IMPROVING ACCESS THROUGH EFFECTIVE HEALTH FINANCING

Reader of the Swiss TPH’s Spring Symposium 2011

Co-editor: Swiss TPH
IMPRESSUM

MEDICUS MUNDI SCHWEIZ
Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

Bulletin Nr. 120, Juni 2011
Improving Access through Effective Health Financing

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LAYOUT: VischerVettiger Basel

PRODUKTION:
Geschäftsstelle Medicus Mundi Schweiz, Martin Leschhorn Strebel

DRUCK: Südwestdruck Lörrach

AUFLAGE DIESER NUMMER: 1500 Ex.
ERScheinungsweise: Vier Nummern im Jahr

NÄCHSTE NUMMER: Gesundheitsversorgung in fragilen Staaten

REDAKTIONSSchluss: 17. Juli 2011

TITELBILD: A nurse stands beside a sign reading at the hospital in Monrovia, Liberia on 26th March 2008.
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NETZWERK

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TRANSFORMING COMMUNITY HEALTH FUNDS IN TANZANIA INTO Viable SOCIAL HEALTH INSURANCE SCHEMES: THE CHALLENGES AHEAD

Community Health Funds (CHFs) aim to build up a risk pooling mechanism protecting the population, to contribute to improved quality of health care, to community empowerment, and to affordable, equitable access to health services for rural population and informal sector communities throughout the year. However, CHFs face a number of problems which so far hamper the achievement of these objectives.

COMMUNITY Health Funds (CHFs) have been introduced in Tanzania in 1996 as a pilot scheme in Igunga district, and in 2001 for the whole country. In 2009, the National Health Insurance Fund (NHIF) was mandated with the responsibility of supporting and managing CHFs through a Memorandum of Understanding (MoU) valid for 3 years.

BACKGROUND:
SUPPORTING THE GOVERNMENT OF TANZANIA IN STRENGTHENING COMMUNITY HEALTH FUNDS

CHFs, and their urban equivalent of TIKAs, are voluntary community-based prepayment schemes which aim at building a sustainable financing mechanism for health care in the districts and municipalities. The idea behind CHFs is to build up a risk pooling mechanism protecting the population, which at the same time will be able to contribute to improved quality of health care, improved health care management in the communities through decentralisation and community empowerment, and affordable, equitable access to health services for rural population and informal sector communities throughout the year. (CHF Act of 2001) Since introduction of the programme, however, CHFs face a number of problems which so far hamper the achievement of these objectives.

In the context of preparing the “Health Promotion and System Strengthening” (HPSS) project funded by the Swiss Government, the Swiss Tropical and Public Health Institute (Swiss TPH) carried out an analysis of the CHF structures in Dodoma Region. This analysis revealed a number of limitations and structural problems for the CHFs, specifically with respect to design, enrolment, servicing, and sustainability of the schemes. The Ministry of Health and Social Welfare (MoHSW) of Tanzania expressed their wish to transform the CHF schemes into a viable social health insurance system, which is able to provide social protection for the rural population of Tanzania. Responding to this request, the Swiss Agency...
for Development Cooperation (SDC) offered to support the development and testing of such structural changes within the framework of the HPSS project in Dodoma Region. This project will be implemented by the Swiss TPH, with support by their partner organisations; Micro Insurance Academy (MIA) and Ifakara Health Institute (IHI).

**THE CHARACTERISTICS OF COMMUNITY HEALTH FUNDS IN TANZANIA**

In 1994, Health Sector Reforms (HSR) in Tanzania placed part of the financing responsibility on the community members with the objective of improving access to and quality of care through additional revenues. Health financing was therefore one of the key areas addressed by the HSR and included the creation of user fees (cost-sharing), social health insurance, CHFs, and private-public partnerships. At the same time decentralisation of health services was promoted with an enhanced focus on district level management. As a result of the HSRs there is a variety of health financing sources in Tanzania today. CHFs take over the role of providing a prepayment mechanism for health care in which community members (notably rural households) pay an annual contribution for their household and receive medical care.

CHF membership is based on household enrolment with a predefined household size of up to 6 members. One membership card is issued per household and is valid for a period of 12 months. The annual contribution from each household is defined by the districts, and varies between $5'000 and $15'000 Tanzanian Shilling (TSH). The CHF schemes are then subsidized by the government in the form of matching grants, complimenting the members' contributions with an equal amount. Membership allows the household access to medical services without further co-payments at the primary level, including drugs. Inclusion of secondary and tertiary level care is at the discretion of the district. Households without a CHF membership must pay the predetermined user fees to access health care. Poor households who are unable to pay the premium may be issued CHF membership or an exemption letter upon recommendation by the Village Council. The funds collected from the memberships are used for health related purposes and activities by the district, partly flowing back to health facilities.

**CURRENT INSTITUTIONAL STRUCTURE OF THE CHFS**

The CHFs are integrated into the district level government structures, as well as the local ward and village administration. Policy guidelines and subsidies are in the responsibility of the national level:

**NATIONAL LEVEL**: Ministry of Health and Social Welfare (MOHSW) and Prime Minister's Office for Regional and Local Government (PMO-RLG); the National Health Insurance fund (NHIF) is presently being charged with overall management of the CHFs (but role towards local governments still needs further clarification)

**DISTRICT LEVEL**: Council Health Service Board (CHSB) and District Health Management Team (DHMT) lead by the District Medical Officer (DMO)

**WARD LEVEL**: Ward Development Committee (WDC) through the Ward Health Committee

**VILLAGE LEVEL**: Village Council through the Health Committee and the Health Facility Governing Committee (HFGC)

Through the CHF Act of 2001 the district and municipal councils are given the authority over the CHF scheme in their area. The CHSB is responsible for monitoring the operations and activities of the scheme, mobilizing and allocating funds, creating exemption criteria for poor households, verifying the collection and expenditure of funds, and reviewing reports from the WDC. The WDC is in charge of sensitising and mobilising community members, tracking the membership base, overseeing premium collections, evaluating CHF operations and providing recommendations. The Village Councils have their role in information provision and further community mobilisation efforts. The Health Facility Governing Committee HFGC of each health facility, finally, is responsible for developing a budget and plan for the activities of the health facility, and assists in the enrolment of community members into CHFs and collecting the corresponding contributions.
This current structure places the CHSB in a dual role of the “provider” and “purchaser” of health services. The CHSB is both responsible for the implementation of CHFs as well as for overseeing the operation of the health facilities. The District has the autonomy to create by-laws within their given area and manage the membership contributions at this level. The CHSB receives input from the District Medical Officer (DMO), the Council Health Management Team (CHMT), and the District Executive Director (DED), and decides on a mechanism to reallocate the CHF resources back to the individual health facilities or to spend them on district level.

STRUCTURAL PROBLEMS FACED BY CHFS
Within this structure, CHFs face a number of problems and limitations which have hindered the schemes ability to reach beyond the low national coverage rate of 7.9% (NHIF data of April 2011).

Challenges are faced in four areas: design, enrolment, servicing, and sustainability.

CHF DESIGN ISSUES
No separation of purchaser-provider roles
Both the CHSB and the DMO presently have to represent both the interests of the health care providers, as well as the interests of the CHF members. These interests, however, may be divergent or even contrary. As an example, the health care providers have a natural interest in
increasing their revenue base, and therefore would tend to higher CHF premiums, while the CHF members of course would have the opposite interest.

Overburdening of current office bearers
Currently in many districts one member of the CHMT is appointed CHF coordinator. This person, together with the DMO, has to shoulder much of the responsibilities and administrative tasks for the scheme, which tends to stretch their capacities to the maximum, as they are usually practicing health professionals (e.g. the district dentist).

Unclear roles and responsibilities of NHIF
While in 2009 a Memorandum of Understanding the NHIF has been mandated by the Government of Tanzania to support the CHFs in management in the whole country, the CHF Act of 2001 still stipulates the district and municipal councils as being responsible for the management of CHFs in their territory. So far a clear distinction between the responsibilities of the councils and of the NHIF has not been achieved. This question will have to be taken up in the context of an extension of the MoU after expiry of the original 3 year period.

Limited/inappropriate benefit package
The benefit package of the CHFs in most districts includes all services provided by primary level health care (health centres and dispensaries), and excludes hospital care. Whether this is an appropriate choice, however, needs to be questioned, as hospital care normally is the expensive risk, carrying the risk of catastrophic expenditures. Moreover, in most cases benefits are limited to one health centre or dispensary and are not portable to other health care providers in the district or neighbouring regions.

Premium determined on basis of acceptability, not costs
In the present system, CHF premiums are determined on the basis of social and political acceptability, not on actuarial calculations of frequency and severity of risk. The premiums reflect the acceptance of the population to pay a modest amount of 3.5 to 7 USD per year for receiving primary level health care for the whole family, but they do not reflect the costs incurred for providing these services. Of course premiums have to be set at a socially acceptable level. In the present situation it is just unknown whether the scheme generates enough income to cover the costs incurred by the health centres.

Insufficient Insurance Management Information System
An excel tool was developed to support data management of CHFs; the tool however is perceived as dysfunctional and thus is hardly being used. Most information is captured in paper format and compiling data is often incomplete and inaccurate. This leads to problems in data collection and analysis, and therefore management decisions are ill-informed. Furthermore, the current MIS is not suitable for national roll-out.

CHF ENROLMENT ISSUES
Access for the poor?
Although the CHF Act states that the power to issue an exemption from CHF payment is vested with the Ward Health Committee upon receiving recommendations from the Village Council, such exemptions hardly are issued. This is not an unusual phenomenon which can be observed worldwide in cost sharing schemes, that exemption mechanisms work poorly and do not effectively protect the poor. The contrary, the objective of increasing CHF enrolment often leads to an increase of user fees in order to make CHF enrolment more attractive. This leaves the poor in an even more vulnerable situation as they are not recognised as exempted cases nor can they afford the higher user fees.

Low trust into the quality of care provision (but understanding of prepayment concept)
Focus group discussions at the village level revealed that enrolment into the CHF remains unattractive as long as trust into the health care system to provide essential elements of quality of care remains low. Experiences of the population to find health centres being out of stock for essential medicines understandably undermine the willingness to enrol into a prepayment scheme.

Drop out in years of crop failure
In years of drought and the resulting crop failures a rural population gives higher priority to food expenses for ensuring the survival of the family during such difficult years. (Re-) enrolment into a prepayment scheme understandably receives less priority and membership numbers as a consequence drop.

Adverse selection problems
The CHF schemes are subject to adverse selection through features of the enrolment mech-
anism. Community members can enrol in the CHFs at the health facilities and receive immediate access to health care. This feature does not encourage people to join before they fall sick. This also allows members to drop out each year and only re-enrol when they need to use the card.

*Current system weak on active enrolment*

In the current CHF model there are no clear roles indicating who is specifically responsible for mobilising community members to join the scheme. In some communities the health facilities are taking the lead in this, in others CBOs have been formed to increase enrolment, and in others the Village Council may include this within their responsibilities. However, in all cases, the presence of an active sales force is not in place. These current practices place the initiative on the community members to join the scheme and do not employ a convenient process for enrolment. Much depends on an active role of health staff, which, however, is not helped by the fact that health staff seem to perceive patients paying user fees out of pocket as being more profitable for them than CHF members.

**CHF SERVICING ISSUES**

*Payment to health care providers*

In the present situation each district sets up their own mechanism for allocating funds to health facilities. The health facilities collect CHF member contributions, submit these funds to the district and are then reallocated money upon request or as determined by the district. The allocation mechanism of the money does not follow a standard formula in any of the districts investigated and is instead based on perceived need. CHF money is pooled at the district level and used amongst all of the health facilities regardless of which facility brought in the most CHF contributions. User fees, on the other hand, are allocated to the health facility which collected them; these practices reduce the incentive for health facilities to enrol members into the CHF.

*Often low quality of services provided*

CHFs were introduced with the aim of community members contributing to their health care costs and in return receiving adequate and quality services. However, community members often are not seeing tangible changes in their health care system. Members are still experiencing shortages of medicines, minimal lab equipment and overburdened health care providers even after their contributions to the CHFs. It demonises the system if members do not see a benefit after their contribution, and this makes it difficult to encourage additional people to enrol.

*Insufficient feedback mechanism of insured into the system*

CHF members are not provided with an effective feedback mechanism to voice their concerns with the system. Many community members interviewed did not know who to raise concerns to. The system is thus not harvesting feedback to improve its operations.

*Insured identification*

A number of problems are also related to unclear ID documents and difficulties in identification of family members on the joint family card. This leads to an unclear verification system for health facilities and inconvenient accessibility processes for the policy holders due to the shared card. The ID cards also don’t facilitate portability of CHF use.

**CHF – SUSTAINABILITY ISSUES**

*Organisational sustainability*

In our observation, successes within the current system are based on the personalities of the people holding specific positions (e.g. the DMO) and are not embedded within the institutional structures of the system. CHFs are not professional insurance schemes and are therefore reliant on support from external actors and part-time commitment from local government authorities. Once such motivated people holding CHF positions are transferred, success stories seem to come to a halt. Further, heavy technical backstopping is provided by donor agencies, which on the long run also is not a sustainable support structure.

*Financial sustainability*

In the current design, financial sustainability of the CHF is not a problem: as the CHF does not pay the health system in relation to services rendered to its clients — but rather redistributes the funds collected — it cannot run into deficit. The problem of financial sustainability is rather shifted to the health facilities, which cannot recover their costs in years of high usage through CHF members, as the funds available for the system remain the same.
THE WAY FORWARD

During the focus group discussions with community members a prepayment solution for health care was clearly appreciated and seemed to be fully understood. Such a solution allows community members to finance health care costs when they have money and to continue to receive care throughout the year (when funds normally would be scarcer). However, dissatisfaction with the present situation of CHFs was also expressed.

Taking into account both the perception of the population and the analysis of structural shortcomings, a number of measures seem to be needed to make the CHFs work better. Such solutions have to provide answers to the problems facing the CHFs. They will have to address the issues identified in the areas of design, enrolment, servicing, and sustainability of CHF schemes. In brief, they may include the following steps:

Design Issues

The most important step in our view is to establish professional CHF governance and administrative structures, which de-link the CHF management from health service providers. This would enable the CHF to focus on health insurance tasks, representing the interests of the insured members, and would enable the health care providers to concentrate on optimising the quality of care they provide. In order to arrive at such a re-organised CHF structure, the support of the NHIF will be a key factor. For this purpose, the NHIF needs a prolonged and specified mandate by the Government of Tanzania.

Other design issues to be addressed concern the question of whether and how the benefit package may be enlarged and adjusted to better reflect the needs and priorities of the population. Concerning the funding of the benefit packages, apart from the premiums paid by the population, the question should be discussed to
which extent contributions by the Central Government and the Local Government Authorities may be expected. Apart from questions of social acceptability, cost considerations with actuarial pricing should be included into determining premiums. Finally, building up a functioning Insurance Management Information System for analysis routines, member tracking, claims tracking, etc., will be required in a professionalised organisational set-up.

**Enrolment Issues**

For strengthening the enrolment mechanisms it will be of paramount importance to safeguard the support of local government structures in a multi-sectoral approach, where village councils, ward development committees, and district / municipal councils all actively engage themselves. In a medium-term perspective exemptions from paying user fees should be replaced by issuing CHF cards to the poor, funded by the Local Government Authorities. In an effort to strengthen enrolment procedures, the employment of dedicated officers for enrolment and a redesign of enrolment and accessing regulations seem to be promising approaches. Of course questions of financial sustainability for financing such a structure need to be analysed and addressed.

**Servicing Issues**

In a medium-term perspective, one needs to consider a shift of the mechanism through which health facilities are reimbursed by the CHF from the present wholesale transfer approach to an approach linking the payment of service providers to the quality and quantity of services provided. The procedures for fund flow to health facilities needs urgently to be improved, in order to improve the impact of CHF funds at health facility level. Such an enhancement of financial management mechanisms should go hand in hand with a strengthening of planning capacities at the HFGCs, and training on financial management for health facilities. Introducing individual ID cards and a portability of cards through a billing or allocation mechanism seem to be much needed reform steps to increase the value and convenience of CHFs for the policyholders.

**Sustainability Issues**

Finally, the overarching concern has to be to reach a sustainable solution for the CHFs, both in terms of their organisational structure, and in terms of financial viability. These two aspects, of course, go hand in hand, as any sustainable organisational structure would require a sound basis of financing. Important steps in this direction seem to us to be the build-up of a professionally managed CHF structure, going along with the introduction of a trained cadre of insurance professionals. Reaching financial sustainability for such a structure will require a deeper analysis of the costs included on the one hand, and commitment of key players such as the Central Government (matching funds), Local Government Authorities (pro-poor funding of CHF cards for exempted population), and the NHIF (either through re-insurance or through a transition into an integrated “Single Payer” Mechanism in social health insurance).

**OUTLOOK**

The task of the HPSS project in Dodoma Region will be to assist the Government of Tanzania in developing such solutions in close cooperation with the Local Government Authorities, the MoHWS, the NHIF and other stakeholders (e.g. PMO-RALG, Development Partners, NGOs), and to test them in practice. Complementary health promotion activities will be supported at community level. Additionally, the Swiss TPH will support accompanying system strengthening efforts to assist health care providers in focusing on service provision and improvement of quality of care in Dodoma Region.

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**Annotation**

This article is based on a situation analysis carried out by Radermacher, R., Vanderhyden M., Meshack, M., Harting, S., and Stoerner, M. In September 2010 in Dodoma Region, Tanzania. The situational analysis used Focus Group Discussions and Key Informant Interviews as well as document reviews to arrive at the results presented in this article.