options as well as the risks and opportunities
- to present the options in a way that facilitates strategic decision-making

## 3. Methodology

The methodological approach included document review of experience from Tanzania as well as international experience with implementation of similar schemes and using such schemes for achieving universal health coverage.

Consultations in Tanzania included consultations with national level stakeholders at policy level as well as with health insurance schemes and regulatory authorities, key resource persons among development partners and researchers. Consultations at district and regional level included discussions with District Medical Officers (DMO), Council Health Services Board (CHSB), Health Facility Governing Committees (HFGC) and CHF managers. Consultations covered both non-pilot and pilot experiences with CHF.

Given the already pointed out potential overlap with a number of other option papers, the intention was as far as possible to link with these. It is, however, not straightforward as the development of the papers are taking place partly concurrently and partly asynchronous. Linkage was attempted through consultations with other teams and sharing of documents.

Since the options paper is intended to feed into the overall strategy development process, the team considers the presentation of the options in a format that is short and concise, but with sufficient information to distinguish between the options, to be an objective in itself. The team will attempt to convey the reform options and their pro's and con's in a non-technical easy to overview manner, which is general enough to allow for use in strategic decision-making, while yet being sufficiently specific to bring

out the differences. The focus will be less on identifying challenges, which has already been explored in a number of documents, and more on highlighting the choices.

## 4. Brief situation analysis

### 4.1. Objectives of health financing strategy and CHF

The CHF system and any options for reform should ultimately be assessed against how they contribute to the overall objectives that we want to achieve with the financing system and for the CHF in particular.

The Health Financing Strategy should help support the mission “ to provide basic health services in accordance with geographical conditions, which are of acceptable standards, affordable and sustainable” and “health services (that) will focus on those most at risk” (National Health Policy 2007).

Five objectives for health financing are listed in NHSSP III:

- Reduce the budget gap in the health sector by mobilising adequate and sustainable financial resources
- Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015
- Improve equity of access to health services
- Improve management of complementary funds raised at local level
- Increase efficiency and effectiveness in use of financial resources

The CHF reform options should hence be evaluated on the overall contribution to resource mobilisation, equitability, financial protection as well as efficiency in resource use. It is noted that the fourth objective is particularly concerned with management of complementary funds at local level , which includes user fees and CHF contributions.

The objectives of CHF as stipulated in the CHF Act are:

*(a) to mobilize financial resources from the community for the Fund provision of health care services to its members*

*(b) to provide quality and affordable health care services through a sustainable financial mechanism*

*(c) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health.*

These objectives address the overall objectives of financial protection, resource mobilization and efficiency; the latter assuming that service management at local level taking local needs into consideration will improve efficient use of resources. However, in practice, CHF hand in hand with the user fees seems mainly to have been perceived as a tool for resource mobilization.

## **4.2. The current CHF system**

The Community Health Fund (CHF) was formally introduced in 2001 under the CHF Act no. 1 of 2001. A number of studies have been conducted to explore the design and the performance of CHF [1-5]: hence it is not the objective of this report to repeat what is already known to the wider audience. The sections below only highlight key design features of this scheme and some deviations across districts, followed by a brief description of what were observed to be the major challenges facing CHF, from previous studies. The presentation follows the financing functions framework.

### **4.2.1. Revenue collection**

#### **- Sources of funds**

The CHF is a voluntary contributory scheme targeting the informal sector in rural areas. Urban councils are also supposed to introduce Tiba kwa Kadi (TIKA) scheme which is a similar scheme to CHF but with somehow a different design. Until the time of this study, none of the urban councils had introduced TIKA. Urban councils that have community health scheme have adopted a CHF model. Only few councils (e.g. Kinondoni Municipal, Babati and Kibaha Town) are in the process of introducing TIKA. CHF/TIKA scheme is community owned and managed by the council authorities. The funding sources for the CHF/TIKA include member contributions, matching grants from MOHSW (financed through taxes or development assistance) and Council contributions, for example for enrolment of poor people.

#### **- Contribution mechanisms**

In CHF each household is supposed to contribute a flat rate premium amount, decided by the district management after consultation with the community, which gives them free access to health services for a period of one year. Most of the districts have set their contribution rates at Tsh 5000 per household per year, although a few of them have contributions amounting to between 10,000 and 30,000 per year. In Kyela district, under the CIDR (Centre International de Developpement et de Recherche) supported Community Health Insurance Fund (CHIF) scheme, membership to CHF is at individual level instead of household, and each individual is supposed to contribute 5000 TZS per year. In the urban-based TIKA, membership contribution is also at individual level.

Household contributions are matched by 100% contributions from the government (matching grant). Districts have access to the matching fund only after fulfilling certain criteria, among them proper membership records (documented through submission of the list of CHF members and deposit slips), by-laws, functioning CHF institutional arrangements and a minimum of 5 mill TZS [6].

Although none of the urban districts have introduced TIKA, the proposed design of this scheme is enrol members on individual basis instead of households. Each member in the household will need to contribute to this scheme before they can access services.

The following sections will mainly focus on the description of CHF which is currently implemented model.

#### **- Collecting organisations**

Facility in-charges are responsible to register members, collect premium and distribute membership cards, with both facility health workers and Health facility governing committee members being responsible for sensitization of the members. In few districts (e.g. the districts in Dodoma under the HSSP program and CHIF scheme in Kyela under support of CIDR)[7], a different approach is being tested by enrolling

individuals at the village level rather than at the facilities, as an initiative to encourage active as opposed to passive enrolment. In such districts, sensitization is considered to be the core role of the Ward Committee members. More recently, NHIF is increasingly taking up larger sensitization campaigns (e.g. mass media, group enrolment, organization of specific enrolment-days in the villages)with support from development partners (GIZ).

#### **4.2.2. Pooling of resources**

##### **- Coverage and composition of risk pools**

About 108 districts had introduced CHF by 2011 and the overall population coverage by 2011 was approximately 6.9% [8]. However, questions have been raised regarding the accuracy of the coverage figures; use of past population figures and incentives in the form of matching grants may both contribute to an upward bias in the reported coverage . All households that are found in Councils with by-laws and a functioning CHF have the choice to enrol with the CHF, but the main target group is the informal sector in rural areas. Most schemes use household enrolment, which reduces the risk of adverse selection compared to individual enrolment. In some districts like Iramba, as well as in Regions such as Tanga and Lindi, there have been initiatives to encourage group enrolment, in addition to households, in order to increase enrolment rate.

In some districts, those who are not able to pay are registered with the CHF through the support of either the NGOs (e.g. in Singida and Kyela-CHIF) or the district budget (e.g. Iramba)[7]. There are also other pilot initiatives to expand coverage for the poor, for example an initiatives of providing NHIF card for poor pregnant women and give their dependents CHF cards in Tanga and Mbeya region (supported by KfW).

##### **- Allocation mechanisms**

Each CHF constitutes a separate district risk pool and there is no reallocation mechanism between them. The matching grants from government are allocated based on total contributions collected; hence the allocation depends on level of contribution as well as number of contributors.

CHF contributions collected at the facilities are supposed to be pooled together at the district level and be deposited at the district CHF account. Sometimes, pools are even smaller since the collected funds in practice remain at the health facility level, and wider pooling as well as re-allocation is not conducted. Recently, there has been a call to reduce the number of accounts at the district level and some districts have already closed the CHF account, with the understanding that it is the Ministry of Finance directives. However, the matter remains unclear on whether the district CHF accounts are supposed to be closed and in which accounts the CHF funds should be deposited. Parallel to this, all health facilities are encouraged to open their bank accounts and it is an understanding that part of the revenue collected at the facility level, including CHF contributions, out-of-pocket payments and NHIF reimbursements will be deposited back to the facility bank accounts after submission to the district authority. Information from the districts, which has, however, not been confirmed with the Ministry of Finance and the MOHSW, indicates that about 30% of revenue collected at the health care facilities will be deposited back to facility bank accounts.

#### **4.2.3. Purchasing of services**

##### **- Benefit package**

According to CHF regulations, households are supposed to register with one primary health care facility from which they will be able to seek care at no additional cost for a period of one year. In this case, CHF

benefits are limited to outpatient care at primary public facilities. Nevertheless, some districts (e.g. Singida Rural, Mbulu , Kyela, Bumbuli and Iramba)[3, 7] have introduced referral benefit packages by signing a service agreement contract with faith based providers and regional hospitals that allows CHF members to have access to inpatient care at contracted facilities, after getting referral letter from the facilities where they are registered. In Singida rural district, access to referral services has a ceiling of 15,000 TZS per visit (Communication with CHF coordinator). In Dodoma region under HSSP (Health Sector Support Program) and other districts like Iramba, Rombo, etc , the CHF card is portable within the district allowing members to use any public health care provider within their registration districts [7]. In Kyela district, transport for referral services is included in the package as the scheme purchased an ambulance to cater for their members [7].

#### - **Provider payment mechanisms**

Under the original CHF design, there was no clear guidance of health care provider payment mechanism. The district authority has the mandate to allocated CHF funds to purchase drugs and supplies after the approval by the CHSBs, and the national level through statements and directives is increasingly advocating for using the major part of CHF funds collected for the purchase of complementary medicines. Such budget allocations were not necessarily linked to activity levels of the individual facility; facilities that provide services do not get reimbursements for the services they provide. It is expected that under the new arrangements whereby facilities are supposed to open bank accounts and deposit parts of revenues to this account, facilities will have access to the use of CHF contributions. If CHF funds is still predominantly to be used for purchase of medicine, then facilities may have to be given authority to do so, or an allocation mechanism may need to be developed.

A special prospective payment arrangement is in place for the districts that have entered into service agreements (e.g. Singida Rural) with faith based providers. Funds are advanced to such providers, who provide services using the advanced funds up to a certain level before they request additional money. The billing is sometimes determined by the number of patients or activities. In such cases the provider payment is to some extent linked to activity level. However, there are no clear criteria on deciding the amount of fund to advance to the contracted facilities.

#### **4.2.4. Organisational and regulatory framework**

Detailed analyses of the organizational and legal structure of the CHF among other health insurance schemes in Tanzania have been conducted in previous studies[6, 9]. In summary, CHF implementation is guided by overall policies and strategies, i.e. the National Health Policy and the Health Sector Strategic Plans (presently NHSSP III) and is legally regulated through the CHF Act and corresponding CHF Guidelines and Operational Manuals. At Council level the CHF is further regulated by Council by-laws. This results in differences in the design of CHF across districts, e.g. differences in contribution rates.

An accountability structure consisting of Health Facility Governing Committees, Ward Health Committee and Council Health Services Boards (CHSB) was set up in relation to the development of CHF. The CHSB is tasked to monitor CHF operations, mobilise and administrate funds, set exemption criteria and promote the CHF to community level. MOHSW in principle oversees CHF, but CHF is also governed by PMORALG , since the CHSB which is the governing body of the CHF is a unit under the Council.

The MOHSW has delegated the responsibility for the CHF Administration, including the administration of the matching grants, to the NHIF through a Memorandum of Understanding in 2009, which however expired at the end of 2012. The cost of administration, coordination and technical assistance to CHFs was assumed to be covered within the 12% administrations costs of NHIF. The NHIF developed a CHF Action Plan including activities in relation to review of the CHF benefit package, registration and collection mechanisms, information systems, promotion of membership and risk equalisation and reinsurance mechanisms. Late approval and lack of funding however delayed implementation. Progress in these areas is yet to be reported.

Under the original design of the CHF the district authority was both the provider of health services and at the same time the CHF contribution pooling organization, hence the purchaser. This limits an active purchasing function with critical demands to the provider side. Some pilot districts that are supported by the SDC under the HSSP in Dodoma and those supported by the CIDR (e.g. Kyela) have decided to introduce a purchaser-provider split. In Kyela district, the CHIF prepares a budget and submit to the district, then the district allocates CHF funds to the CHIF which will be responsible for reimbursing the facilities for the services provided to CHIF members. Under the HSSP initiative, a plan has also been put in place to allow facility reimbursement under the fee for service arrangements. A separate CHF board has been established in the HSSP supported districts. The CHF Boards which will be responsible for all CHF funds as opposed to CHSB whose main task in this new design will be to oversee service provision.

The Social Security Regulatory Authority (SSRA) is concerned with the external accountability of insurance schemes, requiring reports on how the financial resources are used, how benefit packages are defined and whether operations have been in line with regulations. SSRA does not have direct role vis-a-vis CHF at the moment.

### **4.3. Challenges in design and implementation of CHF**

Most of the challenges affecting the implementation of CHF have been documented in the previous studies [1-5]. A major concern has been the low level of enrolment and non-renewal of membership even in districts that has a long history of CHF [3]. The enrolment rate and non-renewal of membership has in many cases been attributed to the limited benefit package of CHF and poor quality of service in accredited facilities, mainly public primary health care facilities.

Including the poor in the CHF is another challenge. Normally districts through community leaders are supposed to identify the poor and the district management is supposed to budget for funds to enrol them in the CHF [3, 7]. However, in many cases districts don't identify the poor and only few districts allocate funds to enrol them in CHF. This challenge is related to another problem of limited cross-subsidization between the ill and healthy individuals and households. Mostly this is attributed to the current design of CHF whereby enrolment is voluntary and mainly at health facility level. In this situation, mainly those who are sick will enrol (passive enrolment) while the healthy individuals who do not visit health facilities frequently have limited motivation to enrol.

CHF management has been noted to be among the challenges facing the scheme. Currently there is no purchaser-provider split in the operation of the CHF. In this case, health providers who are supposed to provide services to the members are also taking the role of managing CHF. For example, facility staffs are

supposed to sensitize patients to enrol with CHF and the facility in-charges are responsible for collecting premiums and submitting to the district authorities. One major question raised in the reviewed articles is whether the health facility staffs have enough time to handle patients and at the same time supervise collection of CHF premiums [3].

Other challenges that have been previously highlighted include limited awareness of the scheme to the wider community, sustainability of the scheme, and non utilization of CHF revenue for service improvement [1-5, 7].

## **5. International experiences**

Community-based health insurance (CBHI) schemes vary considerably in the design of the different financing functions. A cautious approach to generalization across CBHI schemes should be taken due to the large variations. Common characteristics of CBHI include the voluntary non-profit nature of the scheme, targeting primarily rural and informal sector population, building on values of solidarity or mutual aid, pooling of health risks and the involvement of the community in the management of the scheme. Challenges to CBHI internationally are much the same as in Tanzania. General problems faced across CBHIs include

- Limited population coverage
- Limited potential for revenue generation due to low coverage and low ability to pay
- Limited risk sharing due to adverse selection
- Inequities due to problems with inclusion of the poor and regressivity of flat contribution rates
- Limited financial protection as benefit packages are limited to lowest level of care and hence provide limited financial protection for expenditures for hospital services

The remainder of this Chapter will briefly highlight the evidence and international experience with different designs of the financing functions in relation to CBHI and the experience at system level with using CBHI as a stepping stone to Universal Health Coverage.

### **5.1. Financing functions in CBHI**

#### **5.1.1. Revenue collection**

##### **Sources of funds**

The revenue generation potential of CBHI schemes is generally found to be limited and insurance premiums considerably below the actuarially fair premium is needed for membership to be affordable to the target population (e.g. (10). Even low contribution rates are unaffordable to the poorest and government (central or local) funds or charity funds are used to subsidize the enrolment of the poor or vulnerable groups (11). CBHI schemes generally do not target payment of the full cost, but rather is intended as a risk sharing mechanism for the financial burden of user fees, which mostly cover only some operational expenditures such as supplies and medicine and sometimes cover most of the operational expenditures, but rarely all.

### **Contribution mechanisms**

Some studies have found that non-affordability is a lesser problem than liquidity constraints<sup>2</sup> (12); one study reported that deferment of payment to an agricultural micro insurance scheme until the harvest season increased coverage by 11 % points (13). Similarly, rigidities in payment modalities were a greater barrier to enrolment than the premium per se in Burkina Faso (14). Other operational difficulties perceived as inconvenient, e.g. delay in issuing cards, also appears to hamper enrolment (15).

There are examples of initiatives to use information and mobile technology to collect contributions, e.g. M-Pesa mobile payment system (e.g. Kenya's National Hospital Insurance Fund, PhilHealth) for premium collection. These are however yet to be evaluated.

Most schemes use flat rate contributions in the informal sector, which tend to be regressive, since they proportional to income burden the poorer household more than the rich. In few cases sliding scales have been adopted, whereby those of higher economic status pay more than those of lower economic status. In practice, it however often turns out to be difficult to classify households accurately into socio-economic groups. In Ghana the premiums for the informal sector in principle follow a sliding scale depending on income, with the poorest group paying a premium of GH¢7.20 and the richest paying a premium of GH¢48.00. However, in reality, most people are charged a premium GH¢ 7.20 per annum due to the difficulty of categorising people into socio-economic groups (29). Experience from Bangladesh also suggest that a sliding-scale co-payment system that is not well aligned with differences in socio-economic status may also lead to poor enrolment rates (30). Some schemes have exemption mechanisms for the poor (implying that the contribution of other members are used for cross-subsidisation of the poor) or a system through which membership of the poor or specific vulnerable groups (e.g. HIV positives in Ghana) are subsidized through the government, NGO or development assistance. In practice, this also presents a challenge in terms of identifying the poor (This is a theme in Option Paper 5).

### **Collecting organisations**

One type of scheme is developed by the health care provider and with the health care provider having the responsibility for collecting the premium. Sometimes the schemes are developed as semi-autonomous schemes, e.g. Ghana's District Mutual Health Insurance Schemes, with separate structures being responsible for enrolment and collection of contributions. Other types of schemes, such as the MHOs in the francophone countries tend to be independent community owned schemes. Such schemes may rely on community level enrolment officers (active) or central enrolment (passive). Schemes that has a decentralized structure for enrolment tend to have higher enrolment rates, e.g. in Nicaragua a change from enrolment at the insurer's office (requiring the client to forgo a day's work) to allow decentralized agents (market vendors) to do the enrolment resulted in a 30%-point increase in enrolment rate (16).

### **Lessons**

- It is difficult to find functional schemes that do not rely on subsidies.
- The demand for CBHI depends on inconveniences and side costs of enrolment and payment of contribution. It should be easy to pay and to do so, at times when liquidity is not constrained.

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<sup>2</sup> Obviously the issue of affordability will depend on the contribution rates relative to household income in different settings.



## 5.1.2. Pooling of resources

### Pooling

Both from an equity and efficiency (administration) point of view it is desirable to minimise the number of funding pools and especially to avoid small pools. There is international consensus that it is critical to minimise fragmentation of funding pools to achieve universal coverage and equity (17).

Small pools cannot spread risks very widely and will have difficulties handling large health care costs (18). The optimal size of the risk pool therefore also to some extent depends on which benefit package is of interest. Smaller risk pools may be adequate for covering routine care and common diseases ; usually the type of services provided at the lowest level of the health system. Larger pools will be required if the benefit package is to include less common, more expensive services, and to avoid any 'hard budget constraint' imposed by rare random events (19).

The problem with CBHI is that it is often difficult to enrol large parts of the target population, which automatically limits the risk pooling function (20). The problem is even larger when membership is voluntary, thereby increasing the risk of adverse selection, whereby those who enrol are mainly those who expect to need services (the sick), which defeats the purpose of cross-subsidisation from the healthy to the poor.

In order to reduce adverse selection most schemes enroll groups of people, with the household as the minimum, such that although there may be one person in the household that is in poor health, at least there are other healthy members. Group enrolment may also include larger groups. In the Philippines for example, incentives are provided for microfinance groups or community groups to enroll their populations. In Uganda group –based enrolment was used with a minimum requirement of 60% of group to be enrolled (to avoid adverse selection) (21). The most common and easiest measure to implement is the introduction of a waiting period before benefits can be enjoyed (Allegri et al. 2009). The risk of adverse selection can also be reduced by keeping premium low through subsidisation of the cost of service delivery (22). Finally, adverse selection can be reduced, or in case of successful enforcement even avoided, by stipulating mandatory enrolment while at the same time ensuring that the poor are subsidised. In Ghana, membership of health insurance is mandatory, but a ten year grace period has been given before enforcement will start.

For sustainability reasons schemes may also want to restrict adverse selection and enrolment by high risk individuals through risk selection. Risk selection may occur as direct exclusion of certain high risk groups (e.g. HIV positives), or more indirectly through campaigns that disregards high risk groups etc. Fragmentation of funding pools is often inequitable, e.g. when membership is related to occupation (formal sector vs. informal sector), or when membership is related to geographical areas with very different economic development.

Risk equalization aims to adjust for the differences in risks in different schemes *ex-ante* and corrects for the average differences in *expected expenditures*<sup>3</sup>. For insurance schemes this will reduce the incentives to do

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<sup>3</sup> Risk equalization is based on a calculation of the average cost per capita by risk group of a standardized minimum benefit package (plus administrative costs), the risk group specific average cost per capita. For a given scheme with its

risk selection, and for geographically based schemes with very different risk profiles among members it will result in cross-subsidisation from schemes with few high risk members to schemes with many high risk members. The mechanism aims to transfer funds from schemes with lower than expected costs to schemes with higher than expected costs; or to adjust centrally allocated per capita funds to district mutual health insurance schemes for differences in risk profiles (thereby avoiding that one scheme pay directly to another scheme). This was the intention in Ghana, but so far this has however been limited to adjustment for demographic risk factors such as age and sex. Risk equalisation frameworks that effectively adjust for differences in risk factors is information intensive and costly.

Even if risk equalization has adjusted for differences in average expected cost for given mix of members by risk group, some risks remain. Risk equalization does not provide protection against *ex post random variation* in cost. An abnormally high utilization in a given year, due to an epidemic, draught etc., or occurrence of rare diseases that are very costly to treat, could threaten the sustainability of a small scheme. The scheme could hold its own contingency reserves to be used in such a situation, or individual schemes could enter into a reinsurance contract which protects from insolvency in case of abnormal fluctuations in health expenditures. Reinsurance pass on of a defined level of risk by an insurance scheme to a third party, for example a central fund. If health expenditures in a year exceeds the expected average expenditures to a certain extent, then reinsurance can be claimed. The insurance scheme would document the abnormal health expenditures with clear relation to a difference from normal in health expenditure risk distribution (and not for example with relation to inefficiencies in management). Lessons from Ghana emphasize the need to set actuarially fair premiums also for reinsurance, as the NHIF experienced cash flow problems due to high demands from 'distressed' schemes (Witter & Barshong 2009).

### **Fund management**

There is likely to be trade-off between pool size and complexity of the managerial, purchasing, governance and stewardship functions. Equity gains must be traded off against efficiency losses. (19)

#### **5.1.3. Purchasing of services**

##### **Benefit package**

Due to the typical small size of CBHI the benefit package is usually limited to basic services, at most up to the level of the district hospital. In Ghana, since community health schemes have been integrated into the NHIS, members of community health schemes have access to an expanded benefit package and they are allowed to access services from any accredited provider of their choice. A recent review found that effective financial protection requires that benefits are closely linked to population needs (23); for example an insurance scheme in China focusing on inpatient services, did not provide protection against catastrophic expenditures for the many members with chronic diseases requiring continuous treatment at lower level. Findings from Burkina Faso suggests that a comprehensive benefit package is most effective in providing financial protection in a community based financing scheme (24).

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mix of risk groups the expected cost for the minimum benefit package can be calculated. The equalization amount can then be calculated as the difference between the expected cost of providing the minimum benefit package cost and the expected income from premiums. Negative amounts means that the scheme has to transfer payment, positive amounts that it should receive an equalization grant.

### **Provider payment mechanisms**

Provider payment mechanisms can influence provider behavior. Active purchasing of benefits/services that meet the needs of members and choice of payment mechanisms is important for efficient provision of quality services. Basically three types of payment methods exist with some variations and in combinations. These are fee-for-service, capitation and salary (or budget at facility level). Variations in which these types are combined exist, e.g. salary with bonus payment, which may be linked to services (no. of vaccinations) or outputs (vaccination coverage).

A recent review (20) identifies an information gap as regards provider payment mechanisms and CBHI. Most schemes rely on a mix of payment mechanisms, but there is limited evidence for effects of various PPMs in developing countries and in relation to CBHI in particular.

Available studies suggest (cf. (20)) that quantity of services is higher when FFS is applied, and that over prescription and excessive use of injections and intravenous drugs occur where there is no separation between prescribing and dispensing functions. FFS may represent a threat to sustainability in any scheme. Another cautious conclusion (Robyn et al 2013) is that there is some evidence that capitation to facility as well as salary combined with a bonus may lead to efficiency gains and contribute to sustainability while still stimulating activities. Especially, if budget management is decentralized to the health facility level.

Provider satisfaction with PPM seems to have the potential to influence their support to the scheme and active promotion for enrolment. This means that it is important to involve providers in the design of PPM as it has a direct impact on participation and buy-in of local health workers (example of negative effects from Burkina and Guinea ) (20, 25).

Apart from PPM prospective versus retrospective payment may influence providers' ability and willingness to participate. Prospective payment (advance funding) have been especially important for including and maintaining faith-based health facilities as service provider to members, e.g. Malawi, Ghana.

## **5.2. System level: From CBHI to universal health coverage**

There is international consensus that in order to achieve universal health coverage it is critical to minimise fragmentation of funding pools and that it is necessary to integrate funding pools to allow for cross-subsidisation from the healthy to the sick and from the rich to the poor (17,18). CBHI has been introduced as an alternative to cover poor people in the informal sector. Since evidence indicates that CBHI schemes can increase access to health care for low-income rural and informal sector workers, it has been promoted as an alternative to waiting for „ top down tax-based financing or SHI development“ (26).

A few developing countries (e.g. Ghana, Rwanda, Vietnam, Mali) used CBHI as a stepping stone to universal health coverage by building on CBHI when introducing mandatory national health insurance. Coverage expansion is, however, increasingly relying on tax revenues (or donors) for substantial subsidies to specific target populations (Ghana, India, Indonesia, Philippines, and Vietnam). Some countries (Kenya, Philippines, Nigeria, Rwanda, and Ghana) continue to attempt to collect voluntary premiums from households, despite the difficulties in collection and limitations in the revenue generated (e.g. 11,25).

As outlined by Wang & Pielemeier (26) three steps can be identified in low income countries, starting from a basic model, to an enhanced model and finally a nationwide model, while at each step adopting measures

to address the limitations and to improve CBHI in terms of effectiveness, efficiency and sustainability. Such a stepwise approach builds on local community social capital which may be difficult to mobilise in a top-down approach. A recent review of CBHI found 'that a higher level of social capital at community level will positively and significantly impact households decision for health insurance' (27).

The *basic model* is the prototype bottom up scheme which is difficult to sustain unless for very basic package (26). Such a basic model has the potential to

- Offer financial risk protection for the informal sector and the close-to-poor (facilitating access, prepayment, reducing out-of-pocket expenditures)
- Increase awareness of the value and concept of insurance
- Increase utilisation (and health?) of health services among members
- Mobilise limited resources (increased cost recovery)
- Create experience in the management of risk pool arrangements
- Build confidence in risk pooling among participants through their direct experience in limiting abuse and fraud through strong community control mechanisms.

Shortfalls of the basic prototype relates to the small size of the risk pool, which undermines a broad benefit coverage and risk protection; the voluntary nature with the associated risk of adverse selection and consequent financial unsustainability of the scheme; the low ability to pay in the target group which limits the benefits that can be offered; and the exclusion of the poorest. Furthermore, the small pool size and limited ability to pay also put constraints to the level of professionalism in management that can be afforded, which in turn may lead to instability in scheme performance and may reduce the power to negotiate fees and quality with providers.

The *enhanced model* can be used when it is still difficult to scale up to national level, but provides an effective and sustainable model for financing of the informal sector. Enhancement strategies that has been used to improve the basic model (Rwanda is an example) includes

- Inclusion the poorest through subsidised premiums (*which also increase risk pool*)
- Building networks for scheme management and service delivery (small schemes may form a regional or national network)
- Government financial support for reinsurance to protect against expenditure fluctuations and maintain financial sustainability
- Require group enrolment
- Introduction of new provider payment mechanism to control costs (e.g. capitation)
- Cross-subsidy among communities through risk equalisation mechanism

Finally a *nationwide model* may be developed. Strategies for top down consolidation allowing full CBHI scale up may include

- Increasing size of risk pools at regional or higher level
- Political commitment and stewardship at national level with legislation back-up
- Government subsidy to scheme administration and service coverage
- Cross subsidisation across communities and districts with risk equalization mechanisms
- Unlikely that rural and informal sector populations have sufficient funds to fully finance own care -> must be supplemented by government financing
- Combining professional management with strength of community participation

- Continuing community based support for resource mobilization and controls for fraud and abuse
- Uses standardized minimum benefit package
- Strategic service purchasing from public and private NHIF accredited health facilities.
- Capitation, cased based global budget and p4p

The main challenges for the nationwide scale-up of CBHI include to increase or maintain the enrolment rate, to contain costs, to ensure long term sustainability and to integrate with other existing schemes, e.g. for formal sector employees. Examples of nationwide insurance programmes operating at local level include Vietnam, China and Thailand (28).

Few studies report about supply side improvement alongside the introduction of schemes, yet the importance of increasing the quality of services supplied has increasingly been highlighted. If quality is not improved, then increased enrolment will not materialise in increased use of services and improved health (22, 23). Furthermore, it is important that the increased demand for and utilisation of services following increased enrolment is 'matched by commensurate increase in resources' otherwise quality of services may even deteriorate (29).

## **6. Cross-cutting choices**

The options for CHF/TIKA reforms will be presented in Chapter 7. They have been developed along the dimensions of the size of the risk pool (and to some extent the benefit package) and the extent of separation of purchaser and provider functions. For any of these options some common issues emerge in relation to which decisions and actions needs to be taken to shape the CHF/TIKA. This chapter presents some of the main issues.

### **6.1. CHF/TIKA membership – from voluntary to mandatory ?**

Voluntary enrolment results in low coverage and increases the risk of adverse selection. Low contribution rates may reduce the financial barriers, increase enrolment and reduce the incentives for adverse selection; and of course reduce revenues.

Mandatory enrolment allows for cross-subsidization from the healthy to the sick, increases the risk pool and is more likely to provide the basis for sustainable financing at relatively low contribution rates. The two main problems with mandatory enrolment are, firstly, that it may be difficult to enforce, and secondly, that premiums may be unaffordable to some and the imposition of a mandatory premium may therefore be considered unfair.

Announcement of mandatory membership of CHF/TIKA sends a signal about the importance of signing up and may result in more people enrolling. The credibility of such an announcement and the success in achieving 100% enrolment in the target group, however, depends on a reasonable ability to enforce such a decision.

The default method of CHF/TIKA enrolment is presently in the form of passive enrolment in the health facilities. It is the responsibility of the health staff and the HFGC to mobilize members. In practice, this further stimulates adverse selection as most people would only go to the health facility when sick. It

furthermore makes follow-up on renewals and enforcement of mandatory membership difficult as the health facility in-charge is not in possession of lists of households in the communities. Mandatory enrolment is easier to enforce at village level than in the health facility. The Village Executive Officer (VEO) has a list of all households and can easily follow up. It could be considered to introduce a collective bonus (for example at village or community level) for achievement of specific coverage rates, e.g. reductions in contribution rates at high coverage. Mandatory CHF enrolment may be stipulated giving the population a grace period for enrolment.

In some districts user fees at the primary care facilities has been increased as a mechanism of encouraging enrolment to CHF/TIKA. Setting the user fee per visit close to the premium contribution rate is an indirect way of enforcing mandatory enrolment, since most households would incur at least one visit per year. However, care is needed not to set a high user fee rate up to the point that it denies access to those who can truly not afford the CHF premium rate - unless a well-functioning system of subsidization of membership of the poor is in place. Non-affordability to some means that mandatory CHF/TIKA membership must be accompanied by a system of subsidization for those who cannot afford membership contributions, see section 6.5 below.

Community level enrolment is possible even without making CHF/TIKA membership mandatory, but effective implementation of mandatory membership would require community level enrolment. It is the view of the team that mandatory CHF/TIKA- membership should be pursued in the medium to long term and that as a consequence the place of enrolment should be shifted from the health facility level to the community in order to support the enforcement of mandatory membership later.

## **6.2. Unit of enrolment**

If voluntary membership is maintained, then group enrolment or waiting periods would be ways of reducing the risk of adverse selection. The most commonly used group, which is also the current practice, is the household. It may be possible to allow individual enrolment or even enrolment in larger groups than just household. Individual enrolment may lead to increased problems of adverse selection. On the other hand enrolment by larger groups may reduce problems of adverse selection. It could be considered to vary premium level by group size to reflect the difference in risk of adverse selection. People who enroll individually may need to pay higher contribution. Groups, in form of a village or an association etc, could be allowed to enroll at a lower per capita rate, although it may be required that a certain percentage of members enroll (e.g. 60% of members – following example from Uganda) to avoid adverse selection within the group. An alternative measure to curb adverse selection is to introduce a waiting period from enrolment to benefits can be enjoyed.

While group enrolment may be required or encouraged, another issue is the whether the premium apply to the unit of enrolment as a group or to the individual members, i.e. is it a premium per individual or a premium per household. Members working in the formal sector contribute a percentage of income for NHIF, thus contributions reflect differences in ability to pay. Similarly, it could be considered to replace regressive flat rates for CHF members by a sliding scale of premiums. International experience with sliding scales based on economic status is, however, not encouraging. Whereas sliding scales by economic status may be difficult to implement in practice, sliding scales may be used that would also tend to have a pro-poor effect. For example a sliding scale could be used for number of persons enrolled by group, i.e. the

larger the group, the lower the premium per member. This is exactly what happens when a flat rate at household level is applied: the premium per household member is lower in large households. To the extent that poorer households tend to be larger, it could be argued that the present flat rate indirectly represents a sliding scale at the level of household member.

The contribution rate may be linked to the unit of enrolment as a flat rate per unit, e.g. per household, or to the number of group members in the unit. A flat rate contribution per household favors larger households compared to small households. If large households tend to be poorer, then this represents a redistribution from rich to poor. A flat rate per household based on average household size will, however, also discriminate against small households, say, of elderly people whose children moved to town.

### **6.3.Provider payment mechanisms**

Enrolment is clearly linked to the expectations regarding the access to health services and availability and quality of these. One way to stimulate the provision of desired services is to reimburse providers for services provided and to allow members to choose between several facilities (to vote with their feet). This can be done in several ways, mainly by shifting to more demand-side oriented financing in which funds follow the patient and to create a competitive environment.

A competitive environment may be created by introducing portability for same level care and by entering service agreements with the private sector to expand the choice for members, although in rural areas such choices may in practice be limited by geographical distance.

Capitation payment to health facilities is based on the number of members registered with the health facility and an average expected rate of utilisation and average cost per visit an amount per health facility can be allocated. This gives health facilities an incentive to provide sufficiently good health services to attract and retain members, but also to undertake activities which may reduce workload such as information campaigns, advocating for use of bed nets, hygiene etc. Sufficiently good services may be less in a non-competitive environment compared to a competitive environment. Short-sighted providers have less incentive to provide services as they will not immediately be affected if they restrict work hours or don't order new medicines on time. Providers may be less interested in providing services to CHF members registered at other health facilities, unless they pay user fees or a compensation system is in place.

Fee for service payment per consultation or per activity comes in different forms. NHIF is currently using an input-based approach paying per service item: consultation fee, diagnostic tests, medicines. CHF/TIKA could adopt a similar approach or use an output-based approach with a combined rate per consultation based on average total cost of all services per consultation (bundling). The latter would give the provider an incentive to increase the overall number of services (attract clients) and to reduce the inputs used per service. For example, facilities that could reduce the use of malaria medicine by properly test and only treat patients who actually tested malaria positive would stand to gain. Providers would have an interest in providing services to CHF/TIKA members registered anywhere in the district or in districts with which there was a service delivery agreement. (Providers may also have an interest in treating patients rather than refer them to hospital.) This payment mechanism would therefore support implementation of portability (and a restrictive referral system). On the other hand there is an incentive to overprovide services, however to

lesser extent, when a combined rate is used. After all the patient has to come on his own initiative in the first place; the provider may only take over decision-making once the patient is in the office.

The CHF/TIKA members may have observed a specific need in their community, e.g. low immunization coverage, frequent drug stock-outs. To stimulate activity to this end it may be considered to include a bonus for performance in relation to these needs. However, there is no reason to believe that the needs identified by CHF/TIKA members would be much different from those identified by the district and if any payment for performance is introduced at district level it would seem unnecessary for CHF/TIKA to do so specifically.

A mixed system in which the health facilities are partly reimbursed according to members registered with the facility and partly paid by activity or a bonus for a certain outcome. If majority of payment is capitation, then it maintains the positive incentives of capitation, while the fee for service part intends to alleviate any negative effects of effort minimization and reluctance to treat patients from other catchment areas.

Finally, non-financial incentives may also be used to stimulate the intrinsic motivation of providers, such as recognition of good work through prizes and sponsoring initiatives to improve quality of services such as supportive mutual peer reviews.

It is in view of the team important to keep the system simple within as well as across the financing sources in order to keep a harmonized approach to patients irrespective of membership status and to ease the administrative burden on the staff. This would suggest that any bonus system should be implemented broadly and not specifically for CHF/TIKA and that any fee for service system should be harmonized between NHIF and CHF/TIKA. From an administrative point of view, the capitation system is slightly simpler, although the introduction of a compensation mechanism to facilities who treat patients making use of the portability option would complicate it.

The use of CHF/TIKA funds is presently restricted and can primarily be used to supplement the medicines, while a minor part may be used for rehabilitation and small incentives for tea etc. This essentially amount to paying providers using line-item budgeting. The rationale for doing so is to ensure that funds are used in a way that will improve the quality of services. This may be important in the short run and may be important in a system in which there are no specific incentives for improving quality.

However, if a shift is made to provider payment mechanism in which there is potential competition and funds follow the patient, then it should be considered to allow more flexibility in the use of funds, at least from the side of CHF/TIKA. The CHF/TIKA is paying for a service package from the provider and if the provider is able to ensure drug availability then it should not be the purchasers '(CHF/TIKA) concern whether this is achieved through rational prescription, good drug management, projections and timely ordering, or supplementary purchases using CHF/TIKA funds. In fact, if drug availability could be ensured through other measures, then the CHF/TIKA members could perhaps benefit more from funds being spent on equipment, rehabilitation of waiting areas, dispensing units or administrative support to mention a few alternatives. The key prerequisite is though that providers would have an incentive to improve services.



## 6.4. Entitlements and Service availability

If the CHF/TIKA objective is to move towards universal coverage, then the benefit package of the scheme needs to be comprehensive. Currently, the design of CHF limits access to primary level health care facilities, except for some districts that have expanded the services covered to outpatient care in district and regional hospitals. Other few districts have managed to expand access to inpatient care but with co-payments. It is important that all CHF/TIKA members get access to both outpatient and inpatient care together with access to transport for referral. Practically, it will be challenging for the scheme to reimburse transport costs but members could be given access to ambulance services when they are referred to health centers, district hospitals and regional hospitals. An example of how this may work can be found in Kyela district. Proper gate-keeping mechanisms need to be put in place to monitor access to hospital care for the purpose of cost containment. As mentioned above this could also be stimulated through provider payment mechanism. Further, it is important for CHF/TIKA membership cards to be portable across all accredited facilities in order to improve access and give members choices when accessing health services.

Defining the benefit package (or entitlement) is one side (see Option Paper 1 on Minimum Benefit Package); functional accessibility to benefit package is another. CHF is operating in a rural environment where service availability is a major challenge. TIKA on the other hand may be operating in urban areas where health facilities are already over crowded. As a CHF reform strategy propose ways of expanding CHF/TIKA coverage, investment in service improvement is very crucial for the ability of the health system to meet demand and expectations regarding availability of quality health services. To a large extent this is a function which a purchaser, such as health insurance scheme like CHF/TIKA has a limited control of. Since the changes in the CHF design is intended to increase membership and access to services, contributions collected are expected to increase and increased membership in turn is expected to result in increased use of services. Since user fees are not fully covering costs of service provision this will result in increased demand on government resources. A primary driver of demand for health services and willingness to pay is, however, that the product is desirable. Although the CHF product is basically financial protection against health expenditures at point of need, potential members will regard the quality of the health services covered as a characteristic of the CHF product. The success of the CHF reform options will therefore require that

- Resources are mobilized for payment of matching grants from MOHSW as enrolment and contribution rates increases
- Resources are mobilized for subsidization of membership contribution for the poor
- Resources are mobilized for service provision beyond CHF contributions to meet increased demand for health services from an increasing number of members
- Improvements in quality of services are given continued attention.

It is upon the government to give more support to the MMAM program to make sure that services are available for CHF/TIKA members to have access. Without availability of quality and acceptable services, all efforts to improve health insurance coverage through CHF will not give positive results.

One way of accelerating investments to improve access to quality health services that has been suggested is to make use of accumulated reserves with NHIF. This would however require careful considerations. NHIF is mandated to purchase services for its members. It is a dilemma to NHIF that service availability is not always very good where members are located and this could call for supporting investments. This could

be done in several ways. Health facilities can decide to use part of their revenues from user fees, CHF contributions and NHIF reimbursement to invest in minor equipment and rehabilitation, but it may take time to generate sufficient savings. One option, which has already been practiced, is to let health facilities borrow funds for such investments from NHIF and pay back over time using part of their NHIF reimbursements. This approach requires a good deal of administration, and would leave health facilities with few NHIF clients in a difficult position for paying back and for getting loans. Alternatively, the NHIF could provide grants to district health authorities to develop health facilities in under-serviced areas to ensure that their members have access to care across the country. Challenges here include how to determine which districts and sub-districts to target (based on combined considerations, amongst other, regarding number of members and lack of services) and how much to grant and still ensure long term sustainability of NHIF. The extreme would be for NHIF to build and operate its own health facilities. This would move NHIF from purchaser of services to also become a provider, thereby removing the purchaser-provider split. Such considerations regarding the role of NHIF would be part of the wider plans for the general insurance market structure (see option paper 2).

### **6.5. Inclusion of the poor**

Another important issue to be considered moving towards universal health coverage regardless of the option chosen is access of CHF/TIKA benefits among the poor. Basically it is important for public funds, especially general tax funds, to be used to pay premium subscription fees for the poor. The current system of awarding exemptions and waivers for the poor and vulnerable groups proves to be ineffective because not one is responsible to cover their costs of treatment. Waivers and exemptions implemented, but not compensated, at facility level imply that it is the other CHF/TIKA members who pay or contribute to resources consumed by those waived. In the absence of compensation for lost user fees or CHF/TIKA contribution rates, it is very unattractive to waive or exempt patients and it is not unlikely that the poor will be deprived access to care. An effective mechanism would be for a third party to pay for their premiums and then the poor and other vulnerable groups be offered membership cards which will allow them access to health services like any other member. The third party funding source could be the Local Government Authority (LGA) using own funds or matching grant or it could be a national pool for subsidies to the poor, for example to be distributed according to poverty head count. Such a pool could be financed through general or earmarked taxes and/or cross subsidies from NHIF.

Currently the matching grant is paid 1 to 1 against the total CHF contributions collected as an incentive to increase collections. This means that wealthier districts in which people are able to pay higher contribution rates and LGAs are able to generate larger own revenues that can be used to subsidise enrolment of the poor will get higher matching grants than poorer districts that may need the matching grants more. This could potentially result in increasingly inequitable access to health care. To ensure funding for subsidization of membership for the poor it could be considered to retain part of the matching grants in a pool which is distributed along other criteria reflecting relative poverty at district level and which could also be linked to number of poor persons enrolled. (See also option paper 5 on inclusion of the poor)

### **6.6. Information systems**

Proper information management system is important for proper functioning and sustainability of the CHF/TIKA. There are varying information systems that have been put in place across districts. The types of

information systems vary from very simple systems which use simple spreadsheets and computers to very comprehensive systems which require a high level of automation. Table 1 summarizes key information which will need to be collected from the members and providers.

**Table 1: Information to be collected from members and providers**

From Members	From providers	From fund manager
- Name of principal contributor	- Name of the patient	- Amount of premium collected
- Names of dependants	- Type of services sought <ul style="list-style-type: none"> <li>o Registration</li> <li>o Consultation</li> <li>o Diagnosis</li> <li>o Medicine</li> </ul>	- Amount of subsidy for the poor received
- Age of beneficiaries	- Cost of each type of services sought	- Amount of other funds received
- Photos of beneficiaries	- Type of illness	- Number and names of contributing members
- Date of enrolment	-	- Number and names of subsidized members
- Renewal date	-	- Names and types of accredited facilities
-	-	- Amount of claims received
-	-	- Amount of reimbursement given to individual providers
-	-	-

The above information can be collected manually using spreadsheet templates that can be filled by enrolment officers (the people who register CHF/TIKA members) and health facility staffs. This will require a third part who will pass through the facilities to collect all needed information and submit to the fund manager. The fund manager will need to have a computer that will store required members information and information from providers and also keep record of claims and reimbursements together with other information that need to be kept by the fund manager. This kind of a simple approach to collecting CHF/TIKA information is currently the approach undertaken in the districts where GIZ is providing facilities. This approach is simple to be adopted by both providers and CHF managers/coordinators and less expensive. The estimated cost in Iramba of producing a laminated household membership card with photo when sub-contracting to a private photographer travelling to villages was 3500 to 4500 TSh per household for a card that would be valid for several years. The disadvantage of this approach is that it might require too much paper work and manpower in the process of collecting information.

Alternatively, the above information may be collected through automated information system which requires a bit more expensive facilities. A good example of this approach is the one adopted by the SDC under HSSP in Dodoma. This system is linked from the point of member registration to providers and fund managers. CHF/TIKA member's information is collected using electronic devices (mobile phones) and this information is automatically posted to a server. Providers also use electronic devices to automatically access member's information when accessing services and will be able to link required information at the provider level with a particular member using this electronic device. This information is again posted to a server and the fund managers can have access to it. It is approximated that the total cost of CHF management information system per households of six (6) members is about 6300 Tanzania shillings (see box 1). This system further has the advantage that it allows easy follow up for renewal and active

monitoring of patient satisfaction on regular basis. It would be an advantage if the information requirements from providers to NHIF and CHF/TIKA was harmonised.

### **Box 1: Summary of operating costs for CHF Iliyoboreshwa**

The provision of consumable forms together with individual membership cards constitutes the highest variable administrative cost item in the CHF Iliyoboreshwa. Under the assumption that a card lasts an average of 5 years and that 75% of the CHF members renew their policies (new members require a card), the cost per household of six persons distributed over the years comes to around 500 TZS. Other consumables such as receipts and claim forms are estimated to add another 1200 TZS/year. These parts of the variable costs can potentially be reduced further in a larger roll-out, when economies of scale can be utilized better.

The incentive payments to village level enrolment officers for each family enrolled constitute a further element in the variable costs per household. They add some 300 per household, irrespective of whether one is talking of renewal or of a newly joined member, and thus bring the variable cost per household to a total of TZS 2,000.

Amongst fixed costs, each district is staffed by 6 salaried persons. The 7 districts of Dodoma region can also share the costs of a medical adviser. Further fixed costs include the depreciation of assets such as motorbikes, computers, phones, travel allowances when moving to the field, and other similar costs. Fixed costs per insured household will decline sharply with a growing CHF membership. In a district of about 300,000 inhabitants and a coverage rate of 40%, these costs amount to 4,300 TZS per household.

Adding variable and fixed costs, the total administration cost per household amount to about 6,300 per year.

**Source:** Communication with Manfred Stomer -HSSP Dodoma

## **7. Options for CHF/TIKA reform**

In the following five options for development of CHF/TIKA are presented. The key strategic decisions relate to increasing the risk pools and the further development of an active purchaser-provider arrangement. Although in most cases we will be referring to CHF, the options presented in this section apply to both CHF and TIKA. Where either CHF or TIKA requires specific features in the options provided below, this will be highlighted in the descriptions. The options have been developed along the dimensions of the size of the risk pool (and to some extent the benefit package<sup>4</sup>) and the extent of separation of purchaser and provider functions. The five options entail more or less radical changes for the future CHF system:

- Option 1: „ Cost sharing“ – continue with minor amendments
- Option 2: Moving towards insurance – Introducing provider-purchaser split
- Option 3: Expanding risk sharing – Sharing the risk between districts

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<sup>4</sup> Note, however, that the more detailed definition of outpatient and inpatient services covered would be a question of how the minimum benefit package is designed (see option paper 1).

Option 4: Insurance covering the regional referral system

Option 5: Bringing all together – Nationwide CHF/TIKA-pool

The options represent a stepwise approach from the current scheme to a nationwide pool. An overview over the main characteristics and progressive change of the various options is presented in Table 2. For each option a narrative description of the situation from the perspectives of various stakeholders is presented, then advantages and disadvantages relative to objectives of resource mobilisation, efficiency and equity is outlined and finally key assumptions and requirements are listed. Sustainability issues are discussed for all options in Chapter 8.

**Table 2. Overview over main characteristics of the five options. Red text indicates changes compared to previous option.**

	Revenue collection		Risk pooling		Purchasing	
	Sources & contribution	Collecting organisation	Risk sharing pool	Fund management	Benefits	Provider payment
<b>Option 0: Status quo</b>	Voluntary Private	District Health Office	District	CHSB/DMO	Primary health care at local health facility	Budget - CCHP
<b>Option 1: From passive to active enrolment</b>	Voluntary (mandatory) Private (Subsidies for poor)	Community	District	CHSB/DMO	Portability within district Inpatient care at district hospital upon referral	Budget - CCHP
<b>Option 2: Introducing purchaser-provider split</b>	Voluntary (mandatory) Private (Subsidies for poor)	Community	District	CHFB/CHF office	Portability within district, including accredited private facilities Inpatient care at district hospital upon referral	Demand –related (capitation, fee-for-service, P4P elements)
<b>Option 3: Expanding risk sharing</b>	Voluntary (mandatory) Private (Subsidies for poor)	Community	Region national) (risequalization or reinsurance)	CHFB/CHF/TIKA office	Portability within district Including private facilities Inpatient care at district hospital upon referral	Demand –related (capitation, fee-for-service, P4P elements)
<b>Option 4: Insurance for regional health services</b>	Voluntary (mandatory) Private (Subsidies for poor)	Community	Region (national)	RCHFB/RCHF office	Portability within region, including private facilities Inpatient care up to regional health services upon referral	Demand –related (capitation, fee-for-service, P4P elements)
<b>Option 5: Bringing all together in a national pool</b>	Voluntary (mandatory) Private (Subsidies for poor)	Community	National	NHIF	Portability across Tanzania Inpatient care up to national referral hospital services upon referrall	Demand –related (capitation, fee-for-service, P4P elements)

## 7.1. Option 1: Cost sharing – minor amendments

### NARRATIVE DESCRIPTION

#### - *Brief on the main changes*

In option 1 the present 'Cost sharing' model will continue, but with minor amendments. The point of enrolment will change from the health facility to the community level and membership cards will be portable across all accredited facilities within a district (Figure 1). Contributions will be increased to cope with increased demand and service package, but access to services will also be improved as portability within the district is ensured as is access to inpatient care at district level. While enrolment is at household level, each individual will have the option to get their own card. The referral system is strictly enforced to reduce moral hazard and contain costs. Facilities receiving referred patients will need to submit claims of CHF/TIKA patients treated and districts will reimburse the cost after reviewing submitted claims (Figure 1). Government will need to subsidize premiums for the poor (Option paper number five highlights mechanisms for identifying the poor). Increased enrolment will require an increase in allocation of funds for matching grants. Furthermore increased enrolment may lead to increased utilisation of health services, which may require additional funding for staff and other operating costs not covered by the present user fees<sup>5</sup>.

#### - *Roles of different stakeholders*

At LGA level, the CHF/TIKA coordinator will still be coordinating CHF/TIKA at district level, but instead of dealing with the health facility in-charges in matters of enrolment, the CHF coordinator will be working with ward-level coordinators. Ward CHF/TIKA coordinators will collect member contributions and be responsible for depositing them in the Council deposit account. District authorities will need to design a way of motivating health workers at the facilities for quality improvement. The Ward Social Service Committee will be responsible for sensitization on CHF/TIKA and monitoring of revenue collection. CHF Enrolment Officers at village level will be appointed by the Village Executive Officer (VEO), and will also participate in sensitization and undertake the registration and distribution of cards.

The Health Facility Governing Committee will experience no change, *except that as promotion of CHF/TIKA is now left for the general community administrative structures more focus can be given to improving health facility management and service delivery, e.g. monitoring drugs received etc* (Figure 1). Due to the portability of CHF/TIKA card within the district, the HFGC may want to keep an eye on the number of CHF/TIKA members visiting their facility and use this when arguing for their budget allocation in the Comprehensive Council Health Plan (CCHP). The CHSB may decide to pre-invest part of the CHF/TIKA collections in a buffer stock of medicine to be kept at the district hospital to prevent stock outs in the health facilities.

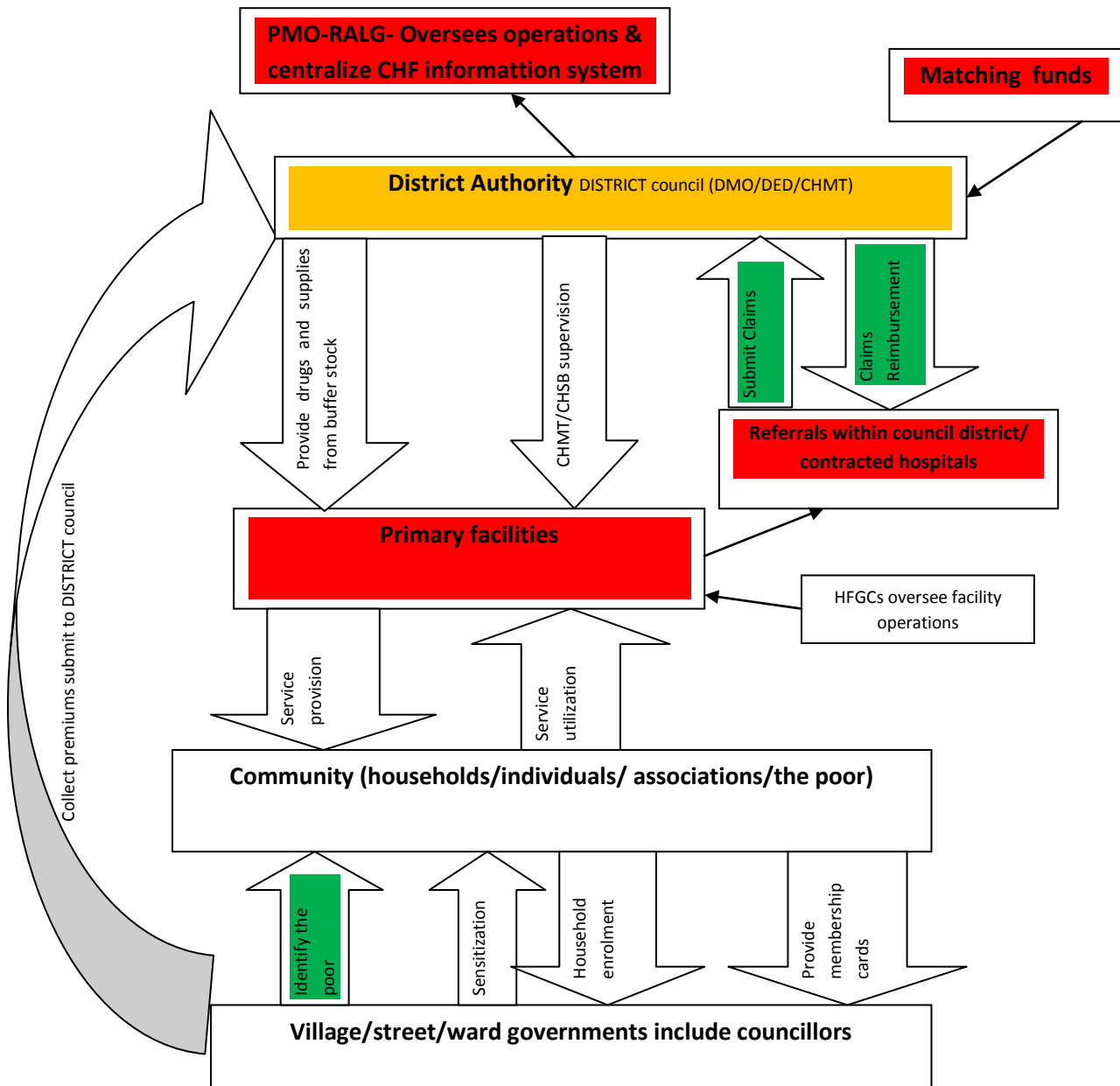
Staff in the health facilities will no longer have to spend time mobilizing and enrolling CHF/TIKA members. When a patient turns up for consultation, the patient will be asked to present the CHF/TIKA card (or a copy

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<sup>5</sup> The CHF/TIKA is a prepayment scheme to provide protection against the financial risks of user fees in relation to use of health services. The user fees are not set to recover all costs, so increased use of services will also require increased use of resources that are not funded from contribution rates. To some extent increased demand can be met from underutilised capacity.

of it), in which case services will be provided free of charge. The number of visits by CHF/TIKA members will be recorded, but otherwise the administrative burden specifically related to CHF/TIKA will be limited. However, there may be some additional work in relation to referral of patients to another health facility, as CHF/TIKA members will only be provided inpatient services free of charge at the hospital if they have been referred from the primary health care level with appropriate documentation.

**FIGURE 1: CHF DESIGN OPTION 1 FRAMEWORK**



For citizens it will be more convenient to enroll as the time (and for some transportation) costs will be reduced. It is no longer necessary to travel to the health facility and to wait in queue among patients in



order to enrol. The contribution rate will be higher; and, though still affordable to most, it will be unaffordable to some. The poorest will be subsidized to enroll.

It would be important to retain household level enrolment, especially in rural areas. This is mainly for affordability reasons which might cause some households to only enroll individuals with high risks, such as children and those with chronic illnesses. For big cities such as Dar es Salaam, Arusha and Mwanza, it might be possible to adopt individual enrolment model, like what is currently proposed under TIKA. However, there is still a need of identifying extremely large households and those who are not able to pay and make sure that they are not denied access or run into financial risks because they cannot afford contributing to TIKA.

Patients who are CHF/TIKA members can choose to attend those services at primary health care facilities where they perceive the care to be better (if they feel that it may outweigh their travel costs). Upon assessment at primary health care level, the patient will, if referred, be treated at no cost (or within a limit) at the district hospital. As each patient will have the option to get their own individual CHF/TIKA card (possibly just as a photocopy) there will be no delays in care seeking if a household member has travelled with the card.

Since CHF under this option is still operating as a cost sharing mechanism, the PMORALG will need to improve its engagement in the management of CHF scheme. The PMORALG will need to make sure that the currently used financial systems, such as EPICOR, are able to capture information on collection and use of CHF premiums across all districts. Further, the PMORALG will also need to have a good information system to monitor health service utilization among CHF members and pool together information on membership to CHF across all districts.

Since revenue under this option is utilized and budgeted like any other revenue from the central government and LGAs own funds, NHIF should not be involved in the management of CHF. As proposed above, the PMORALG should take all the functions that were imposed to the NHIF, including the allocation of matching funds to the districts. This will help to reduce complications of having a large number of regulations and rules imposed to the LGAs from different agents, some from PMORALG and others from NHIF, all targeting on managing the CHF.

The MOHSW should retain its role as a policy maker and giving policy directions in the improvement of the CHF.

#### **LIKELY EFFECT ON OBJECTIVES**

The advantages and disadvantages of Option 1 in relation to overall health care financing objectives are listed in Table 3. Shift in the point of enrolment is likely to lead to higher enrolment rates and thus resource mobilization. This is especially the case if individuals who are involved in premium collection are well known and trusted by the community. The inclusion of district hospital services in the package will justify an increase in the contribution rate, but at the same time the increase may have a negative effect on enrolment. Funding secured for subsidization of membership of the poor will contribute to improvement in financial risk protection, increased enrolment and resource mobilization.

Conditions for improving efficiency and quality in service delivery will be improved, but will be subject to commitment of individuals (i.e. in-charges in health facilities and members and staff within the governance structure) rather than an integrated element of the CHF/TIKA design.

**Table 3. Option 1: Main advantages and disadvantages against overall health care financing objectives**

OBJECTIVE	Advantages	Disadvantages	Mitigation proposed
<b>Financial risk protection</b>	Inclusion of inpatient services at district hospitals in the package limits the risk of catastrophic expenditures	Increased contribution rate is unaffordable to some.  Poor non-members, may have increased risk of catastrophic health expenditures as users fees are increased to make higher contribution rate attractive.	Functional and funded subsidisation mechanism for the poorest.
<b>Efficiency in resource mobilisation</b>	Decrease in cost of enrolment to individual household as enrolment moves closer to client, is expected to increase enrolment rates and hence resources mobilized.	More burden on the ward and village level governing structures  Voluntary enrolment entails risk of adverse selection limiting the resource mobilization potential	Incentives to enrolment officers Household or group enrolment  Waiting period  Mandatory enrolment
<b>Efficiency in service delivery</b>	Additional funds may be invested in efficiency improvements that address local needs.  Health facility staff can focus more on service delivery	No particular incentives for improving efficiency  Improvements rely on quality of information and commitment of HFGCs, CHMT/DMO, CHSB  Risk of moral hazard: bypass of referral system; demand for unnecessary medicine	Performance based payment  Capacity strengthening of HFGCs Enforce referral system
<b>Quality of services</b>	Increase in available funding for services and medicines leads to better service quality and availability of medicines.  HFGCs can focus more on monitoring service delivery and resources, e.g. medicine, in facility.	Weak incentive for quality improvement Medicines may be reserved for those who pay cash.  Improvements rely on quality of information and commitment of in-charges, HFGCs, CHMT/DMO, CHSB	Direct reimbursement of providers for services and medicines provided to CHF members (Options 2-5).  Supervision

OBJECTIVE	Advantages	Disadvantages	Mitigation proposed
<b>Equity</b>	<p>Better access to services and medicines for members at facilities across district.</p> <p>Increase in size of risk pool may increase redistribution from the healthy to the sick.</p> <p>Subsidization of premium for the poor improve equity</p>	<p>Flat rate is regressive. Poor pay a higher proportion of income.</p> <p>Non-members who cannot afford increased user fees may delay treatment</p> <p>Voluntary enrolment entails risk of adverse selection, limiting the pool for the sickest.</p> <p>No cross-subsidisation between districts. Matching grant favors communities that can afford high contribution rates</p>	<p>Functional subsidization mechanism for the poorest.</p> <p>Mandatory enrolment</p>

### ASSUMPTIONS AND KEY REQUIREMENTS

It is assumed that the CCHP allocations and subsequent disbursements will indeed be based on reported needs in health facilities, such that facilities which attract more clients in a system with portability will also be allocated correspondingly more resources to cope with the increased demand.

Apart from the general requirements that MOHSW and PMORALG mobilize resources, this option will require that the roles and responsibility of the HFGC, the ward social service committee and the VEO are redefined. It is further required that the MOHSW develop/strengthen the gate-keeping function of primary health care units.

## 7.2.Option 2: Moving towards health insurance – separating purchaser and provider

### NARRATIVE DESCRIPTION

#### - *Brief on the main changes*

In option 2, CHF/TIKA is moving towards a health insurance function in which the purchasing of services is separated from the provision of services. The point of enrolment is at the community level and the administration of the CHF/TIKA is undertaken by a CHF/TIKA Office separated from the District Health Office and overseen by an independent CHF/TIKA Board (Figure 2). The CHF board will be responsible for hiring individuals to collect premiums from the households at village level. It is important to make sure that the identified individuals are not at the same time full-time employed (e.g. teachers) to avoid taking the task of collecting CHF premium as a secondary task. Alternatively, the CHF/TIKA Board might decide to outsource the task of collecting premiums from the community to an independent agent, such as commercial bank or NGO (as what is currently practiced by CIDR in Mbeya). However, commissioning this task has a disadvantage of adding to administration cost if the collecting agency aim to maximize its profit. In addition, if individuals assigned to collect premiums are not well imposed/known to the community, it might be a challenge to get people to enroll.

Under option 2 the CHF Office will reimburse health facilities for services to members and in this way payments will be linked to demand<sup>6</sup>. Technical support to the CHF Office might be provided by NHIF, e.g. for claims processing, upon request.

As in option 1 resources are still pooled at district level and services covered are district health services ensuring portability within the district; contributions will, as in option 1, be increased to allow for this expansion of the package. The referral system is strictly enforced to reduce moral hazard. Expansion of membership for the poor is financed through subsidies (see Chapter 6.5).

- *Roles of different stakeholders*

Under this scenario, the LGA will have a minimal direct involvement to the management of CHF. Basically the DMO and DED may enter into the CHF board as advisors, while the core members of this board will be elected from the community. The process of advertising and recruiting the members of CHF board could be coordinated by the DED office. The current district CHF coordinators could be absorbed and be members of this board. The CHF Board will enter into annual service agreements with relevant providers, irrespective of ownership, but based on rates, quality and accessibility of members.

The Health Facility Governing Committee will be able to focus more on improving service delivery, e.g. monitoring drugs received etc., but may also be giving more attention to how resources are mobilized and managed in order to improve services and attract more users as a separate CHF purchasing function would naturally lead to a system where funds follow the patient/member in one way or another. The HFGC may want to keep an eye on the number of CHF members visiting their facility and use this when arguing for their budget allocation in the CCHP to cover additional costs related to increased utilisation.

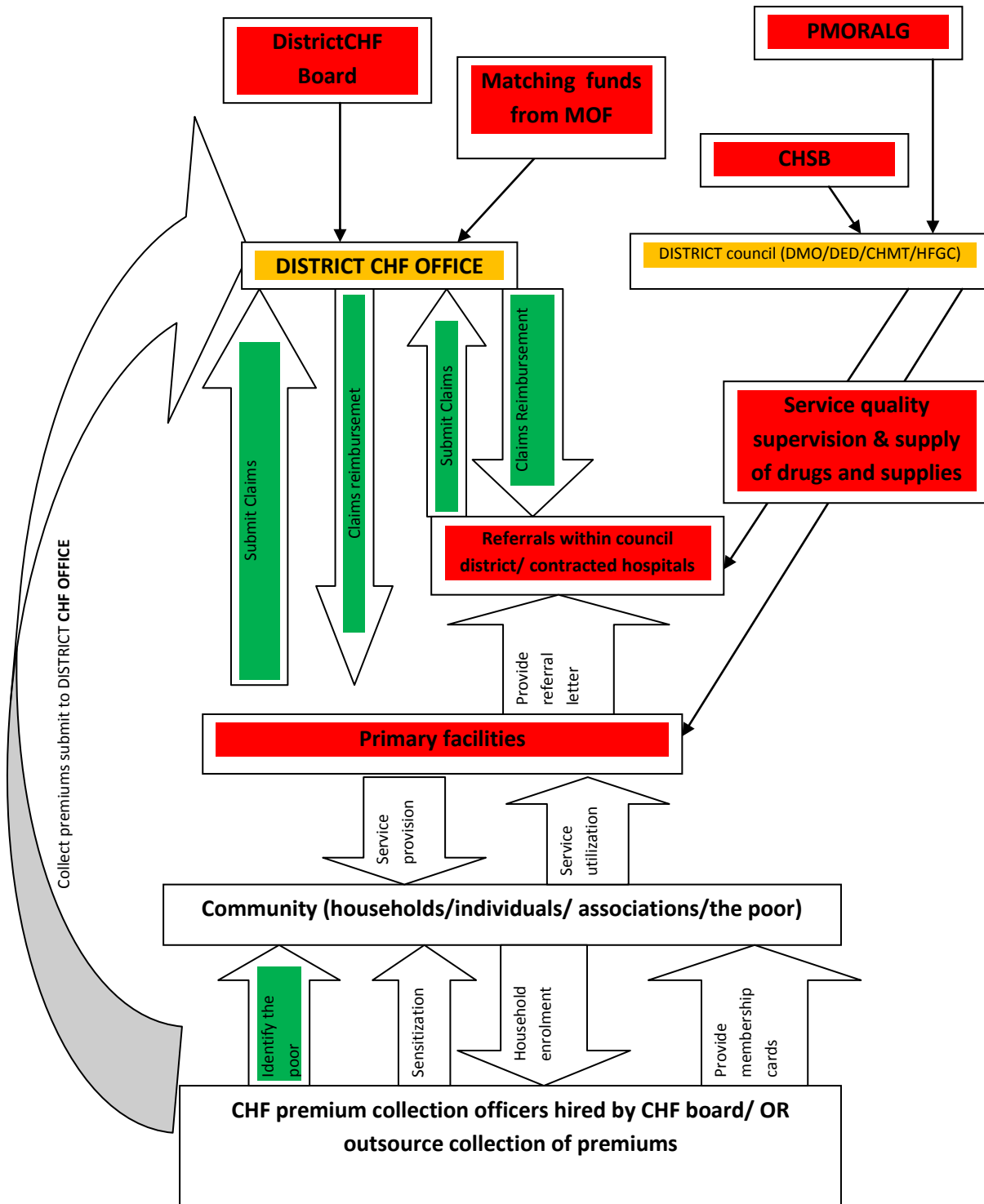
Staff in the health facilities, as in option 1, will no longer have to spend time mobilizing and enrolling CHF members. When a patient turns up for consultation, the patient will be asked to present the CHF card (or a copy of it), in which case services will be provided free of charge. The number of visits by CHF members will be recorded, but otherwise the administrative burden specifically related to CHF will be limited, unless a fee for service (claims) based reimbursement system is adopted. In that case the provider will need to spend time filling the claims forms in the same way as is done for NHIF members. There may also be some additional work in relation to referral of patients to another health facility, as CHF/TIKA members will only be provided inpatient services free of charge at the hospital if they have been referred from the primary health care level. Since the resources channeled to the health facility depends on either the number of members listed with the facility or the number of services provided to members, the staff will have an interest in improving services in order to attract more members and/or provide more services.

For citizens it will be more convenient to enroll as the time (and for some transportation) costs will be reduced. It is no longer necessary to wait in queue among patients. The contribution rate will be higher, and, though still affordable to most, it will be unaffordable to some. The poorest will be subsidized to enroll.

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<sup>6</sup> Either in the form of general demand reflected in registration of citizens with a specific health facility and/or in the form of specific demand by patients.

**FIGURE 2: CHF DESIGN OPTION 2 FRAMEWORK**



Patients who are CHF members can choose to attend services at those primary health care facilities where they perceive the care to be better (if they feel that it may outweigh their travel costs). Upon assessment at primary health care level, the patient will, if referred, be treated at no cost (or within a limit) at the

district hospital. Complaints over services can be channeled to the CHF office, which is now independent from the provider side. The CHF Office will monitor satisfaction with services among members.

As the CHF is moving towards the direction of being an insurance scheme, it will be necessary to reduce the role of PMORALG in its management. The PMORALG is the owner of all public facilities in the councils hence inefficiencies may arise if it is also the manager of health insurance scheme which purchase services from these public facilities. The PMORALG's role under this option will be service provision quality monitoring. It should pay more attention in making sure that LGAs provide needed services of good quality. In addition, the PMORALG would have a key role in monitoring use of revenue from reimbursement of claims in the facilities through LGAs.

Since CHF under this option is embedded within the district with its separate board, it would be necessary to have a minimal involvement of NHIF. The district CHF schemes should have autonomy in the operation of the scheme but they should be audited by the National Auditing Office to ensure prudence. NHIF can play an advisory role upon request of the CHF offices but should not play part in setting rules and regulations in the management of CHF. All sensitization and resource mobilization activities should be the responsibilities of the CHF offices in the districts. For the purpose of tracking CHF information at the national level, it might be important to have a CHF national manager situated at the NHIF who will be responsible for harmonizing information across all districts. In this case both information on enrolment to NHIF and CHF will be monitored at the same place. The CHF manager can be an employee of NHIF, hence not requiring additional cost to cover salary.

The MOHSW should retain its role in giving policy directions in the improvement of the CHF. The ability of the CHF schemes to mobilize revenue may vary, and some CHF schemes might not be able to cover claims from the facilities based on member contributions only. It would be necessary for the MOHSW to continue subsidize the schemes through a matching grant mechanism on a 1 to 1 basis at national level. However, the matching grant should be allocated across schemes partly in relation to fund mobilization, partly taking into account differences in the cost of service provision across districts. Such subsidies can be disbursed to the council CHF Offices directly from the treasury (Ministry of Finance).

#### **LIKELY EFFECT ON OBJECTIVES**

The advantages and disadvantages of Option 2 in relation to overall health care financing objectives are listed in Table 4. As in Option 1 financial risk protection will be improved for members, but for the poorest this will depend on development of a functional subsidization mechanism for the poor.

Compared to Option 1 incentives are introduced to stimulate increased efficiency and quality in service delivery, these incentives may also have unintended effects, in terms of over supply of services or over reporting of activities so control measures will be needed. In the absence of effective competition the incentives will be weakened.

Access to services is improved as the CHF/TIKA Office may enter into agreement with private providers, e.g. FBOs. Risk sharing is still limited by adverse selection, although increased enrolment rates will increase the risk pool within the district.

**Table 4. Option 2: Advantages and disadvantages against overall health care financing objectives**

OBJECTIVE	Advantages	Disadvantages	Mitigation
Financial risk protection	Inclusion of inpatient services in the package limits the risk of catastrophic expenditures	Increased contribution rate is unaffordable to some.  Poor non-members, may have increased risk of catastrophic health expenditures as users fees are increased to make higher contribution rate attractive.	Functional and funded subsidisation mechanism for the poorest.
Efficiency in resource mobilisation	Decrease in cost of enrolment to individual household as enrolment moves closer to client, is expected to increase enrolment rates and hence resources mobilized.	More burden on the ward and village level governing structures  Voluntary enrolment entails risk of adverse selection limiting the resource mobilization potential	Household or group enrolment  Waiting period  Mandatory enrolment
Efficiency in service delivery	Funds may be invested in efficiency improvements that address local needs.  Health facility staff can focus more on service delivery  Health facility reimbursement linked to demand for services (general registration– capitation; services – fee for service)	Risk of moral hazard: Patients may want to bypass referral system; patients demand for excess medicine  Risk of over-supply of services (fee for service) or under-supply of services (capitation)	Capacity strengthening of HFGCs  Performance based payment  Cost control measures, e.g. claims verification, combined payment methods.
Quality of services	Increase in available funding for services and medicines leads to better service quality and availability of medicines.  HFGCs can focus more on monitoring service delivery and resources, e.g. medicine, in facility.  Health facilities have an incentive to provide better quality services, because they are reimbursed when they can attract patients	Medicines may be reserved for those who can pay cash.  Improvements rely on quality of information and commitment of HFGCs, CHMT/DMO, CHSB  Patients’ perception of quality may not reflect true quality  Incentives are weakened in the absence of effective competition	Direct reimbursement mechanism to providers for services and medicines provided to the waived population.  Supervision  CHF office to monitor patient satisfaction among members and acting on complaints
Equitability	Better access to services and medicines for members at facilities across district. Service agreements with FBOs may increase access further.  Increase in size of risk pool may increase redistribution from the healthy to the sick.	Flat rate is regressive. Poor pay a higher proportion of income.  Non-members delay treatment due to increased user fees  Voluntary enrolment entails risk of adverse selection, limiting the pool for the sickest.  No cross-subsidisation between districts. Matching grant favors communities that can afford high	Functional subsidization mechanism for the poorest.  Mandatory enrolment

OBJECTIVE	Advantages	Disadvantages	Mitigation
		contribution rates	

### ASSUMPTIONS AND KEY REQUIREMENTS

It is assumed that health facility staff will respond to financial incentives. This in turn assumes that the financial incentives for the facility is translated into benefits to the health staff in the form of better working conditions, e.g. availability of necessary equipment and medicine, tea, clean environment, or direct financial motivation. It is further assumed that FBOs will be interested in entering into service agreements. This will depend on the conditions including the rates and payment mechanism that can be negotiated and timeliness of payment. It is also assumed that patients' will indeed be willing to travel for better care. Finally, it is assumed that provider payment mechanisms will be developed and a harmonized approach chosen across funding sources.

Apart from the general requirements that MOHSW and PMORALG mobilize resources, this option will require that the roles and responsibility of the HFGC, the ward social service committee and the VEO are redefined and that roles and responsibility of the CHF/TIKA Office and the CHF/TIKA Board is developed and institutionalized. PMORALG will need to approve the establishment of a separate CHF/TIKA account. It is further required that the MOHSW develop/strengthen the gate-keeping function of primary health care units.



### 7.3. Option 3: Expanding risk sharing

#### NARRATIVE DESCRIPTION

- *Brief on the main changes*

In option 3, the only change compared to option 2 is that while resources are still pooled at the district level risk sharing is expanded beyond the district to the regional or national level (Figure 3).

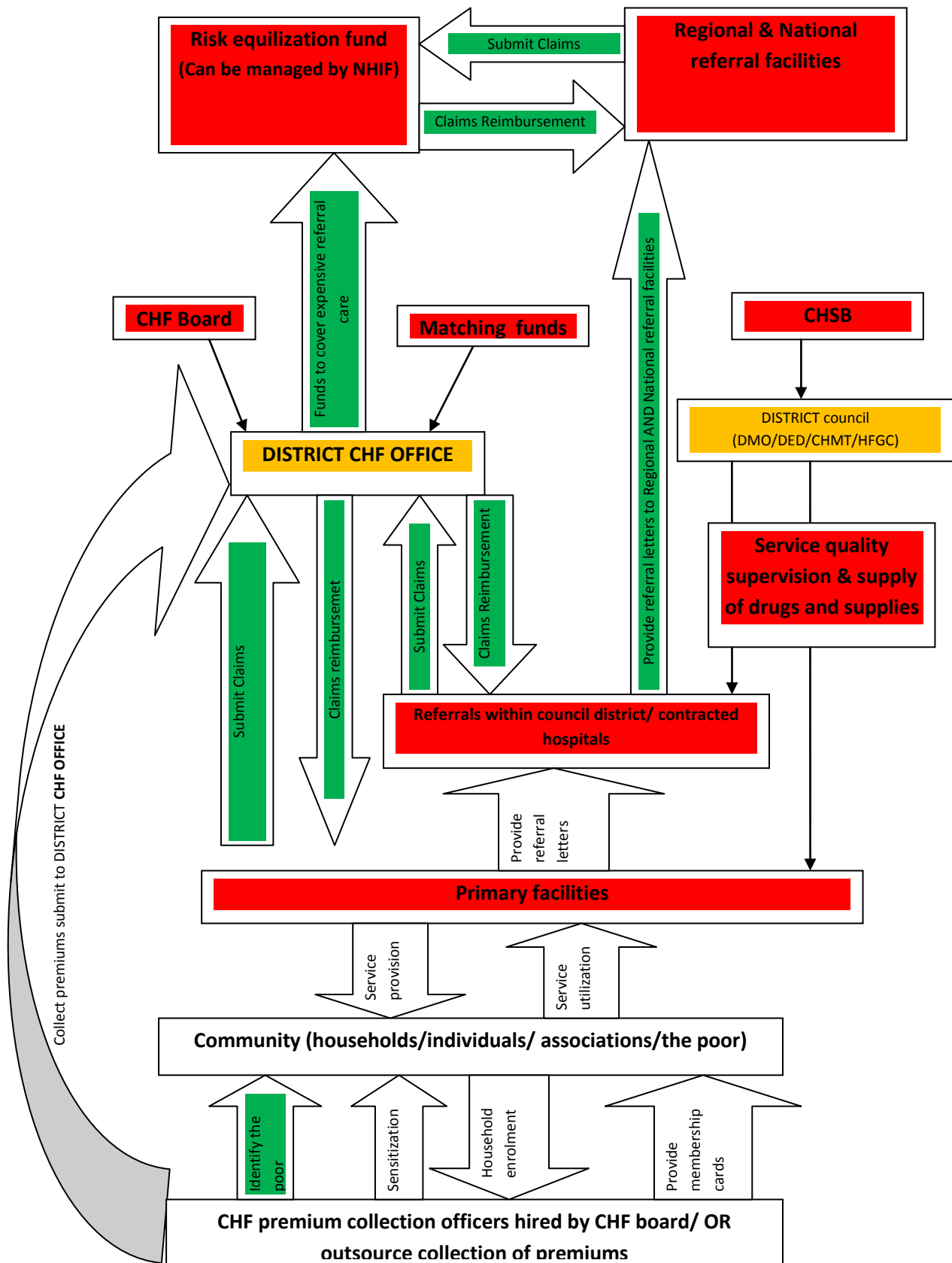
This can be done through a risk equalization mechanism, which redistributes resources between CHF according to differences in risk of incurring health care expenditures. Risk equalization is intended for addressing risk stratification, i.e. the difference in the composition of member groups according to risks (see also Chapter 5.1.2). CHF managers that are concerned about the sustainability of their CHF may be less active in enrolling members that may be considered high cost, e.g. people with chronic illnesses. To counter any such risk selection strategies or geographically related differences in risk profiles between schemes risk equalization mechanism will distribute less funds to schemes with many low risk members than to schemes with many high risk members. Risk factors may include demographic, socio-economic and epidemiological factors. Risk equalization will be simpler to implement, if contribution rates are harmonized within the CHFs covered, which is more likely to be feasible at regional than national level, not least because service availability is very different across the regions. The risk equalization mechanism may also take into account differences in ability to pay the contribution rates, if subsidization of membership contributions by the poor is considered the responsibility of CHF and there is no separate funding for this (cf. Chapter 6.5). Risk equalization in principle requires that funds are transferred from some (low risk) schemes to other (high risk) schemes. In a system as under-resourced as in Tanzania there is strong risk that direct transfer of member contributions to a national pool would be perceived as unfair and would negatively impact on enrolment. It is, however, possible (as also alluded to earlier in the paper), to use a share of the matching funds to compensate for differences in risk profiles of members.

Another variant of the expansion of risk sharing is to introduce a reinsurance system which shares risks ex-post as opposed to risk equalization which shares risks ex-ante. With reinsurance the individual CHF contribute a smaller amount to a reinsurance fund (managed by the NHIF), in order to avoid having to set high contribution rates to ensure available financing for rare and expensive events. Such a reinsurance policy spreads the risk of such rare, but expensive, events across CHFs. It could be considered to include regional and national referral services in the benefit package, if such a reinsurance mechanism was in place. Reinsurance is more important the smaller the scheme and the more rare and costly services are included in the benefit package. The CHF will submit claims to the NHIF for abnormal expenditures. NHIF would then assess the claims against approved expected (normal) expenditures and, if abnormality is justified, reimburse the difference to CHF..

The above mechanisms are administratively complex. Very clear definition of normal and abnormal levels of expenditures for given health risks would be needed; and abnormal expenditures requiring reimbursement from reinsurance would have to be very well documented. In other words, well-functioning accounting systems should be in place in all schemes as well as strong audit mechanism. Risk equalization mechanisms which adjust for ex-ante differences in risk profiles of members are less demanding in terms of administration, but would also require more detailed data collection unless one is content with restricting risk factors for incurring health expenditures to few demographic variables. Since systems and capacity would need to be developed, introduction may take some time. Without a uniform minimum benefit

package neither the risk equalization nor the reinsurance can work properly, so this would need to be in place as well.

**FIGURE 3: CHF DESIGN OPTION 3 FRAMEWORK**



Finally, but beyond the scope of looking at CHF reform options as it concerns the overall insurance market structure, it could be considered to expand risk sharing by creating an integrated pool with NHIF through a risk equalization mechanism that would reflect the differences in risk created by the difference in eligibility criteria for NHIF and CHF. This could also be combined with some level of cross-subsidisation from NHF to CHF.

- *Roles of different stakeholders*

The roles of different stakeholders will not change compared to option 2 except for the CHF Office that will need to submit information about member composition focusing on the risk factors for risk equalization formula or, in case of reinsurance, to submit an annual projection balancing expected contributions and expenditures to be approved by the reinsurer (NHIF) and subsequently submit claims for reinsurance if necessary, and for NHIF that will distribute the matching grants taking into account the risk equalization formula (if this variant is chosen) or will retain part of the matching grants in a reinsurance fund, will have to approve annual projections by CHFs and will handle claims for reinsurance. This is likely to require additional staff.

#### **LIKELY EFFECT ON OBJECTIVES**

Compared to Option 2 this option has the advantage of creating a larger integrated risk pool for CHF members which will allow for risk sharing within a region or within the country. The risk equalization mechanism will ensure that more funds are allocated to CHFs that have higher needs compared to those with lower needs. The development of an integrated risk pool or a reinsurance mechanism may further provide a possibility for including rarer and expensive services in the benefit package such as regional or national referral services. The main disadvantage is the increased administrative burden and control functions on the CHF managers and the NHIF. Given that the CHF member composition may not vary much between CHFs and that risk selection may not be a major risk, the question is whether the cost of risk equalization is outweighed by the benefits. Harmonisation of contribution rates across CHFs may result in some CHFs having to increase their contribution rates, which would increase the number of households to whom rates would be unaffordable.

#### **ASSUMPTIONS AND KEY REQUIREMENTS**

In addition to option 2 assumptions, it is assumed that the necessary data for risk factors in member populations is available and of reasonable quality. This option will require either that the relevant risk factors are identified and a risk equalization formula is developed, or that fluctuations in CHF annual expenditures are analysed and the cost of reinsurance against excess expenditures above varying thresholds is analysed and that NHIF based on this propose a reinsurance policy based on an actuarially fair premium.

### **7.4. Option 4: Regional CHF**

#### **NARRATIVE DESCRIPTION**

- *Brief on the main changes*

In Option 4, the purchaser functions of CHF will be clearly split from the provider functions of the district health services. The point of enrolment will be at the community level, but the risk pooling will be at regional level governed by an independent Regional CHF Board (Figure 4).

This option is more practical for a big city like Dar es Salaam whereby individuals who live in one district might find themselves work or spend most of the time in another district. In this case, the district demarcations are obscured. The Regional CHF office might function jointly with the regional NHIF structures. The package of health services may include referrals for inpatient care as well as more elaborate diagnostic services to the regional referral hospital and membership is portable within the regional health system. Contribution rates will be increased and harmonized within the region, but access to services will also be improved. Membership for the poor will be funded through government subsidies. While enrolment is at household level, each individual will have the option to get a card. The referral system is strictly enforced to reduce moral hazard.

Regional CHF could be used as a transition towards harmonized national CHF (or CHF & NHIF) pool. It will help to sort out the differences (heterogeneity) across districts by pooling resources and organize purchases at the regional level before moving to the national level harmonization of collection and purchasing.

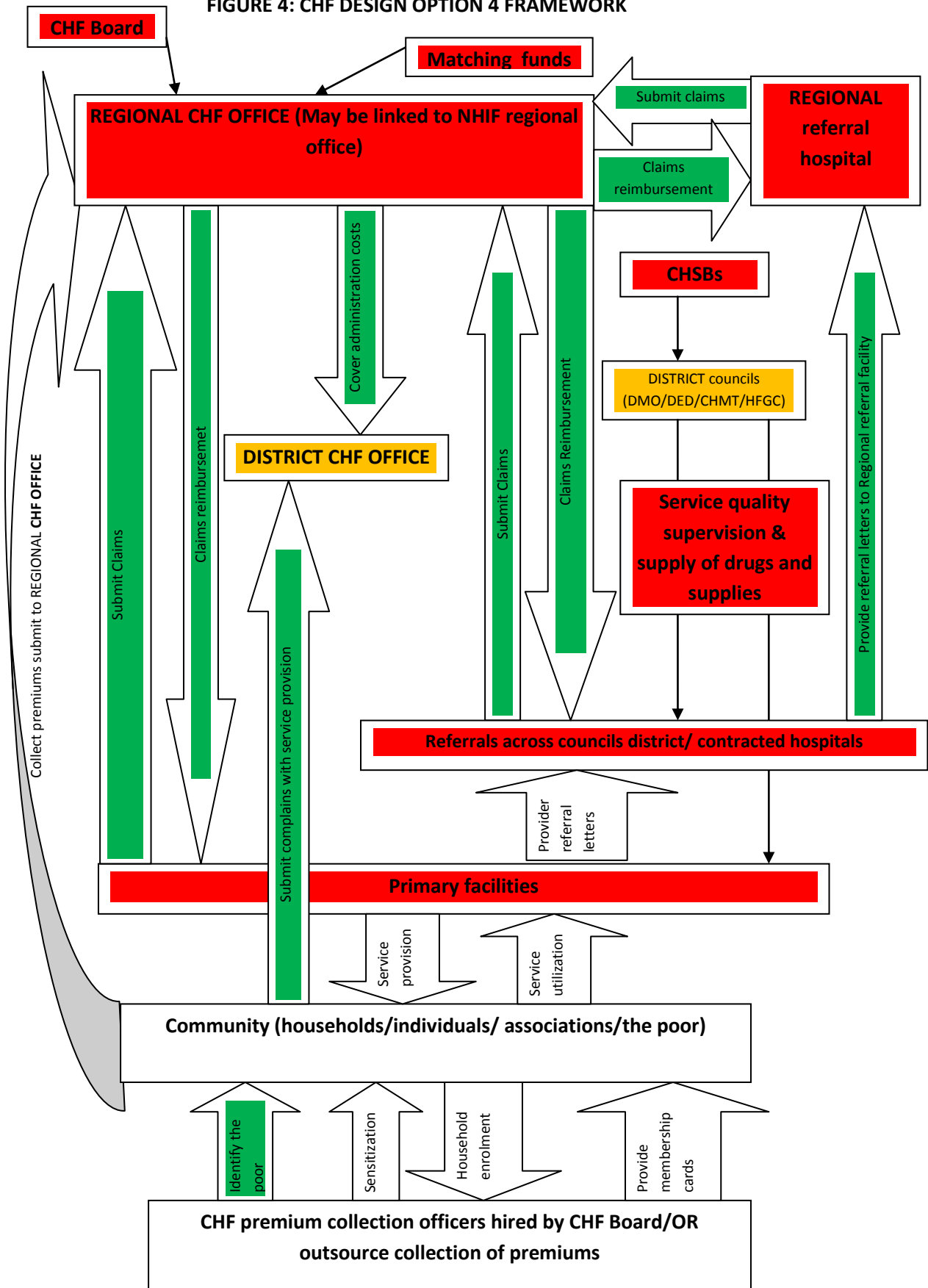
- *Roles of different stakeholders*

At LGA level, a CHF office (see Option 2) may be maintained with the main responsibility of coordinating issues related to enrolment and functioning as an office for complaints. As in other options, the CHF board will be responsible for hiring staffs for premium collection at the village and ward level. These individuals should not be full time employees of the government or private sector. The district CHF office will be linked to a Regional CHF Office that might be established jointly with the regional NHIF offices, making use of some of the same capacities. At the moment the NHIF has compliance managers and claims processing staffs across all regions that can be used to manage CHF at regional level. It might be necessary to hire more staffs to cope with a possible increase in enrolment and the increased number of claims from the facilities. At regional level a Regional CHF Board will be established. This Board will enter into annual service agreements with relevant providers, irrespective of ownership, but based on rates, quality and accessibility to members.

As in other options, with the responsibility for CHF enrolment shifted to the CHF Office, the Health Facility Governing Committee will be able to focus more on improving service delivery as will staff in the health facilities. Health facilities will have incentives to improve efficiency and quality of services and will be compensated for higher activity levels. As in options 2 and 3 the administrative work may increase depending on the provider payment mechanism chosen (see Option 2). Regional portability will (most likely) require a claims system for patients residing in other districts than the health facility, since an unbalanced distribution of cross-district patients may over-burden the LGA health budget in receiving districts. The number and costs of cross-district patients will be monitored. There will be some additional administrative work mainly at hospital level with enforcement of criteria for referrals and documenting referrals to regional health services. The reimbursement of lower level health facilities for completion of treatment may also serve to limit referrals.

For citizens it will as in previous options be more convenient to enroll than currently. Compared to previous options the contribution rate will be slightly higher in order to cover also the access to regional referral services, i.e. inpatient care and diagnostic services provided only at the level of the regional hospital. The higher contribution rate will still be affordable to most people, but will be unaffordable to some. For the poor it will be possible to obtain a subsidized membership.

FIGURE 4: CHF DESIGN OPTION 4 FRAMEWORK



Patients who are CHF members can choose to attend services at primary health care facilities where they perceive the care to be better. Upon assessment at primary health care level, the patient will, if referred, be treated at no cost (or within a limit) at the district or regional hospital. Complaints over services can be channeled to the CHF district office, which is independent from the provider side.

The NHIF will enter into closer collaboration with CHF at the regional level. For effectiveness in operation the regional NHIF and CHF will share offices and may share some specialized technical staff. NHIF will provide technical support to CHF for claims and data verification and contract negotiations. NHIF and CHF may jointly negotiate conditions and services with private providers (FBOs) or such negotiations may be delegated to NHIF to keep administrative costs lower. The NHIF national office can be use to centrally pool CHF information collected across regions.

The MOHSW and the PMO-RALG will not have direct involvement in the management of the CHF. This will give them more time to concentrate on making sure that service provision at the facilities is effective and of high quality. The CHF regional offices will be audited by the National Auditor General office (NAO) and regulated by the Social Security Regulatory Authority (SSRA).

**LIKELY EFFECT ON OBJECTIVES**

Advantages and disadvantages of Option 4 in relation to overall health care financing objectives are listed in Table 5. As in previous options financial risk protection will be improved for members and even more so as regional referral services are included, but for the poorest this will depend on development of a functional subsidization mechanism for the poor.

The provider incentives introduced in previous options will continue to stimulate increased efficiency and quality in service delivery. The regional CHF Office will be able to develop capacity and draw on technical support from NHIF regional offices to more effectively address unintended effects of financial incentives to providers, in terms of over-supply of services or over reporting of activities. Through joint office with NHIF at regional level, CHF administration costs can be contained.

Access to services is improved as the CHF Office may enter into agreement with private providers, e.g. FBOs. Risk sharing is still limited by adverse selection, although increased enrolment rates will increase the risk pool. One danger is that enrolment and therefore resource mobilization is negatively affected by the regionalization of CHF, moving ownership away from the district. It will be very important that members and potential members have confidence in the CHF governance structures and experience improvements in access to and quality of services.

**Table 5. Option 4: Advantages and disadvantages against overall health care financing objectives**

OBJECTIVE	Advantages	Disadvantages	Mitigation
Financial risk protection	Inclusion of inpatient services at both district and regional referral level in the package limits the risk of catastrophic expenditures	Increased contribution rate is unaffordable to more people.  Poor non-members, may have increased risk of catastrophic health expenditures as users fees are increased to make higher contribution rate attractive.	Functional and funded subsidisation mechanism for the poorest.

OBJECTIVE	Advantages	Disadvantages	Mitigation
Efficiency in resource mobilisation	Decrease in cost of enrolment to individual household as enrolment moves closer to client, is expected to increase enrolment rates and hence resources mobilized.	More burden on the ward and village level governing structures  Voluntary enrolment entails risk of adverse selection limiting the resource mobilization potential  <b>Risk of 'alienation' as CHF pooling moves to regional level</b>	Household or group enrolment  Waiting period  Mandatory enrolment  <b>Ensure improvement in services are felt</b>
Efficiency in service delivery	Funds may be invested in efficiency improvements that address local needs.  Health facility staff can focus more on service delivery  Health facility reimbursement linked to demand for services (general registration– capitation; services – fee for service) (special reimbursement for cross-district patients)	Risk of moral hazard: Patients may want to bypass referral system; patients demand for excess medicine    Risk of over-supply of services (fee for service) or under-supply of services (capitation)	Capacity strengthening of HFGCs  Performance based payment  <b>Cost control and verification strengthened in Regional CHF office. Combined payment methods.</b>
Quality of services	Increase in available funding for services and medicines leads to better service quality and availability of medicines.  HFGCs can focus more on monitoring service delivery and resources, e.g. medicine, in facility.  Health facilities have an incentive to provide better quality services, because they are reimbursed when they can attract patients	Medicines may be reserved for those who can pay cash.  Improvements rely on quality of information and commitment of HFGCs, CHMT/DMO, CHSB  Patients' perception of quality may not reflect true quality  Incentives are weakened in the absence of effective competition	Direct reimbursement mechanism to providers for services and medicines provided to the waived population.  Supervision  CHF office to monitor patient satisfaction among members and acting on complaints
Equitability	Better access to services and medicines for members at facilities across district. Service agreements with FBOs may increase access further.  <b>Increase in size of risk pool and pooling of contributions and matching grants at regional level increases scope for redistribution from the health to the sick</b>	Flat rate is regressive. Poor pay a higher proportion of income.  Non-members delay treatment due to increased user fees  Voluntary enrolment entails risk of adverse selection, limiting the pool for the sickest.  <b>Risk of bias in benefit incidence as those close to services, with better education or resources for transport may use services more.</b>	Functional subsidization mechanism for the poorest.  Mandatory enrolment  <b>Include transport in benefit package ?</b>  <b>Negotiate with PMORALG and MOHSW for investments in under-served areas ?</b>

## ASSUMPTIONS AND KEY REQUIREMENTS

In addition to assumption imposed under option 2, this option will require that roles and responsibility of the Regional CHF Office and the CHF Board is developed and institutionalized and adjusted correspondingly for the LGA level. This will entail a clear division of responsibilities with NHIF.

### 7.5. Option 5: Bringing all together in a national pool

#### NARRATIVE DESCRIPTION

##### - *Brief on the main changes*

In Option 5, the CHF is operating as a national scheme (one single CHF- risk pool) providing coverage for the informal sector, i.e. those who are not automatically enrolled in NHIF or NSSF (Figure 5). The community base is maintained in the sense that the point of enrolment will be at the community level, and there is a district level CHF coordinator, possibly joint with NSSF and NHIF at a 'district health insurance office'. The benefits will be portable across Tanzania, but the package is (initially) more restricted for CHF members than for NSSF and NHIF members as CHF contribution rates are relatively low. Some cross-subsidization from NHIF/NSSF members will, however, allow for gradual improvement of the package. Office administration will be shared with NHIF.

##### - *Roles of different stakeholders*

For citizens it will be convenient to enroll at community level. As in option 2 and 3 the CHF office will identify individuals who will be responsible for collecting premium from the community or outsource the task of collection. Collectors may utilize existing financial services such as M-Pesa, Tigo pesa, Airtel money, etc, to facilitate easy collection of premiums. The contribution rate will be increased compared to status quo, but the benefit package will also reduce financial access barriers to a wider range of services and provide better financial protection. The contribution rates will be affordable to most households, but not all. Membership contributions will be subsidized for poor and vulnerable groups.

Patients who are CHF members can choose to attend primary health care services where they perceive the quality to be best and will have access to a range of both public and private accredited health facilities. Upon referral from the primary health care level, inpatient treatment and specialized diagnostic services within a defined minimum benefit package is free. If the patient falls sick while travelling within Tanzania, there is no worry as the CHF membership is portable across the country. CHF members just need to remember to travel with the CHF card. Complaints about health services can be lodged with the local CHF coordinator. From time to time patients will participate in patient satisfaction surveys.

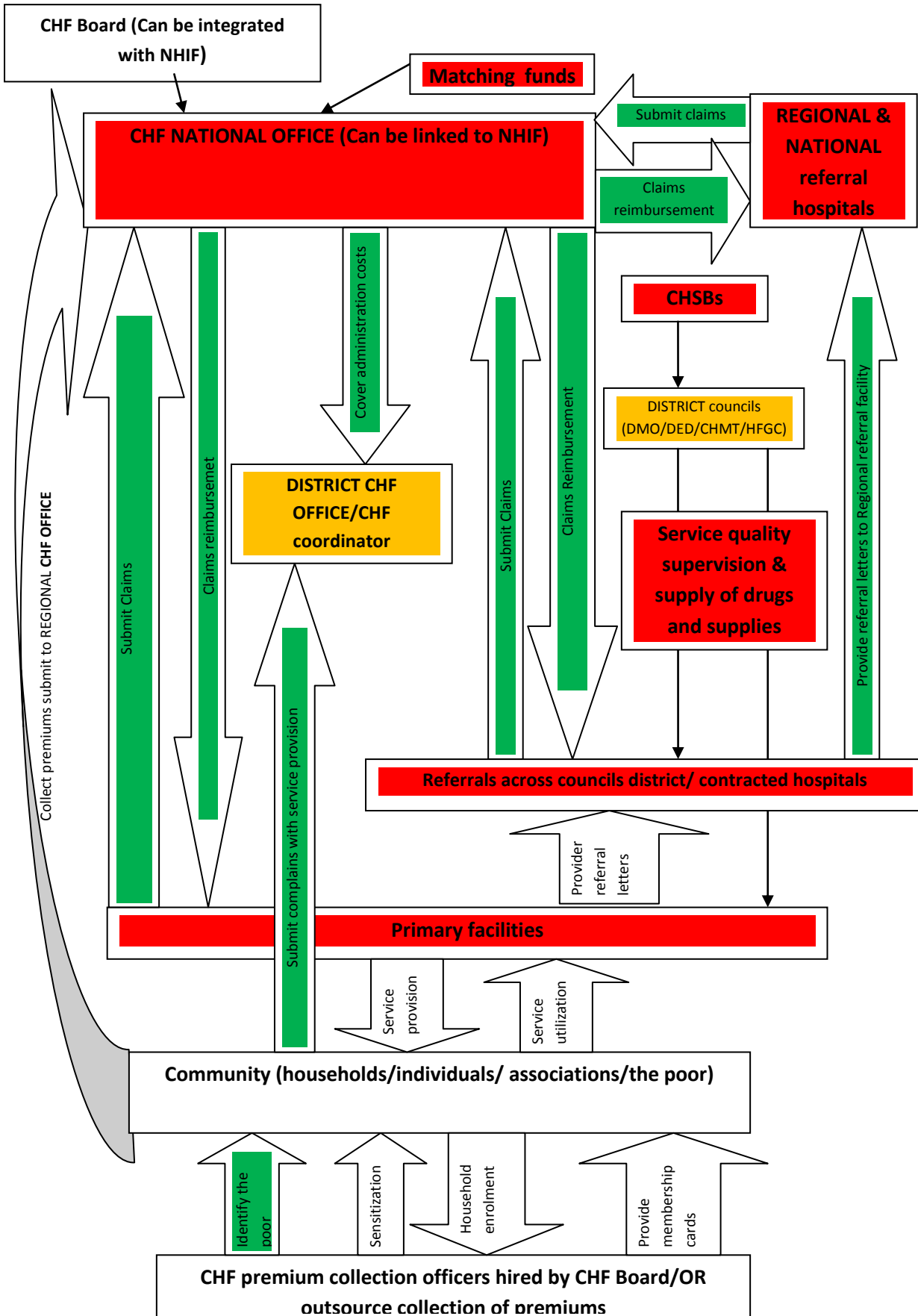
Health facility staff will be able to focus on service delivery and will, as in previous options, have incentives to attract CHF members (in case of capitation) or patients (in case of fee for service) through provision of efficient services of good quality. Claims or registered service use for CHF members will be submitted to the CHF office through the DMO following the same flow as NHIF. Claims will be used for reimbursement and registered service use will be used for negotiation of fees and capitation rates. Documentation in case of referrals to district, regional or national hospital services will be required.

Health Facility Governing Committees will have a role independent of the CHF to focus on the management of the health facility using funds generated through user fees and reimbursements from CHF, NHIF and



NSSF. HFGC will also play an active role in mobilizing resources through the CCHP to meet increased demand for services.

**FIGURE 5: CHF DESIGN OPTION 5 FRAMEWORK**



At LGA level the DMO will manage and the CHSB will oversee the operations of the district health services. This will include processing of claims, analysis of service use and negotiations on fees and rates (possibly through national representatives). Monitoring of efficiency and quality of services will be an important part of management. A CHF coordinator or a joint 'district health insurance office' will be in place and will, apart from being the main contact point for citizens and patients, be responsible for coordination of enrolment. At village level the VEO is, as in other options, the main person responsible for the enrolment.

At national level, the CHF Scheme will share offices with NHIF (and may be considered a sub-scheme alongside a 'formal sector sub-scheme'). A national CHF Board may be appointed, but it may also be considered to have a joint NHIF/CHF Board, especially if the vision is to have one single risk pool at a later stage. Further, NHIF has already in place technical expertise in dealing with pooling and purchase arrangements. Nevertheless, capacity will need to be improved if CHF will be joined with NHIF at the national level to handle additional membership effects on use of services and claims processing.

For effective purchaser –provider split, the MOHSW and PMO-RALG will not have a role in supervising CHF. PMO-RALG will focus more on supervising health facilities to make sure that they deliver quality health services and MOHSW will focus on policy and strategy development.

#### **LIKELY EFFECTS ON OBJECTIVES**

Compared to previous options the main advantage of this option is that financial protection may improve somewhat as there is scope for expansion of the package to cover more expensive services and national referral services as the risk pool is increased, although the risk pools at regional level (option 4) would already be of considerable size.

Resource mobilization will be higher than presently, but, as for option 4, there is a danger that moving the ownership of the scheme away from the district level might reduce the enthusiasm and enrolment rate slightly. Confidence in governance structures and perceived improvements in access to and quality of services will be crucial for attracting and retention of members.

As in option 2-4, the increased autonomy over resources at health facility level and a clearer link of reimbursements to demand for services is, however, expected to result in more efficient and better quality services. Increased harmonization of NHIF and CHF procedures and information and fund flows will improve administrative efficiency. A joint CHF/NHIF office at national, regional and district level will improve administration and take advantage of existing capacity, e.g. for cost control, fund management, data analysis etc.

Equity across the country will be improved as the benefit package and contribution rates are harmonized, as long as premiums are subsidized for the poor and de facto access to services are improved across the country (e.g. through the MMAM).

#### **ASSUMPTIONS AND KEY REQUIREMENTS**

Apart from assumptions applying to option 2, it is assumed that the centralization of the CHF management will be generally acceptable to citizens.

Apart from the general requirement that GOT mobilise the additional resources needed to cope with increased demand and to subsidise the poor, and those applying to option 2, this option will require that

the roles and responsibilities of the various levels (district, regional, national) of the CHF Scheme is developed and institutionalized. This will also entail a clear description of the roles and responsibilities vis-à-vis the NHIF. A national CHF Board (or CHF/NHIF Board) will have to be defined and appointed.

## 8. Financial sustainability issues

Costs and benefits of implementing various health care financing programmes are rarely assessed. Detailed calculations of costs and benefits is not possible within the present resources and data available. Under this chapter we examine the ability to pay different premium contribution rates across households. We also discuss revenue potential at different premium rates and make comparison with the cost of utilization in order to determine sustainability of the CHF scheme. The funding gaps at different premiums are also identified for potential subsidization by the government and other financing sources.

### 8.1. Ability to pay and revenue generation

#### ABILITY TO PAY

##### - *Overall ability to pay*

In most of the districts that have started CHF, contribution is normally set at the household level and it ranges from a minimum of 5,000 to a maximum of 30,000 TSh. In addition, one district in Dar es Salaam is proposing premium amount of 50,000 TSh for TIKA enrolment. We used these premium rates to explore the proportion of households who will be able to pay and the amount of revenue that will be generated if all households that are able to pay will contribute. We also explored the deficit that will need to be topped up by the government to pay premium for the households that will not be able to contribute.

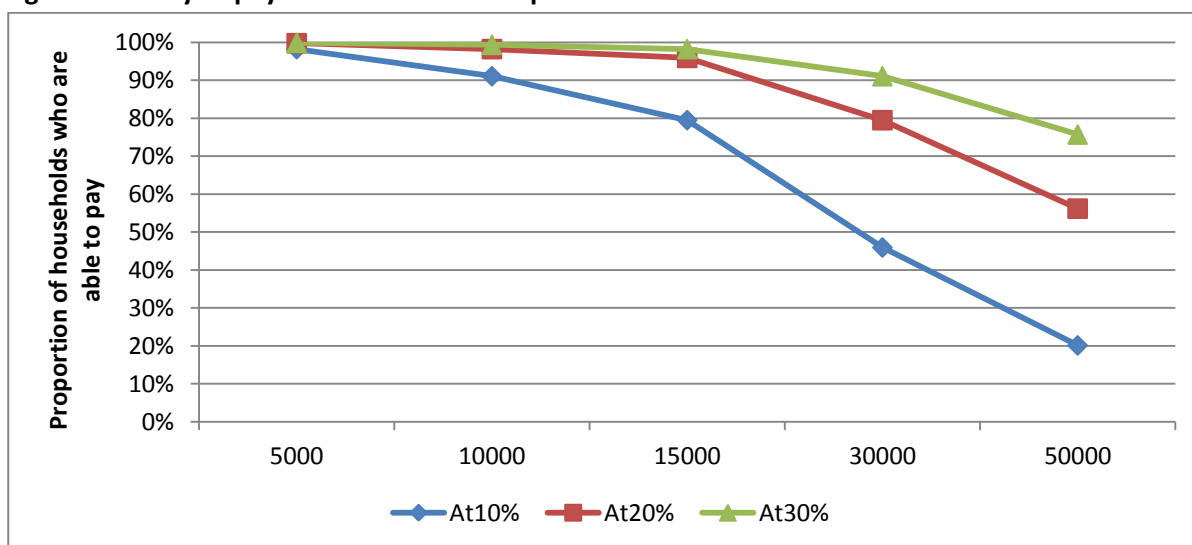
For this analysis, a household was considered able to pay if the CHF/TIKA premium rate is less than 30% of its total non-food expenditure. This assumption was adopted due to the fact that for welfare reasons payments for health care should not distort consumption of other basic necessities like shelter, clothing and utilities. Previous studies have used different cut-off points, including 10% 15%, 20%, 30% or 40% of total non-food consumption or total household consumption. This analysis defined any contribution to health care beyond 30% of household consumption as catastrophic spending. Sensitivity analysis was also conducted using 10% and 20% cut-off points. The analysis used National Household Budget Survey (HBS) for year 2007 which contains detailed information on both food and non-food consumption expenditure.

Figure 6 shows the proportion of total households in the informal sector who are able to pay different CHF premium contribution rates using the three catastrophic thresholds. Basically, almost all households are able to pay the contribution of 5000Tsh, regardless of the threshold chosen. More than 90% of the households were also able to pay the contribution amount of 10,000 per year. Increasing the premium amount to 15,000Tsh reduce the proportion of households who are able to pay to about 80% when using the 10% threshold while more than 90% of the population are able to pay this contribution amount when defining catastrophic spending using the 20% and 30% thresholds (Figure 6). The proportion of households able to pay 30,000Tsh as CHF premium contribution per year significantly reduce (46%) when using the 10% threshold while more than 80% are able to pay this amount when using the 20% and 30% thresholds. The ability to pay across households significantly reduce when the CHF premium contribution amount is set at 50,000Tsh per year (Figure 6). Generally, a large proportion of households can afford to pay the premium

amount of 30,000 using catastrophic thresholds of 20% or 30%. About 20% of the population would need to be subsidized by the government if catastrophic spending is defined by 20% threshold while only 10% will be subsidized when using 30%. However, if the government adopt a more protectionist approach by defining catastrophic as 10% of non-food consumption<sup>7</sup>, then more subsidies will be needed from the government to pay premium for about 50% of the population who cannot afford to pay 30,000Tsh annual premium contribution.

Analyses in the next sections use the threshold of 30% to define ability to pay. For sustainability reasons a significant proportion of revenue need to be collected from the households to cover a large proportion of health care costs. This implies that the proportion of households who need government subsidies should not be too large due to limited fiscal space. If resources are available, the government may decide to define ability to pay using a lower threshold in order to provide financial protection to a large proportion of households.

**Figure 6: Ability to pay at different catastrophic thresholds**

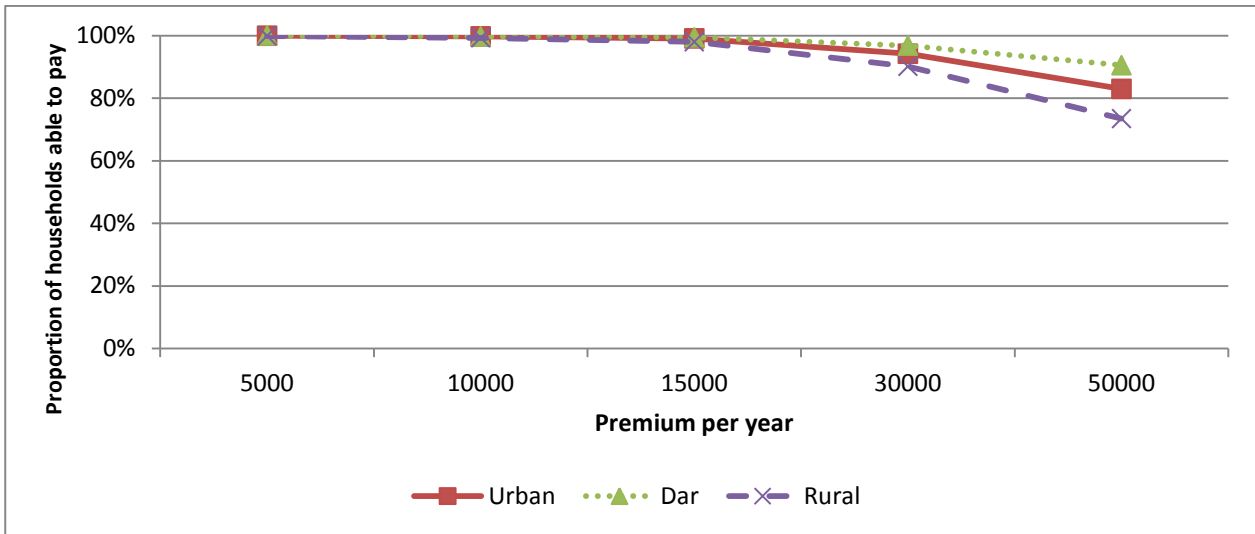


**- Regional variation in the ability to pay**

Comparison across localities indicates no significant variation in the ability to pay across localities when premium is set at 5,000 Tsh, 10,000 Tsh or 15,000Tsh (Figure 7). About 97% of all households in Dar es Salaam and other urban districts are able to pay the premium amount of 30,000Tsh while this proportion reduce to 90% in rural areas. More variation in ability to pay across localities is observed when the premium rate is set at 50,000Tsh per year. In this case more than 90% of the households in both urban and rural localities can afford the premium contribution of 30,000Tsh while less households can afford the 50,000Tsh premium per year.

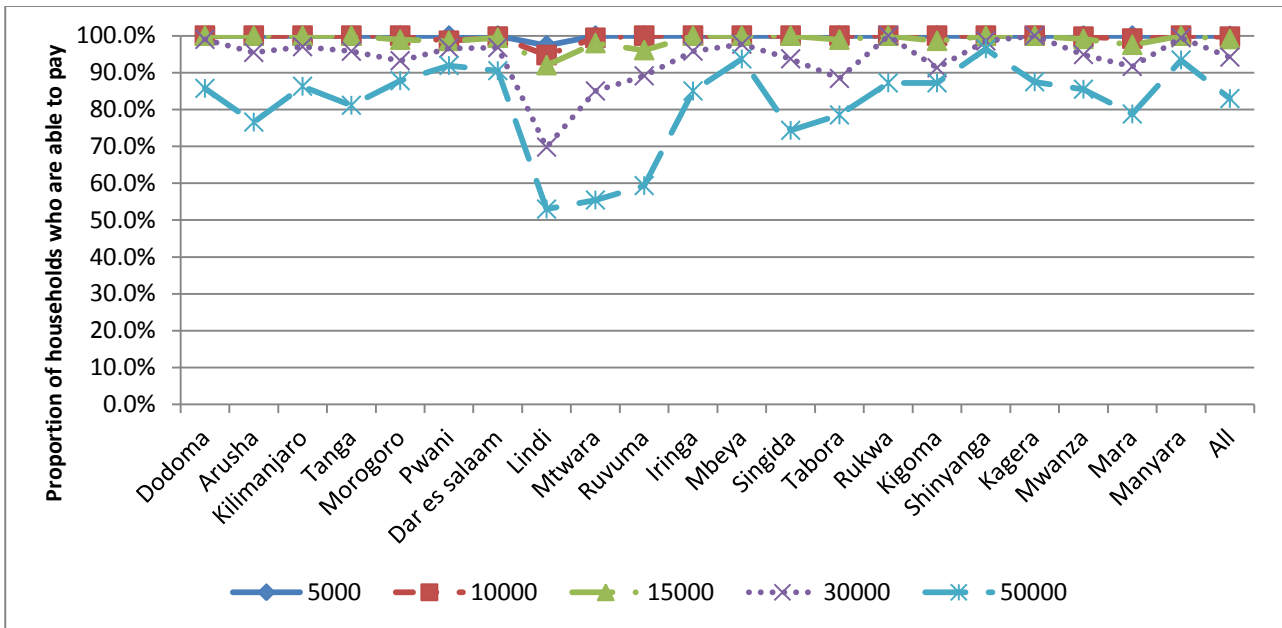
**Figure 7: Variations in ability to pay across localities**

<sup>7</sup> Or if 10% of non-food expenditure is considered to be the limit that people find acceptable for voluntary enrolment.



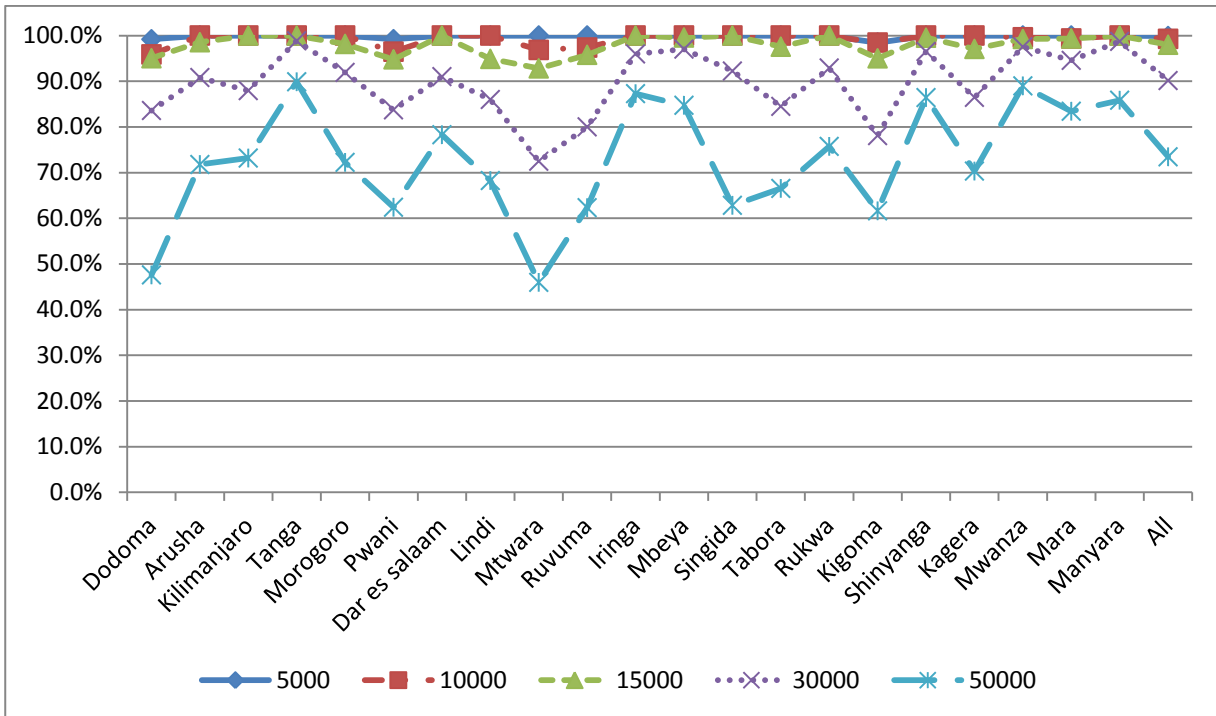
Further analysis of the variations in the ability to pay across regions indicates that while more than 90% of the households in urban and rural localities can afford the premium rate of 30,000Tsh per year, some of the regions might find it difficult to raise this amount (Figures 8 & 9). For example while 97% of all households in urban localities can afford the premium rate of 30,000Tsh per year, only 70% and 85% of the population can afford this premium amount in Lindi urban and Mtwara urban respectively (Figure 8).

**Figure 8: Urban localities**



Similarly, while on average 90% of the households in rural localities can afford the 30,000Tsh, only 70% and 78% of the households in Lindi and Kigoma rural districts can afford this premium amount (Figure 9). In this case, while the government will need to provide subsidies for those who are not able to pay the subsidies should be responsive to the differences in the ability to pay across localities.

**Figure 9: Rural localities**



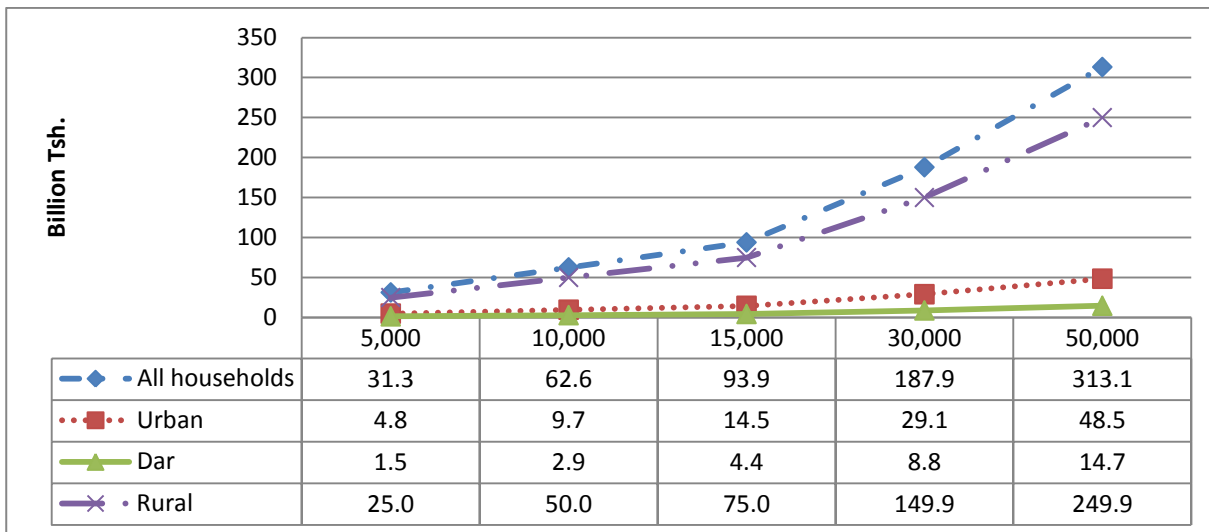
## REVENUE GENERATION

This section analyses the maximum amount of CHF revenue that can be generated at different premium rates if all households who are able to pay joins the scheme. The analysis excludes any amount of matching funds which government will be contributing to the schemes and any amount of subsidy that the government contributes for those who are not able to pay.

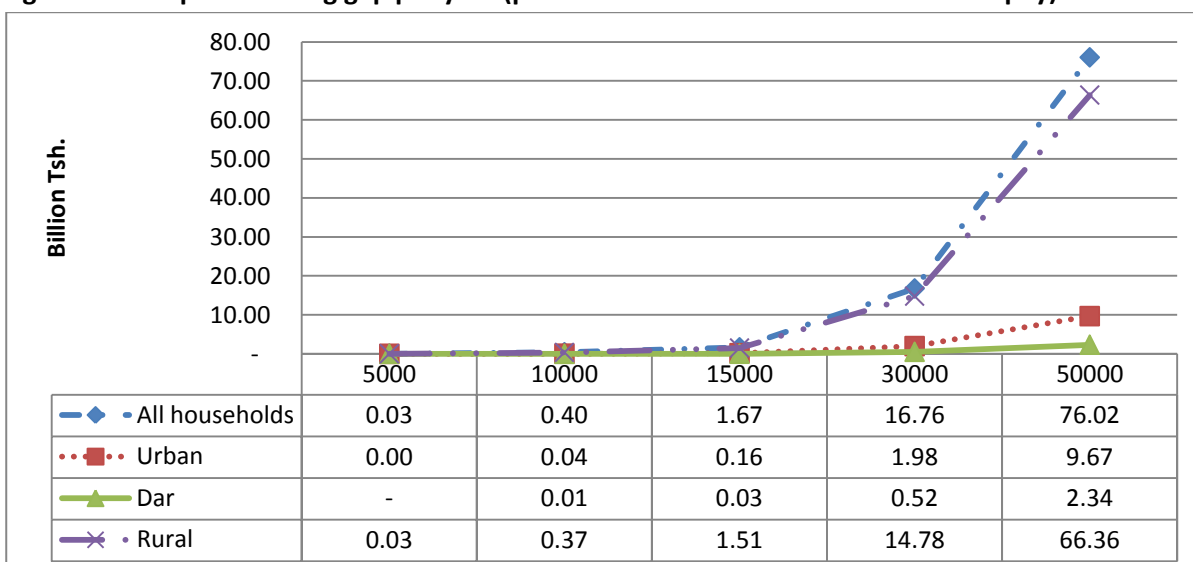
If the premium is set at 30,000Tsh, an amount that we think would be more feasible, a total of about 188 billion Tsh can be generated. The rural households contribute about 150 billion Tsh while Dar es Salaam and other urban households contribute about 9 billion and 29 billion Tsh respectively. More amount of revenue will be collected at a higher premium rate of 50,000 Tsh (Figure 10) but as we have noted before, this is at the expense of less affordability to pay (Figure 6).

At the 30,000 Tsh premium amount a total of about 17 billion Tsh will need to be subsidized by the government to pay premium contributions for those who are not able to pay (Figure 11). The amount varies from about 17 billion Tsh in rural localities to half a billion in Dar es Salaam and 2 billion in other urban localities. The government will need to subsidize a large amount of premium for the poor if the premium amount is set at any amount below 30,000 Tsh (Figure 11). It is important to note that the funding gap shown in figure 11 does not include the cost of identifying those who are not able to pay which might add up to the total subsidy required from the government.

**Figure 10: CHF/TIKA revenue potential per year**



**Figure 11: Pro-poor funding gap per year (premiums for those who are not able to pay)**



## 8.2. Cost analysis

Having reviewed the CHF/TIKA revenue potential, this section presents an analysis of costs involved in treating CHF/TIKA members. Calculations using the 2008 SHIELD survey data show that average number of outpatient visits per capita per year among NHIF insured members is approximately 2.6 visits with variations across localities. In Dar es Salaam, the average number of visits is 2.2 while in other urban and rural areas is 3.3 and 2.6 respectively. For inpatient care, the average number of admissions per capita per year is 0.067; Dar es Salaam having 0.061 visits, other urban districts 0.072 visits and rural localities 0.068

visits. For this analysis we assume that if services are improved and the benefit package is expanded, outpatient utilization rate among CHF members will increase up to a level similar to that of NHIF members<sup>8</sup>.

Using unit cost per outpatient visit and per inpatient admission estimated by [10], we calculate the total cost of treating CHF/TIKA members per year. The unit cost for outpatient care takes an average of unit cost at public and FBO/NGOs dispensaries, health centres and district hospitals. The inpatient care unit cost takes an average of unit cost at public and FBO/NGOs health centres and district hospitals.

**- Cost of providing outpatient treatment for CHF members**

As noted before the amount of total revenue increases with increase in premium contribution amount. Table 6 shows that the total amount of treating all CHF/TIKA members if the scheme covers only outpatient care is about 501 billion Tsh per year. This cost is constant across all premium amounts (Table 6) assuming that the government will always subsidize the cost of those who are not able to pay, hence the CHF/TIKA membership will always enroll the whole targeted population in the informal sector regardless of ability to pay. However, if the CHF enrolls only those who are able to pay, treatment costs will decrease with an increase in premium amount implying that the number of beneficiaries seeking care declines with increasing premium amount. The gap in the fourth column of table 6 sum together the amount that the government needs to subsidize CHF premiums for the poor (Figure 11), the matching fund that the government pays for CHF (if this will continue) and the amount of costs in excess of total revenue (contributions plus subsidized premiums). This represents total funding needed from the government to fund CHF members cost of service utilization, excluding payroll costs and investment costs. This funding gap to cover outpatient cost for CHF members is equivalent to about 22% of the current total health sector budget

**Table 6: Cost of providing outpatient care per year (billion TZS)**

Premium level	Revenue from those who are able to pay	Treatment cost for all beneficiaries	Gap (Revenue minus cost)	Proportion of cost covered
5000	31.28	500.69	(469.41)	0.06
10000	62.22	500.69	(438.47)	0.12
15000	92.27	500.69	(408.42)	0.18
30000	171.11	500.69	(329.58)	0.34
50000	237.09	500.69	(263.60)	0.47

**- Cost of providing inpatient treatment for CHF members**

If the CHF/TIKA only covers inpatient treatment only, total revenue generated with premium amount of 30,000Tsh per year will exceed the total cost of providing services by 76%. The premium amount of 15,000Tsh will be enough to cover 95% of total inpatient costs (Table 7). Again the gap in the fourth column of table 7 sum together the amount that the government needs to subsidize CHF premiums for the poor

<sup>8</sup> This may be on the high side, given that NHIF members often live in places with better physical access to services, but may then allow for increased cost of transport for referrals.



(Figure 11), the matching fund that the government pays for CHF (if this will continue) and the amount of costs in excess of total revenue (contributions plus subsidized premiums), hence representing total subsidy from the government.

**Table 7: Cost of providing inpatient care per year (billion TZS)**

Premium level	Revenue from those who are able to pay	Treatment cost for all beneficiaries	Gap (Revenue minus cost)	Proportion of cost covered
5000	31.28	97.19	(65.91)	0.32
10000	62.22	97.19	(34.97)	0.64
15000	92.27	97.19	(4.92)	0.95
30000	171.11	97.19	73.92	1.76
50000	237.09	97.19	139.90	2.44

**- Total cost of providing services for CHF members**

Summing together the costs of providing outpatient and inpatient care together with administration costs (the unit cost of 6,300 Tsh per household per year, as per box 1, was assumed making a total of 40 billion Tsh per year) revenue generated from households contributions to CHF/TIKA at 30,000 Tsh premium amount covers about 27% of the total cost (Table 8). In this case, the government will need to subsidize about 73% of the total costs of providing services for CHF/TIKA members. As above government subsidy in the fourth column of table 8 represent total subsidiy, summing together the amount that the government needs to subsidize CHF premiums for the poor (Figure 11), the matching fund that the government pays for CHF (if this will continue) and the amount of costs in excess of total revenue (contributions plus subsidized premiums). The funding gap required to be filled to cover the total cost of providing services to CHF members is equivalent to about 31% of the 2013/14 health sector budget.

**Table 8: Total cost per year (billion TZS)**

Premium level	Revenue from those who are able to pay	Treatment cost for all beneficiaries	Gap (Revenue minus cost)	Proportion of cost covered
5000	31.28	637.33	(606.05)	0.05
10000	62.22	637.33	(575.11)	0.10
15000	92.27	637.33	(545.06)	0.14
30000	171.11	637.33	(466.22)	0.27
50000	237.09	637.33	(400.24)	0.37

## 9. Conclusion - Comparing the five options

Five broad options for CHF reform have been presented above. The main features and differences appear in Table 2. Table 9 below summarises the authors' assessment of the likely effects and the likely relative magnitude of the effect of adopting each option.

**Table 9: Summary and assessment of relative effect on objectives for the five options**

	Resource mobilisation	Financial protection	Efficiency	Access & quality	Equity
<b>Option 1: From passive to active enrolment, expanding the package</b>	++	+ (members)	0 (+)	0 (+)	+
<b>Option 2: Introducing purchaser-provider split</b>	+++	+ (members)	+	+	+
<b>Option 3: Expanding risk sharing</b>	+++	++ (members)	+	+	++
<b>Option 4: Insurance for regional health services</b>	++++	+++ (members)	++	++	++
<b>Option 5: Bringing all together in a national pool</b>	++++	+++ (members)	++	++?	+++

Note: 0 – no effect; + indicate a positive effect; number of +'s indicate relative magnitude of effect.

It is important to emphasize that unless membership is subsidized for the poor, then the financial protection through CHF/TIKA is likely to decrease for the poor as contribution rates increase and user fees most likely also increase. This effect is lowest for option 1 and highest for option 5 as more services are included in the benefit package and contribution rates are correspondingly higher.

Apart from the likely effects on objectives, the various options have different organizational strengths and weaknesses. The main specific strengths, weaknesses, opportunities and threats for each option is presented in Table 10 below to facilitate comparison. There are, however, also some more general considerations.

A general strength for the development of any of the CHF reform options is that CHF is embedded in a functioning decentralized governance structure and tradition which provides a solid basis for development of CHF reforms. With increasing 'centralisation' of the management through option 1 to 5, it will be a challenge to maintain the local base, but it is suggested to do so through continued close-to-client responsibilities in relation to enrolment. The reforms also rely on local civil society engagement through the Health Facility Governing Committees and the Council Health Services Board in the general improvement of health services and response to client needs.

General weaknesses that cuts across all options is the voluntary nature of the scheme and the fact that the scheme in itself does not provide financial protection for the poor. These weaknesses can be addressed by introducing (morally) mandatory membership and subsidization mechanisms for the poor.

General external opportunities include the recent decision to establish bank accounts for health facilities, thereby placing more (visible) management authority at the health facility level, which may also open for harmonization of the way funds generated at facility level (user fees, NHIF reimbursements, CHF funding) is treated. The fact that the NHIF has already been operating for a number of years and has contributed to public awareness, development of structures and mechanisms for provider payment and an organizational set up, may also be perceived as a general advantage that can be built on. Also a number of on-going pilot interventions are contributing to the experience.

General threats to any of the options are that sufficient funding for matching grants, for enrolment of the poor and for increased service delivery cost cannot be mobilised. This could result in deterioration in quality of services and lack of financial protection of the poor, as well as decreasing interest in enrolment. Focus in general on fraud and cost containment in the use of public funds is very important, but could also result in very detailed documentation requirement and lengthy and (costly) procedures for disbursements, causing unpredictable delays, which may in the end make contracting with CHF and service provision to CHF members less attractive.

Option 1 to 5 is increasingly complex to implement and could be regarded as a possible stepwise approach choosing 2-3 steps to a national system, which may even in the end include one single risk pool not just for the informal sector, but for all Tanzanians. It is estimated that Option 1 can be implemented in the short term, option 2 in the short to medium term, option 3 and 4 in the medium term, and option 5 in the long term.

With increasing complexity also come increasing economic costs, although it is hard to assess the exact implications without much more detailed analysis. There is, however, likely to be economies of scale, e.g. instead of having all district CHF organisations negotiate a regional CHF organization may negotiate for all districts. Also efficiency gains on handling of claims and reimbursements and management of cost containment measures by a more professional administration may outweigh the additional costs of administration and may result in better services. Investment in the development of the organization is, however, needed before the benefits can be realized.

Finally, it should be emphasized that where scale up of community-based insurance has been relatively successful, it has been accompanied by increases in need for funding for service delivery. As the calculations suggest the total cost of providing comprehensive care for the whole targeted population outweighs the amount of total revenue contributed by all able to pay members. More subsidies will be needed from the government to cover premium contribution for the poor, matching funds and costs beyond what the total CHF revenue can cover.

**Table 10. Overview over main organizational strengths, weaknesses, opportunities and threats envisaged for the five options.**

Option	Internal factors ( CHF system)		External factors	
	Strengths	Weaknesses	Opportunities	Threats
<b>Option 1: From passive to active enrolment, expanding the package</b>	<p>Embedded in existing community structures</p> <p>Relatively simple and inexpensive to implement</p>	<p>High level of fragmentation of funding (district CHF pool)</p> <p>Capacity to meet documentation requirements for matching grants low.</p> <p>Weak incentives for quality improvement</p> <p>Weak referral and gate-keeping system may overburden hospitals</p>	<p>Roll-out can build on several pilot experiences within Tanzania, e.g. from Iramba, Kyela and Dodoma (CHF Innovations Study).</p> <p>Community governance structures are relatively well developed.</p> <p>Household lists are kept and may be used for mobilization and stepping stone for introducing mandatory enrolment later.</p>	<p>Importance of taking CHF use patterns into account in the CCHP allocation for recurrent expenditures is not understood.</p>
<b>Option 2: Introducing purchaser-provider split</b>	<p>Enrolment is embedded in existing community structures</p> <p>Capacity to document requirements of matching grants improved</p> <p>Reimbursement linked to demand for services</p> <p>Independent office strengthens complaints mechanism</p> <p>Integration of private providers</p> <p>Fairly simple to implement, though more resource demanding than option 1.</p>	<p>High level of fragmentation (district CHF pool)</p> <p>Capacity to control costs and monitor quality of services low</p> <p>Patients perception of quality may be very limited.</p>	<p>Roll-out can build on existing pilot experiences within Tanzania.</p> <p>Public and private providers are already used to NHIF procedures.</p> <p>NHIF accredited private providers would qualify for CHF contract without further need for assessments.</p> <p>NHIF has some capacity for data analysis and claims verification.</p> <p>Increased coverage with mobile phones and internet connectivity allows faster and smarter handling of information.</p>	<p>Short term focus on provider payment related to present demand may skew resource allocations in LGA: Lack of understanding of necessity to invest in the development of non-performing public health facilities and under serviced areas.</p>

Option	Internal factors ( CHF system)		External factors	
	Strengths	Weaknesses	Opportunities	Threats
<b>Option 3: Expanding risk sharing</b>	<p><u>In addition to Option 2:</u> Risk sharing at regional level</p>	<p><u>In addition to Option 2:</u> Good measures with quality information for risk equalization difficult to find. Information intensive. Harmonisation of contribution rates may affect local ownership. <b>Administratively more complex and costly</b></p>	<p><u>In addition to Option 2:</u> NHIF would have the capacity to develop reinsurance policy for district CHF. NHIF would have the capacity for analysis of risk factors for risk equalization formula.</p>	<p><u>In addition to Option 2:</u> If not transparent and poorly understood acceptance could be low. Weak Health Management Information System Poverty index at district level not available.</p>
<b>Option 4: Insurance for regional health services</b>	<p><u>In addition to Option 2:</u> Risk sharing at regional level Joint office with NHIF provides easy access to technical support. Strengthened capacity for cost control &amp; claims verification. Regional office can negotiate on development of regional health system Regional rates can vary due to variation in access to services.</p>	<p>Patients perception of quality may be very limited. 'Alienation' of CHF as it moves to regional level, although people may still feel a regional affiliation. Regional contribution rates do not take into account variation in access to services within region. <b>Administratively expensive, although there may be some economies of scale?</b></p>	<p><u>In addition to Option 2:</u> NHIF has a regional team, the technical capacity of which can benefit the CHF. In larger cities boundaries of municipalities are crossed daily for work and other business, and is perceived as a natural entity.</p>	<p><u>In addition to Option 2:</u> LGAs may feel less committed to respond to demands of a regional CHF organization than to local constituency.</p>
<b>Option 5: Bringing all together in a national pool</b>	<p>Risk sharing at national level Only one set of harmonized contribution rates and benefits to be developed.</p>	<p>'Alienation' of CHF as it moves to national level Contribution rates do not take into account variation in access to services. <b>Administratively expensive, although there may be some economies of scale?</b></p>	<p>NHIF has a good reputation for service coverage. NHIF already has a Directorate for CHF.</p>	<p>'Alienation' of CHF as it moves to national level. Disappointment of CHF members not understanding that CHF package is different from NHIF package may negatively affect retention of members.</p>

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## Annex 1: Terms of Reference - CHF/TIKA Reforms

### 1. Background

Tanzania is entering a new phase of health financing reforms based on those undertaken since the early 1990s. The first phase of reforms moved the Tanzanian health financing system from a purely budget financed system to a mixed financing model with the hope of increasing availability and quality of care. In this first phase, user-fees (in 1993), Community Health Funds (CHFs – from 1997 onwards) and the National Health Insurance Fund (NHIF – in 1999) were introduced in order to leverage additional funds, build community ownership and create stronger accountability of service providers. The system now has countrywide coverage, albeit with low population coverage.

At the same time, Tanzania has gone through a period of decentralization with profound effects on the way budget financing works. Management and (partly) financing of social services, including primary and first level referral health care, moved to Local Government Authorities (LGAs) and a system of central-local intergovernmental transfers (Block Grants) was introduced, together with a pooled funding mechanism for donor funding (the Health Basket Fund).

A third development has been the overall increase in health expenditure. Total Health Expenditure (THE) increased from US\$734 million in 2002/03 to US\$1.75 billion in 2009/10 (National Health Accounts 2009/10). Per capita expenditure doubled from US\$21 to US\$41. A strong influence on this has been the immense increase in donor funding, which grew from US\$200 million per year to nearly US\$700m per year (while the share of donor funding increased from 27% to 40%).

While these developments have helped to achieve very significant health gains by containing the HIV/AIDS epidemic, reducing malaria and child mortality, and other successes, challenges remain. There is a large body of evidence that shows that spending from public sources, especially domestic, is still too low to finance a package of essential health services, user-fees are a barrier to access when coverage of pre-payment schemes is low, funding is not distributed equitably between and within districts, and the limited funds available are not used efficiently to achieve the maximum effect. Accountability and transparency can also still be improved.

In order to meet these challenges in an environment in which citizens demand more and better services, and in which development aid is reducing, Tanzania is now embarking on a new round of health financing reforms that will build on the foundations of previous reforms, strengthen existing systems, and develop new approaches where needed.

In 2007, the Government of Tanzania adopted a *Health Policy* with the policy vision “to improve the health and well being of all Tanzanians with a focus on those most at risk [...]”. This vision remains still valid, and the GOT is committed to moving towards *Universal Health Coverage* and to ensure that all citizens have access to quality services and be protected from financial risk. As part of *the Health Sector Strategic Plan III*, a decision was taken to develop a Health Financing Strategy to ensure that this vision would become reality.

Oversight for the development of the Strategy has been given to an Interministerial Steering Committee (ISC), comprising of key ministries and departments, to ensure that proposed reforms be comprehensive, accepted and supported by all stakeholders, and implemented with the support of all stakeholders. To

achieve this aim, the ISC has identified key areas for reforms and requested several reports to inform the development of the Strategy. These are:

1. Minimum Benefit Package(s): options to sustainably structure access to benefits;
2. Insurance Market Structure: options for the Social and Private Health Insurance architecture;
3. Performance financing: options for linking allocations to performance of service providers;
4. Equity-based financing: options for improving the equity targeting of (esp. budget) resources;
5. Inclusion of poor & vulnerable: options for identification and financing of services for this group;
6. CHF reforms: options for the re-design of the CHF system;
7. Private sector resources: options strengthening equitable funding from the private sector;
8. Financial management: options for improving accountability and timely availability of funds;
9. Innovative financing and fiscal space: options for increasing public financing for health;

Terms of Reference (TOR) have been developed and approved by the ISC for each focus area. This set of TOR guides the assignment in the area of CHF reforms: options for the re-design of the CHF system.

## ***2. Status of Focus Area***

The Community Health Funds (CHFs) in Tanzania are District-based schemes that are providing basic access to health care to its members (mainly the informal sector). However, CHFs are facing a number of challenges that need to be addressed with comprehensive reforms. Initially, CHFs had been designed in order to provide additional funds for improved health service delivery at the primary health care side, as well as providing financial protection for people that are facing out of pocket spending for accessing health care services. However, health services at the primary health care level are usually not reimbursed for their services provided to CHF members, thus not profiting directly from treating CHF members in their facilities. In addition, members that are enrolled into the CHF are usually only able to access primary health care services, and are not covered for referral services and thus facing catastrophic expenditure when falling seriously sick. Another challenge is the limited portability of benefits, and sometimes members are not even covered by CHF when attempting to access health care services in another facility than they have enrolled with (and certainly not across districts). In addition, the management of CHF at the district level is run by the Council Health Service Board where both, provider and purchaser are represented. This means that there is no insurance mechanism implemented, and bad quality health service provision has no consequences. Also, in reality operations are conducted by CHF coordinators that are often only working part-time in this function and do not have sufficient time and knowledge to run CHF operations and sensitisations of communities.

## ***3. Steering & Oversight***

The assignment is aimed at informing the ISC, which will have the final say in all issues related to the process, assisted and supported by the ISC Secretariat and the TWG HF. The TWG HF will develop TOR, pre-select consultants and pre-approve reports for submission to the ISC. The ISC will give final approval of TOR, consultants and report. The financing organization will ensure that contracting and compliance with contractual obligations from both sides will be fulfilled. The ISC Secretariat will support on these issues.



In addition, the consultant is expected to participate during the CHF Days that will discuss major areas of CHF Reform and its vision. The consultant is expected to present main streams of CHF options to the HCFC and ISC (e.g. the inception report), and will be given a first feedback during that meeting towards elaborating those main options further in a more detailed way. The consultant should develop 3-5 options for CHF reform, of which one option should focus on the present CHF design (CHF as a cost-sharing tool), while the other 2-4 options should elaborate more in detail different choices for re-design (please see specific content requirements under the section “objectives”).

#### **4. Objectives**

The overall objective of this assignment is to develop comprehensive, adequate and feasible reform strategies / options for the focus area CHF Reforms to be presented to the ISC for feeding into the Tanzanian Health Financing Strategy.

The specific objective is to discuss two main streams for the areas of CHF reform, with an emphasis on focusing on the development of the CHF as a tool for Universal Health Coverage, and thus for transforming it to an output-based, insurance-based scheme. Therefore, one option should be developed considering the implementation of CHF as a cost-sharing tool (status quo), with improvements in certain areas, and 2-4 specific options to be developed based on the assumption that CHF is implemented as an insurance model.

#### **5. Scope and Methods**

The consultant is expected to review relevant documents (see below list of studies that need to be included), conduct interviews with key stakeholders such as MoHSW, NHIF, SSRA, Development Partners active in this field (GIZ, SDC, WB, WHO) and researchers such as the Ifakara Health Institute. In areas where he/she feels the need to gain further inside from practitioners and people from the “ground”, field visits can be arranged. The consultant should consider international experience, especially on re-financing options where he/she should also link with existing and on-going/planned initiatives.<sup>9</sup>

The consultant should to present main streams for the scenario/option development to the HCFC and ISC, possibly before the CHF days. After consultation, recommendations will influence the further development of specific options. Finally, between 3-5 reform options / scenarios that are specific enough to bring out differences and general enough to allow for use in a strategic document and for adaptation and modification in implementation are expected. Each of the options / scenarios is to be backed up by a SWOT analysis presenting internal strengths and weaknesses and external opportunities and threats to allow the ISC to assess the different options/scenarios and to make a choice.

#### **6. Tasks**

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<sup>9</sup> E.g. GIZ is planning to support a study assessing international experiences of sustaining/re-financing community based health initiatives and schemes, with a possible focus on Tanzania. The study will be conducted in January 2013

Under both streams, the consultant should undertake the following:

**a. Governance and Regulation**

- i. Assess the legal and regulatory framework required to expand financing options for the CHF, and highlight legal amendments as well as institutional links that are necessary for successful implementation
- ii. Assess the decision-making process at the different levels (national and council level), define clear responsibilities for each level, including the specific roles of MoHSW, NHIF, PMO-RALG, Councils, Communities & Users
- iii. Discuss the establishment of a national overseeing body, e.g. a National CHF Steering Committee vs. District level overseeing body
- iv. Review the current set-up of CHF Management oversight by NHIF and explore advantages and disadvantages of an independent, national oversight CHF body
- v. Propose mechanisms for complaints and accountability, including but not limited to the role of the Health Facility Governing Committees
- vi. Recommend, with supporting arguments, whether the CHF should be voluntary vs. mandatory

**b. CHF Administration and Sensitization**

- i. Assess different options for the improvement of CHF administration, and discuss the legal and regulatory framework requirements of different options (e.g. separation of Council Health Service Board OR engagement of external unit in CHF administration)
- ii. Discuss mechanisms for staff employment and oversight, and define HR capacities required in managing the CHF
- iii. Identify information and communication technology requirements for effective and efficient implementation of CHF in Tanzania. The suggested IT system should be user friendly and where possible compatible with existing systems in LGAs
- iv. Recommend mechanisms for sensitization (eg by whom? active or passive enrolment mechanism?)

**c. Pooling and reimbursement of Funds**

- i. Discuss different levels of fund pooling and flow/transfer of funds (e.g. health facility level)
- ii. Identify reimbursement mechanisms and/or allocation formula(e) that incorporating output-orientation and equity/solidarity mechanisms and which allow for portability

**d. Pro-poor**

- i. Explore broad options for identification of the poor through discussion with relevant stakeholders, and especially with the consultant working on ToRs 5 (Inclusion of poor & vulnerable: options for identification and financing of services for this group)

**e. Benefit Package**

- i. Assess advantages and disadvantages of including Primary health care level only **vs.** referral care level only **vs.** primary and referral care

**a. See also ToRs 1 (Minimum Benefit Package )**

- ii. Assess the feasibility of the inclusion of transport into the benefit package
- iii. Consider whether and how ADDOs and FBOs might be included under CHF

**f. Sustainability/Financing**

- i. Assess the management/administration costs of CHF and outline funding sources and mechanisms
- ii. Provide a comprehensive assessment of existing and potential funding sources for financial sustainability of the CHF, including at least:
  - 1. Government funds
  - 2. Contributions from the National Health Insurance Fund (NHIF)
  - 3. Contributions from the National Social Security Fund (NSSF)
  - 4. Private insurance (including micro insurance schemes)
  - 5. Out-of-pocket payments (e.g. co-payments)
- iii. Assess subsidization levels and mechanisms, and the feasibility of equitable re-insurance mechanisms among Districts and with the National level and/or and improved matching grant system
- iv. Assess the feasibility of Covering the minimum benefit package
- v. Consider options for individual vs. family premium and recommend accordingly
- vi. Consider mechanisms of creating an efficient pooling mechanism of funds), investigate the efficiency of the fund transfer mechanism from national level to the CHF and highlight how financial flows and transfers can be streamlined (see also ToRs 2 & 9)
- vii. Align with the consultant responsible for the identification of the poor with regards to the review the exemption and waivers policy and having transparent mechanisms in place for services/population groups that have been exempted so far

**g. Monitoring and Evaluation**

- i. Assess existing mechanisms for monitoring of health care delivery to CHF members (e.g. through mhealth/clinical paths) , and propose improved linkages to the standard HMIS system in Tanzania

**7. Timeframe and Deliverables**

The suggested timeframe for this assignment is February to mid-April. The following table shows the timing at which deliverables are expected:

#	Deliverable	Weeks after signing
1	Inception report incl. report outline (presentation to the ISC and HCFC)	2 weeks
2	Draft report	7 weeks

3	Presentation to ISC	10 weeks
4	Final report incl. executive summary	12 weeks

### 8. Professional requirements

At least two consultants are required for this assignment. There will be one international-level lead consultant with significant practical experience in Health Insurance (Reform) and one national health financing and insurance specialist. This team may be composed of two individually contracted consultants (in which case the lead consultant will approve the national consultant for contracting, and clear his/her contributions for payment by contractors or by a consultancy firm).

<b>Lead consultant</b>	
<b>Profile</b>	<ul style="list-style-type: none"> <li>• Masters degree in a relevant field (Health Systems, Financing, or Economics; Public Health or Medical degree with a relevant specialization).</li> <li>• A minimum of 10 years of work experience in health work.</li> <li>• Work experience on health financing reform in several low- and/or middle income countries, especially in Sub-Saharan Africa.</li> <li>• Familiarity with the Tanzanian health financing system is a strong asset.</li> <li>• Excellent analytical skills</li> <li>• Excellent report writing skills.</li> </ul>
<b>Tasks</b>	<ul style="list-style-type: none"> <li>• Report to the ISC and the contracting party and take responsibility for work outcomes.</li> <li>• Coordinate the report writing and present to the ISC.</li> <li>• Manage and coordinate the specialist consultant.</li> <li>• Clear specialist consultants' contributions for payment by contractor.</li> </ul>
<b>National consultant Health Financing</b>	
<b>Profile</b>	<ul style="list-style-type: none"> <li>• Masters degree in a relevant field (Health financing, economics, public health with relevant specialization, social security).</li> <li>• A minimum of 5 years of work experience in a relevant field (including health insurance, regulatory bodies, MoHSW, health systems and health financing research)</li> <li>• Excellent knowledge of the Tanzanian health and health financing system and recent reforms.</li> <li>• Good knowledge of the Tanzanian (social) health financing system.</li> <li>• Connectedness in the Tanzanian health and health insurance sector.</li> <li>• Good organizational skills.</li> <li>• Good report writing skills.</li> <li>• Excellent command of English and Kiswahili, written and spoken.</li> </ul>
<b>Tasks</b>	<ul style="list-style-type: none"> <li>• Report to the lead consultant.</li> <li>• Assist the lead consultant in planning, managing and implementing activities, especially during interviews and stakeholder consultations.</li> <li>• Collect all relevant health financing documents.</li> <li>• Provide written inputs for the report in the field of specialisation</li> </ul>

## 9. *Relevant materials*

Relevant materials for all areas include:

- National Health Accounts 2009/10 (MOHSW 2011)
- Health Sector PER – various editions (MOHSW 2011)
- Tanzania Health Systems Assessment (MOHSW with HS2020, 2011)
- (Draft) Health Financing System Analysis (TWG HF 2012)
- Making Health Financing Work for the Poor (World Bank 2011)
- SHIELD reports (IHI, various years)

Relevant materials for the focus area include:

- CHF Innovations Study
- CHF Best Practices
- National Essential Health Interventions Package (MOHSW 2000)
- National Health Services Costing Study Report (GIZ 2013)
- Service Delivery Indicators Report (SDI) (WB 2012)
- Service Provision Assessment (SPA) (NBS/USAID 2012)
- Study on specific needs of people living with disabilities (GIZ 2013)
- Kamuzora P, Gilson L. (2007), 'Factors influencing implementation of the Community Health Fund in Tanzania' in *Health Policy Plan*, 2007 Mar;22(2):95-102;
- Community health fund as a complementary financing option in Tanzania, J.E. Sendoro, CHF Coordinator, Ministry of Health and Social Welfare.
- Regulatory framework study, Lancker, et al.2008 and Bultman, et al.2011

The reform options should be presented in a way that they can be included in a draft health financing strategy. A maximum 5-page summary of the key messages and options should be compiled.

## Annex 2: Schedule of meetings

Date & time	Counterpart name & position
<b>13 May</b>	
11 am	Birte Frerick GIZ
2pm	Josselin Guillebert, CIDR
<b>14 May</b>	Tawa Meramba TNCHF
10am	
12am	Mariam Ally Head, Health Financing Unit
2pm	Health Care Financing Committee
<b>15 May</b>	
2pm	Manfred Stoermer, Prof. Meshack , HPSS Dodoma
<b>16 May</b>	
10am	Ansgar Mushi Director Research-SSRA
<b>17 May</b>	
9am	Jacques Mader Jacqueline Matoro Oliver Praz
10.30 am	Birte Frerick GIZ
12.00	Max Mapunda , WHO
2 pm	Ansgar Mushi Director Research, SSRA
<b>20 May</b>	
9 am	Ali Mtulia NSSF-SHIB
	Wrap up meeting
<b>17 June</b>	
11am	Field trip-Iramba -Silvery Maganza- CHF Coordinator, Mr. Hezron M.- DED, Dr. Japhet- DMO
<b>18th June</b>	
12 noon	PMO-RALG CHF coordinator
2pm	HSSP-CHF-Dodoma Prof. Meshack
<b>20<sup>th</sup> June</b>	
9am	DMO Kinondoni
<b>24<sup>th</sup> June</b>	
9am	NHIF-CHF manager Mr. Rehani