

# Community Health Funds in Tanzania: A literature review

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## **ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome
CBHF	Community Based Health Financing
CHF	Community Health Fund
CHSB	Council Health Services Board
GTZ	Germany Technical Assistance
HIV	Human Immune Virus
MHIS	Micro Health Insurance Schemes
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MPEE	Ministry of Planning, Economy and Empowerment
NHIF	National Health Insurance Fund
NHP	National Health Policy
NSGRP	National Strategy for Growth and Reduction of Poverty
NSSF	National Social Security Fund
RSTGA	Rungwe Small Tea Growers Association
SDC	Swiss Agency for Development and Cooperation
SHIB	Social Health Insurance Benefit
TIKA	Tiba Kwa Kadi
TNCHF	Tanzania Network of Community Health Funds
URT	United Republic of Tanzania
URT	United Republic of Tanzania
WDC	Ward Development Committee
WHC	Ward Health Committee

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## **1 INTRODUCTION**

The Community Health Fund (CHF) was introduced in Tanzania as part of the Ministry of Health's (MOH) endeavor to make health care affordable and available to the rural population and the informal sector. The scheme started in 1996 with Igunga acting as a pilot district, and was later expanded to other districts. Whilst there have been various reviews of the performance of individual CHFs, there has not yet been an overall synthesis of its performance in Tanzania. This paper aims to address this gap and was commissioned by the Swiss Development Agency for Cooperation (SDC) and the Ministry of Health and Social Welfare (MOHSW) in preparation for a CHF best practice workshop to be held in January/February 2007 in Dar es Salaam.

The objectives of the review are:

1. To give a general overview of the existing CHF relevant projects/studies/initiatives in Tanzania;
2. To highlight in a concise way the main issues/challenges that these projects/studies/initiatives raise;
3. To create a base of information that will contribute to enhancing a common understanding of CHF challenges among the different stakeholders.

The methodology primarily involved a desk review of the available literature on existing CHF schemes in Tanzania. This included national policies, CHF supervisory reports, research studies and evaluation reports. Where relevant, international literature was drawn upon; but it is important to note that a full review was beyond the scope of this study.

### **1.1 Outline**

The paper begins by briefly outlining the background of the CHF before examining current trends in: coverage; membership and enrolment; sources of revenue; and expenditure patterns. The report then summarizes the evidence with respect to four key areas of concern, namely: reaching the poor; management and accountability; service provision issues; and future sustainability of the scheme. For each area, the main issues raised in the literature are presented; and each section ends with a summary of areas for future investigation or research. The report concludes by suggesting some ideas for the future operation of CHF in Tanzania.

## **2. BACKGROUND TO COMMUNITY BASED HEALTH FINANCING**

### **2.1 The Concept of Community Based Health Financing**

Community Based Health Financing (CBHF) has emerged in developing countries as a response to the existing challenges in the health financing system which include low economic growth, constraints on the public sector and low organizational capacity (Carrin 2003). CBHF is a mechanism whereby community members (households) finance or co-finance costs associated with health services, offering them greater involvement in the management of community financing scheme and organization of health services (Carrin 2003).

CBHF schemes can be seen as a step towards universal coverage following the widely acknowledged difficulties which exist in tax financing and social health insurance, especially in less developed countries (LDCs). Problems embedded in tax financing include: a typically small tax base and large informal sector; dependence on donors; weak income and asset taxes; and high dependence on international trade. A move towards social health insurance also poses challenges, namely: difficulties in arriving at a national consensus for a scheme's structure; income inequalities; and, weak government managerial capacity and poor infrastructure which limits the facilitation of collections, reimbursements and monitoring (Carrin 2003; Carrin, Waelkens et al. 2005). Given these problems, CBHF schemes are seen as an option for extending insurance coverage in low-income countries, particularly among rural and informal sectors of society (Kelley, Diop et al. 2006).

### **2.2 Wider health financing reform in Tanzania**

Tanzania, like many countries in sub-Saharan Africa, faces the twin pressures of a tight public health care budget and the need to improve access to health services, especially for the poor and those working in the rural areas and/or the informal sector. As part of wider reforms in health care financing, Tanzania introduced user fees in 1993. This followed the failure of the government to provide free health care to all its citizens through tax financing due to the increase in treatment costs, emergence of pandemic diseases such as HIV/AIDS and the overall poor performance of the economy (Quijada and Comfort 2002). Over time, other financing mechanisms have been added including the introduction of schemes resembling prepaid insurance such as the National Health Insurance Fund (NHIF): Community Health Funds (CHF) and its urban equivalent, TIKA; and various Micro Health Insurance Schemes (MHIS) such as Umasida and Vibindo. More recently, the National Social Security Fund (NSSF) has introduced a health care benefit package known as Social Health Insurance Benefit (SHIB).

### **2.3 The Community Health Fund in Tanzania**

The CHF started in 1996 with a pilot scheme in Igunga district which was later expanded to other councils with the expectation of covering the whole country (MOH 1999). The scheme was identified as a possible mechanism for granting access to basic health care services to populations in the rural areas and the informal sector in the country. As such, its primary aim was not to raise additional funds but to improve access to health care for the poor and vulnerable groups. The CHF is a form of pre-payment scheme designed for rural

people in Tanzania (Munishi 2001). It is based on the concept of risk sharing whereby members pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount in health care user fees if they fall sick.

According to the Community Health Fund Act of 2001 the objectives of the CHF are: (i) to mobilize financial resources from the community for provision of health care services to its members; (ii) to provide quality and affordable health care services through sustainable financial mechanism; and (iii) 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 (URT 2001)

## **2.4 Operation of the Community Health Fund**

Membership to the CHF is voluntary and each household within a district contributes the same amount of membership fee, as agreed by members of the community themselves, and is given a health card (URT 2001). The card entitles the household to a basic package of curative health services throughout the year. Normally, coverage is for the household head and other household members below the age of eighteen years. Households that do not participate in the CHF scheme are required to pay user fees on an individual basis at the health facilities at the point of use.

## **2.5 TIKA**

*Tiba Kwa Kadi*, or TIKA as it is more commonly known, is the urban equivalent of the CHF and is similar in design. It is intended mainly for urban and peri-urban areas, and membership to this scheme will be on family or household, as well as socio-economic groupings (MOH 2000). Unlike the CHF, contribution to this scheme will be at a flat rate per member of the household or family. TIKA is still largely at the pre-implementation phase of planning and development, and aims to achieve 15% coverage of the urban population by 2010. Like the CHF, it aims to increase community participation through the generation of additional resources for health facilities (Burns and Mantel 2006).

# **3. COVERAGE AND ENROLMENT**

## **3.1 District rollout of the scheme**

Currently, the CHF has been introduced in 69 district councils (URT 2006). In 2003 the MOH undertook a study of factors affecting enrolment and coverage and suggested a number of possible explanations for the slow roll out (MOH 2003). At the regional level reasons included: lack of commitment by some regional and district officials; inadequate follow-up from the MOH; lack of capital for initiation of the scheme; lack of uniformity on premiums; inadequate mechanisms for continuation of membership; and unclear referral mechanisms (MOH 2003).

## **3.2 Willingness to join the scheme**

Various studies have been conducted to assess the willingness of the community to join CHF (see, for example, Agyemang-Gyau (1998), Steinwachs (2001), and Beraldes and Carreras (2003)). These studies also identify how much community members are willing to

pay for CHF: for example, in Mtwara rural, members are willing to contribute between 4500 and 6500 Tsh per household (Beraldes and Carreras 2003); whilst in Lushoto, members willingness to contribute varied between 3000 and 10,000Tsh (Agyemang-Gyau 1998) given that the services granted are improved. In reporting their findings, Beraldes and Carreras argued that the concept of insurance is poorly understood amongst community members and they therefore required a lot of sensitization to join the CHF.

There is some evidence that certain schemes have shown relatively encouraging trends in enrolment. For example, an unpublished Masters thesis study by Mwendo (2001) in Iramba district suggested that up to 53% of the study sample interviewees (n=212) were consistently members of the CHF since its establishment in 1998. Moreover, 95 percent of community members were aware of CHF. In Rungwe, Sheuya (2006) showed that a joint public private partnership initiative between the Rungwe CHF, and Rungwe Smallholder Tea Growers Association (RSTGA) and the Wakulima Tea Company helped to increase membership substantially. RSTGA/Wakulima have agreed to pay the CHF contributions for their members and have currently paid the CHF 50 million Tsh to cover 5000 member households with the expectation of eventually covering all RSTGA/Wakulima members, estimated to be 65,750 (about 15,000 households).

### **3.3 Reasons for falling enrolment**

In some schemes, a decline has been found where enrolment was previously relatively high. Shaw (2002) found that enrolment of community members to the scheme in Igunga and Singida rural districts was 6 and 4 percent respectively, which was low in comparison to expectations of 30 percent. Chee et al, (2002) in their assessment of the CHF in Hanang district found that membership in 2001 was around 3 percent of total households; however, more recent data indicates that this fell further to 2.2 per cent in 2003 (Musau 2004). This is an alarming finding given that CHF membership had reached a peak of 23 percent in 1999 yet within just a few years had apparently fallen dramatically to less than 3 percent. Shaw (2002) argues that one of the reasons for low enrolment rates could be the low user fees set in public facilities as these give little incentive for community members to join an alternative financing system like the CHF. User fees in some councils like Nzega are set at 1000 shilling per visit at health centre level and many community members are willing to pay the user fee rather than the higher CHF premium (Mhina 2005). Similarly, high membership fees set by some councils are also likely to be a barrier to enrolment. For example, the MOH CHF Facilitative Supervision report noted that Karagwe is proposing an annual fee of 30,000 per household to those currently paying 15,000 shillings, a figure already above the average in comparison to many other district councils contributions (MOH 2006).

Msuya et al. (2004) cited low income and income un-reliability as further reasons for low enrolment. They found that 60% of richer households in Igunga district joined the scheme compared to 33% of the poorest households. Other reasons include: lack of information due to insufficient sensitization/education to the community; introduction of NHIF which took out public servants who were potential members of CHF, non-coverage of referral care; perceived poor quality of health care services at public facilities (drug availability and inadequate service provision); poor staff attitudes; and broad exemption policies which leave a limited number of people contributing to the CHF (Mwendo 2001; MOH 2003; Mhina 2005; MOH 2006). Finally, Bonu et al. (2003) argue that the poor enrolment rates in many CHFs may be linked to a perception of poor quality of care. Thus, those who

initially register into the scheme may drop out quickly if the quality of care does not reach expectations.

### **Key issues: Enrolment**

- Roll-out of the scheme across councils is slow
- Membership to CHF is still low in some districts and falling in those districts where it was initially relatively high
- More systematic data is required on current enrolment rates and the size of total households within the councils
- Better understanding of households' willingness and ability to join the scheme is needed
- Further research/evaluation is needed on successful strategies to maintain membership and increase enrolment

## **4. REACHING THE POOR VIA THE COMMUNITY HEALTH FUND**

### **4.1 National Policies**

The Vision of the Tanzania National Health Policy (NHP) is to improve the health and well being of all Tanzanians with a focus on those most at risk, and encourage the health system to be more responsive to the needs of the people (MOH 2003). It is also the aim of the government to put in place mechanisms for risk sharing and cross-subsidization in order to ensure solidarity and equity. In addition, the Tanzania National Strategy for Growth and Reduction of Poverty (NSGRP) places a greater emphasis on equity in the delivery of health and social services so as to improve access for children, women, the poor and other vulnerable groups especially in rural areas (URT 2005).

### **4.2 The potential of the Community Health Fund for reaching the poor**

A review of the international literature indicated that CBHF schemes do appear to extend coverage to a large number of rural and low income populations that would otherwise be excluded (Preker, Carrin et al. 2002). Similarly, another major systematic review of community health insurance provides evidence that CHF type schemes can provide protection to their members by significantly reducing the level of out of pocket payments for health care (Ekman 2004). This same review, however, also argued that, in practice, most schemes fail to cover the very poorest groups. In Tanzania, Msuya et al. (2004) argue that CHF has improved access to health facilities for the poor. This is because members were more likely to seek health care from formal health care providers compared to non members. CHF membership also reduces the use of traditional healers and the use of alternative medical care as self medication, especially for the poor. Membership to the CHF reduces the risk of households selling their assets for the sake of getting money for treatment during disease outbreak.

Despite the evidence showing improvement of access for members, it is important to return to the question of persistently low enrolment rates. If the scheme only reaches a small proportion of the population then it will be difficult for it to impact on improving equity of access for the health system more generally. CHF schemes have great potential to improve

access for poorer groups by removing payment at the point of use and allowing members to pay when they can afford to (i.e flexibility in contribution); however, in practice, even relatively small contributions can often be too high for the poorest to pay (Bennett, Kelley et al. 2004).

### **4.3 Exemptions and waivers and the Community Health Fund**

The terms exemptions and waivers are often used interchangeably in the literature although they refer to different groups. According to the CHF design manual, an exemption is a statutory entitlement to free health care services granted to individuals who automatically fall under the categories specified in the cost sharing operational manual, eg, MCH services, children under five, pregnant women. A waiver is granted to those patients who do not automatically qualify for statutory exemptions but are in need of the same and classified as 'unable to pay' in the operational manual (MOH 1999; URT 2001). District councils are expected to fully subsidize the CHF membership fees for those who have been exempted or waived. This was recently re-emphasised by the former Tanzanian President, Benjamin Mkapa, in his speech at the regional RMO meeting in 2005: "...relevant councils should set aside funds in their budgets for purchasing CHF cards for their less fortunate constituents without the means to afford them..." (President Mkapa 2005)

Whilst identifying those entitled to exemptions is relatively straightforward, identifying those entitled to waivers presents a bigger challenge. District councils decide on their own identification criteria yet there is no consensus on what the guidelines should be. The Ministry of Health and Social Welfare recently commissioned a wide ranging review of the operation of exemptions and waivers in Tanzania (Burns and Mantel 2006). The authors argued that the current exemptions system may, in fact, favour the better off more than the poor since most of those exempted belong to households which are able to pay the CHF membership fees. They suggested that the poorest often do not have access to waivers, either due to a lack of information or denial of the waiver by a provider. In addition, it is argued that the approach has loopholes that allow misuse and, sometimes, abuse of the system, and lengthy and cumbersome identification processes often deter people from applying (Burns and Mantel 2006).

The weakness in the implementation of waivers is evident in districts where only a few people are waived and no clear criteria is set out for identifying the poor, as reported by several authors (Laterveer, Munga et al. 2004; Msuya, Jutting et al. 2004; Burns and Mantel 2006). In some instances, exemptions and waivers are not accepted at non-government facilities; here, patients have to pay or have the option of paying on credit (Burns and Mantel 2006). In Kilombero district, Manzi (2005) found that waivers were rarely provided or not provided at all, and people were not informed about their existence. Additionally, waiving decision is left to the community which has low technical back-stopping and low awareness of waivers. Due to long procedures, there are only a few cases where poor people are waived and, as a result, people end up treated on credit in case of facilities acceptance.

### **4.4 Successful strategies in reaching the poor**

Despite the above difficulties in the implementation of waivers/exemptions, some districts have made efforts to both identify the poor and make the waiver system work more effectively. In Mwanga district, officials have been able to identify the poor and maintain

lists of the poor in all health facilities so that the application of waivers is straightforward (Burns and Mantel 2006). Other districts have consolidated all forms of cost sharing into the CHF, and households who cannot afford to pay are identified and provided with a CHF card (Burns and Mantel 2006). In Muheza district, the council has released Tsh 3,000,000 for the year 2005/06 and secured additional funding to provide CHF membership cards for the poor, estimated to be 733 families (Siegert 2005). Some of the criteria employed to identify the poor in Muheza include: elders and widows who have no means of support; physically/mentally handicapped persons; orphans less than 18 years; and those with poor housing and no access to safe drinking water (Ndangala and Kalimalwendo 2005). The lessons learnt should be widely shared with other districts, and more information is needed on the practicalities of compiling and maintaining pro-poor lists and the subsequent impact on actual access for the poorest groups.

#### **4.5 Cross subsidisation**

In CHF settings, there are two main issues concerning cross subsidisation. The first issue is at the community/household level which involves cross-subsidization between the poor and the rich, and between ill and healthy individuals or households. Here, the CHF is expected to raise revenue and subsidize the poor who are not able to pay and, therefore, it is important to have a mixture in the composition of members in a community scheme (Carrin 2003; Carrin, Waelkens et al. 2005). The previous sections showed low CHF enrolment rate in some councils (Chee, Smith et al. 2002; Shaw 2002; Musau 2004) and evidence also suggests that low enrolment is often a sign of adverse selection (Carrin 2003). Adverse selection occurs when healthy people with a low risk of illness decide not to join a scheme or to drop out of a scheme, leaving an insurance pool with higher risk (i.e. sicker) members which might threaten the overall sustainability of the scheme. It is important to encourage a mixed risk pool so that healthier and wealthier members can cross-subsidise those who are sick and poorer.

The second issue concerning cross subsidization is at the regional level, and concerns the different abilities to raise revenue between different councils or regions. Some councils are located in geographical areas with good soil and rainfall which assure good harvest; however, for those regions or councils located in dry areas, raising enough revenue is a problem. In the long run, there is a need to address the issue of cross subsidization in such settings.

#### **Key issues: Reaching the poor**

- There is a lack of information on the socio-economic status of members and non members
- The waivers system is poorly understood by many community members and health staff, and there are challenges in implementation at the district level
- Some districts have made positive efforts to identify the poor and the lessons should be more widely shared
- To what extent is it possible to cross-subsidize between councils to account for imbalances in revenue generation?

## **5. MANAGEMENT AND ACCOUNTABILITY**

### **5.1 Community Health Fund management**

The district is the centre of CHF activities with the CHSB responsible for : introducing the CHF scheme to community level stakeholders including the Ward Development Committee (WDC), the village council, households and health care providers;and supervision of financial management records and the operation of the health facilities (MOH 1999; MOH 2005). In addition, district councils are expected to conduct CHF sensitisation activities in collaboration with the community members. The management of the CHF and how funds are accounted for has, however, only been the subject of a limited number of evaluations conducted at the district level.

### **5.2 Use and management of funds**

Chee et al (2002) in their evaluation of the Hanang CHF argue that there are some weaknesses in CHF financial management and information systems, especially in the operation at the Ward Health Committee (WHC). An important question is whether facility staffs who are often left with the day to day management of the scheme have the financial and management capacity to handle the fund in addition to delivering services to patients. Lack of knowledge/capacity and experience in community mobilization and financial management is among the factors that have hindered the implementation of CHF in other councils (MOH 2006). According to Laterveer et al (2004), districts are not clear on CHF management rules and procedures, and they reported that there was mismanagement of CHF funds in about 27% of CHF implementers. In other instances, they found CHF funds were not utilized and, hence, remained idle at the district level. There also appear to be problems in conducting regular audits, despite the CHF Act of 2001 insisting that schemes employ competent and qualified auditors to audit CHF accounts (URT 2001). An assessment by the MOH showed that not all councils conducted regular audits or reported to community members (MOH 2003).

### **5.3 Community participation**

The intention of the CHF is to involve the community in management issues and for financial planning and management skills to be available at the community level (MOH 1999). According to the CHF design manual and CHF operation manual, the scheme needs to give the community a greater say in the planning and management of CHF activities so as to strengthen community participation in Health (MOH 1999; MOH 1999). The act establishing CHF specifies that four community members should be included among the members of the Council Health Services Board (CHSB), two of which should be female (URT 2001). The tasks of CHSB are to: monitor CHF operations; mobilize and administer funds; set exemption criteria for users of the health services provided by CHF; review reports from the WHCs and other sources; monitor and make verification on collection, expenditure and control of funds; and design the annual health plan. The community is also represented by the WHC which comprises of the councilor, the ward executive officer, a head teacher from a primary school located in the ward, two community members elected by the community, and the clinical officer or assistant clinical officer in charge of a health care facility (URT 2001). The members of the CHSB and the WHC are expected to deliver information to the other CHF members on the operation of CHF with the objective of

making them feel involved in CHF operations; however, the CHF Act, 2001 does not bind CHSB and WHC members to be members of CHF.

The MOH evaluation noted that, in some councils, community members are unaware of how the membership fee is set (MOH 2003). Similarly, the evaluation by Chee and colleagues in Hanang district also concluded that communities had little participation in the overall management of the CHF (Chee, Smith et al. 2002). They found that CHF members had never been invited to meetings to discuss the benefits and management of the programme, or been informed about how the CHF funds were being spent. On the other hand, the same evaluation stated that the most CHF members still had a positive attitude towards the programme and the majority believed that the CHF would lead to an increase in the supply of drugs and improved services at participating facilities.

In some ways, community participation can be facilitated through “Willingness to Pay” studies conducted in several councils (see for example, Baraldes and Carreras (2003) in Mtwara and Agyemang-Gyau (1998) and Steinwachs (Steinwachs 2001) in Lushoto). These studies help to provide an understanding of the willingness of the community to participate in CHF and how much they are able to contribute. This, in turn, might encourage higher enrolment since the contributions can be set in accordance to their ability to pay.

### **Key Issues: Management and accountability**

- The knowledge of financial management is weak in many councils
- Accountability of funds is a problem and in some councils there is lack of regular audit
- CHF members in some councils are not always sufficiently involved in CHF decisions
- Representation of CHF members in CHSB and WHC is not guaranteed

## **6. PROVISION AND USE OF SERVICES**

### **6.1 Quality of services**

Several studies have shown an improvement in the provision of and access to health care services after the introduction of CHF. For example, Shaw (2002) shows that the CHF fund helped to purchase microscopes, reduce drug stock-out, and improve the availability of or introduce other important equipment and supplies in various hospitals. Other studies have also shown an increase in health service utilization for CHF members (Msuya, Jutting et al. 2004; Musau 2004). Despite this, there remains a need to address some important issues concerning provision of services.

### **6.2 Community Health Fund Benefit package**

The CHF is designed to finance a basic package of curative and preventative health services at dispensaries and health centres (MOH 1999). This means that where a CHF member is in need of referral care, the only option is out-of-pocket payment which can lead to catastrophic expenditure. Some district councils, such as Hanang, Igunga, Mwanza and Rombo, have gone beyond the original CHF design and extended the coverage of CHF benefits to hospitals using CHF revenue, although there is little information on the impact of this. Addressing the issue of referral services is important for enrolment since limited

service coverage has been identified as a key reason for not joining the scheme. Inclusion of referral services in the CHF package would encourage a higher uptake of membership, given that secondary services are more costly and present a bigger financial burden than primary services (Burns and Mantel 2006).

CHF members are told to choose the provider (private or public) from which the household will be accessing health care at the beginning of the year (MOH 1999). The choice is made every year and members are not allowed to switch to different providers within the same year (MOH 1999). The effect of this may be to limit the scope for members to search for higher quality services if they are not satisfied with the provision of a particular facility (Steinwachs 2001). In most councils, access to private for profit health services is still limited and some faith based organizations do not accept CHF cards (Burns and Mantel 2006). There is, as yet, only limited information on the number of private facilities available which have a service agreement with CHF, particularly in the rural areas.

To strengthen service delivery in the primary public health facilities, the issue of Tanzania's human resources crisis in health care needs addressing. Although this issue is not CHF specific, it affects CHF operations. It is well documented that there is a problem of understaffing in the health sector in Tanzania (Dominick and Kurowski 2005). Moreover, health sector staff are not always properly motivated, especially those working in remote areas; and, with little motivation, service delivery in facilities in rural areas is undermined. Since the CHF depends on these rural health facilities, it is important to address how motivation can be improved to enhance the quality of service delivery in rural primary facilities, thereby encouraging more members to join the scheme.

### **Key Issues: Provision and use of services**

- Need to address the question of how to widen CHF coverage to referral level services
- What is the extent of private provider involvement in the provision of service for CHF members?
- Low motivation of health staff endangers the quality of service provision in rural health facilities and threatens CHF enrolment

## **7. SUSTAINABILITY OF THE COMMUNITY HEALTH FUND**

### **7.1 Trends in member contributions**

It is expected that the largest source of revenue to the CHF is member contributions. Other sources of revenue include: user fees payable at primary health facilities; the government matching grant (the government tops up the amount collected through membership contributions by 100%); grants from councils, organizations and donors; and any other money lawfully acquired from any source (URT 2001). Overall, as the section on enrolment showed, CHF membership is still relatively low and drop out rates are increasing, even for those schemes that have been in operation for some time such as Igunga and Singida (Shaw 2002). This downward trend in enrolment might effect the revenue generation and, if it is widespread, may pose problems for the sustainability of the CHF.

Uncertainty in revenue generation is exacerbated by the fact that many members rely heavily on agriculture for income and harvests in recent years have been variable. Tanzania recently experienced a serious drought which led to repeatedly poor harvests and this could be one of the factors leading to falling enrolment rates in Igunga and other councils. There is some evidence to suggest that membership to CHF is correlated with local performance in agriculture (Shaw 2002). If farming production deteriorates then this, again, may pose a threat to the CHF. An urgent issue is how to ensure sustainability of CHF and what other sources of funds might be available to generate revenue.

### **Key issues**

- Decreasing trend in revenue as a result of low enrolment
- Increasing drop out rates poses a threat to sustainability
- Unreliability of income as a result of seasonality in agriculture

## **8. POSSIBLE IDEAS FOR DEVELOPMENT OF THE COMMUNITY HEALTH FUND**

This section outlines some initial thoughts on the operations of the scheme with respect to a subset of issues - enrolment, management, equity and sustainability - and based on what has been found from the literature review. It is not intended to be prescriptive but, instead, to stimulate debate. For many areas, it is clear that further targeted research and evaluation is urgently required.

### **8.1 Enrolment and coverage**

One of the biggest challenges to the CHF is that of enrolment. Two issues are important: (i) the identification of the contributing population; and (ii) how to collect the contributions (Carrin 2003). For members to join a community scheme, member involvement from the beginning of the formulation of the scheme is needed in order to make them feel part of the initiative. If members are more involved, the potential for membership fees to be set at an affordable rate is much higher and the benefit package will be clear to all members, avoiding the possibility of over expectations of the benefits package.

The evidence stresses the importance of being strategic when sensitizing for the establishment of a community health scheme. It is important that community members are integrated at the beginning and, to ensure that a large number of the community members are involved in the CHF, it may be useful to link with and learn from existing community schemes (Kelley, Diop et al. 2006). Councils could consider consolidating the CHF with existing community initiatives and leave the control of the scheme to the existing management, or encourage group membership, as is the case of Rungwe CHF (Sheuya 2006).

It is also important to address the issue of how to set the contribution rate. Ideally, the CHF premium should be based on community willingness and ability to pay so as to enhance community participation and improve enrolment rates (Agyemang-Gyau 1998; Beraldes and Carreras 2003). Having flexibility in membership fee, payment timing and rate of

contribution is also important. In addition to the traditional annual payment, councils could consider two payments per annum, monthly payments or seasonal payments (Steinwachs 2001). The community needs to agree on the rate of contribution and the CHF managers' should give them the opportunity to choose the most convenient mode of contribution.

## **8.2 Management and accountability**

At the national level, the government has the responsibility of monitoring, regulating and guiding the operations of CBHF schemes (Carrin 2003). An important component of this is monitoring the CHF at the district level. There are a number of ways in which this could be strengthened. The simplest approach would be to instruct district councils to submit monthly, quarterly, or annual reports of the operation of CHF to the MOHSW, thus assisting the centre's knowledge of schemes' operations. The reports could consist of enrolment issues, revenue and expenditure, together with a summary of limitations or obstacles encountered and the MOHSW could design a standardized template to ensure uniformity of council reports. Currently, the MOHSW has directed councils to prepare such reports; however, councils only appear to complete and send these reports when applying for the matching grants. Regular reports would help the Ministry to better monitor the progress of the scheme and share good practice throughout the country.

The community also needs to be engaged in this process and have access to information concerning the performance of their scheme. The MOHSW and the Ministry of Local Government should insist that councils share CHF operation reports with members. Scheme members also need to be aware of the flow of their contributions and how this leads to improved services. In this way, the ownership of CHF will be at community level rather than just the council authority.

Another approach towards monitoring the implementation of the CHF is through frequent visits to the schemes themselves which, again, will assist in building a knowledge base of how the schemes operate on the ground. A lack of sufficient qualified staff and resources to conduct the field work is, however, likely to be a major constraint and, to overcome this, the MOHSW could assign some funds for this activity during the budget process and establish its implementation as a milestone, assuring commitment. Donor partners could be involved in facilitating this, as has been the case with GTZ and the Muheza CHF. In addition, there is a need to strengthen the MOHSW's CHF coordination unit by increasing the number of staff so as to easily facilitate the supervision of this scheme; currently, there are just few staff attached to this unit.

## **8.3 Reaching the poor**

The literature review showed that there are still challenges to overcome in the implementation of waivers to protect the poor whilst also noting documented examples of good practice (eg in Mwanga and Muheza). Much is still needed to be learnt on the practicalities of strengthening access to the poor via the CHF. The MOHSW could document the best performance in those councils with better operation of waivers and share these with other councils.

Another challenge is how to finance the revenue loss as a result of waivers and exemptions. Innovative solutions are required, for example, religious organizations and other cooperatives might be requested to subsidize part of the cost. Some donor partners (eg

GTZ) have provided technical assistance to help districts find ways of financing the revenue gap resulting from waivers. A deliberate effort could be made to convince other donors and NGOs to replicate this. Group membership (either social or economic) should also be encouraged as this provides a larger pool from which to finance waivers.

In the long run, there is a need to address inequities across different councils or geographical areas. The main challenge is how the poor should be financed across different communities. It is important to cross subsidize between the poor and the wealthy, and between the ill and the healthy across different communities. A risk equalization fund might be formed between neighbourhood councils from which funds to finance the poor might be drawn. The risk equalization fund could progressively include more councils to later form a bigger pool that integrates more than one region. This would be a step closer towards universal coverage to ensure access to all.

#### **8.4 Increasing and Sustaining Revenue**

Currently, the revenue generated through the CHF is low and the predominant source of revenue is user fees, rather than CHF premiums, especially where the enrolment is very low. If the CHF is to contribute to the progression towards universal coverage of health care, strategies for enhancing CHF revenue to make it sustainable are important. The vision should be towards comprehensive financing of health care, meaning that the CHF should not simply end at financing care in primary facilities, but should also advance to funding hospital and referral care. To increase revenue, there is a need for collective pooling of funds. Some districts have managed to consolidate all forms of cost sharing into the CHF; however, there is also a need to convince different stakeholders in rural settings to join the CHF, for instance, religious organizations, cooperative unions and other community groups could be involved during CHF meetings to publicise the benefits of joining the scheme.

### **9. CONCLUSION**

The CHF remains a crucial mechanism for involving the community in health care financing and represents an important step towards universal coverage. Although around half of all districts currently participate in the scheme, uptake amongst the community remains low. The reasons for this are varied and include: perceptions that the quality of services in government facilities are poor; limited benefits package; and doubts over the local management of the scheme. This review has shown that substantial challenges in implementation remain, particularly around management and accountability of the scheme, and ensuring that the poorest groups are not excluded.

Despite these issues, there are also clear examples where councils have been able to overcome difficulties and introduce innovative solutions. Where the scheme is seen to be doing well, faster uptake is likely to be encouraged, and these examples of good practice therefore need to be shared more widely and documented more systematically. The MOHSW and donor partners have a role to play in monitoring the roll out of the scheme and ensuring that information is gathered regularly on enrolment rates and uptake by the poorest groups.

## 10. REFERENCES

- Agyemang-Gyau, P. (1998). The Ability and Willingness of People to Pay for their Health Care: The Case of Lushoto District, Tanzania. Department of Tropical Hygiene and Public Health. Germany, University of Heidelberg. **Postgraduate Master of Science Course: Community Health and Health Management in Developing Countries**.
- Bennett, S., A. G. Kelley, et al. (2004). 21 Questions on CBHF: An overview of community-based health financing, PHR plus.
- Beraldes, C. and L. Carreras (2003). Willingness to pay for community health fund card in Mtwara Rural District, Tanzania.
- Bonu, S., R. Manju, et al. (2003). "Using willingness to pay to investigate regressiveness of user fees in health facilities in Tanzania." Health Policy and Planning **18**: 370-382.
- Burns, M. and M. Mantel (2006). Tanzania Review of Exemptions and Waivers, Report submitted to the Ministry of Health by the Euro Health Group.
- Carrin, G. (2003). Community Based Health Insurance Schemes in Developing Countries: facts, problems and perspectives. Discussion Paper No. 1-2003. Geneva, WHO.
- Carrin, G., M. Waelkens, et al. (2005). "Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems." Tropical Medicine and International Health **10**(8): 799-811.
- Chee, G., K. Smith, et al. (2002). Assessment of the Community Health Fund in Hanang District, Tanzania. Dar es Salaam, PHR plus.
- Dominick, A. and Kurowski (2005). Human Resource for Health - an appraisal of the status quo in Tanzania mainland. Dar es Salaam.
- Ekman, B. (2004). "Community-based health insurance in low-income countries: a systematic review of the evidence." Health Policy Plan. **19**(5): 249-270.
- Kelley, A. G., F. Diop, et al. (2006). Approaches to Scaling up Community-Based Health Financing Schemes. USA, PHRplus.
- Laterveer, L., M. Munga, et al. (2004). Equity Implications of Health Sector User Fees in Tanzania: Do we retain the user fee or do we set the user f(r)ee? Leusden, Netherlands:, ETC Crystal for REPOA.
- Manzi, F. (2005). Experience of Exemptions and Waiver Mechanisms in Kilombero District. Satellite Workshop on Health Insurance, Dar es Salaam, MOHSW.
- Mhina, L. G. (2005). Factors contributing to high drop-out of CHF members in Nzega District, University of Dar es Salaam. **Master of Public Health**: xiv, 59p.
- MOH (1999). Community Health Fund (CHF) Operations Guidelines, URT.
- MOH (1999). Community Health Fund (CHF): Design, URT.
- MOH (1999). Community Health Fund: District Health Plan Model. Dar Es Salaam, Ministry of Health.
- MOH (2000). Community Health Fund Design in Urban and Peri-Urban Areas. Dar es Salaam, MOHSW.
- MOH (2003). Assessment of CHF in Tanzania: Factors Affecting Enrolment and Coverage. Second Draft Report, MOH.
- MOH (2003). Assessment of CHF in Tanzania: Factors Affecting Enrolment and Coverage. Dar es Salaam.
- MOH (2003). National Health Policy, URT.
- MOH (2005). Managing the Community Health Fund: An operations manual.
- MOH (2006). The Community Health Fund Facilitative Supervision Report. Dar es Salaam, Ministry of Health.

- Msuya, J. M., J. P. Jutting, et al. (2004). Impacts of Community Health Insurance Schemes on Health Care Provision in Rural Tanzania. ZEF.
- Munishi, G. (2001). Constraints to Scaling Up Health Interventions: Country Case Study: Tanzania, CMH Working Paper Series No. WG5:16.
- Musau, S. (2004). The Community Health Fund: Assessing Implementation of New Management Procedures in Hanang District, Tanzania, Bethesda, The Partners for Health Reformplus Project, Abt Associates.
- Musau, S. (2004). The Community Health Fund: Assessing Implementation of New Management Procedures in Hanang District, Tanzania. Bethesda, The Partners for Health Reformplus Project, Abt Associates.
- Mwendo, H. M. (2001). Accessibility and sustainability of health services Iramba District: three years after community health fund implementation, University of Dar es Salaam. **Master of Public Health**.
- Ndangala, C. P. and E. Kalimalwendo (2005). Improving the pro-poor aspect: New partnership in health financing-the case of Tanga Councils. Satellite Workshop on Health Insurance. Dar es Salaam, MOH.
- Preker, A., G. Carrin, et al. (2002). "Effectiveness of community health financing in meeting the cost of illness." Bulletin of the World Health Organisation **80**: 143-150.
- President Mkapa, B. W. (2005). Speech at the Regional RMO Meeting, Mtwara Tanzania.
- Quijada, C. and A. Comfort (2002). "Maternal Health Financing Profile: Tanzania." Partners for Health Reform plus (PHRplus)(WP 003).
- Shaw, R. P. (2002). Tanzania's Community Health Fund: Prepayment as an Alternative to User Fees.
- Sheuya, S. A. (2006). Assessment of the Rungwe Smallholder Tea Growers Association and wakulima Health Fund Programme: Draft Report. Dar es Salaam, University College of Lands and Architectural Studies (UCLAS).
- Siegert, N. (2005). Impact of Pro-Poor CHF Membership Program on Equitable Access to Health Care, GTZ, Dar es Salaam.
- Steinwachs, L. (2001). The Potential of Social Structures in Regard to Health Financing and the Perspectives of the Local Populations – A Qualitative Empirical Study, GTZ.
- URT (2001). The Community Health Fund Act, United Republic of Tanzania. **1**.
- URT (2005). National Strategy for Growth and Reduction of Poverty (NSGRP), United Republic of Tanzania.
- URT (2006). Ministry of health and Social Welfare Budget Speech 2006/07.