Health Care Financing in Tanzania
2005 FACT SHEET **No.3**

COMMUNITY HEALTH FINANCING

DESCRIPTION

Community Health Financing was designed with the intention of providing an alternative to paying fees for service, as cost-sharing is expanded beyond the hospitals to health centers and dispensaries. The scheme is intended to facilitate risk sharing among healthy and sick people, rich and poor.

The implementation of the scheme is coordinated under the Health Sector Reform and Local Government Reforms context. It is expected to strengthen community participation, ownership and empowerment as (i) households recognize public health services have a value and that they, as contributors, have the right to express their demands; and (ii) as it provides complementary resources at the local level to respond to community-defined needs.

The program was initially piloted in Igunga in District in 1996. After two years it was rolled out to 9 more districts. An evaluation of the program in 10 districts[1] recommended extension of the scheme throughout the country. Community Health Financing is currently operational in 42 district councils in various stages of implementation.

Comment [JMcL1]: I was told 42

How does it operate?: Community Health Financing encompasses both fee for service and the Community Health Fund. Each District Council has to request the establishment of CHF. After which the Health Sector Reform Secretariat provides sensitization and orientation. Prior to initiating community health financing, each District Council has to have in place a Council Health Services Board and Facility Committees, and has to pass a CHF By-Law. Each district determines the amount to be charged for services (fee schedule) and sets the annual membership fee (paid in two installments) based upon their own assessment of their population's ability to pay. Households decide whether to join the Fund or to pay fee for service. Note the government does not set the fees. The fee schedule therefore vary from one Local government Authority to another.

To encourage communities to join, CHF membership fee revenues are matched 1-1 by the Ministry of Health. Fund revenues, matching funds and revenues from

[1]External Evaluation of Community Health Fund, MUCHS (2000).

user fees are deposited into a single account which is then employed for locally defined activities which are planned and form part of the activities in the Comprehensive Council Health Plans (CCHPS). The Health Services Board includes representatives of the community who utilize basic health facilities. Such activities have included purchasing additional drugs and medical supplies when a shortage occurs, providing solar power to health centers to expand hours of service, providing coffee/tea to staff to ensure that they remain on site throughout hours of service, purchasing new microscopes, gloves, detergent, scales for growth monitoring, transport for nurse midwives to visit pregnant women and transport for referral.
Contributions: Each family is asked to contribute a predetermined amount per year. The amount has ranged from Tshs 5,000 to 15,000 depending on districts' decisions, but the average is Tsh5,000.

Exemptions & Waivers: The following services are exempted from paying fees (and do not require CHF membership cards): MCH services (including all services for pregnant women and children under five), tuberculosis, leprosy, paralysis, typhoid, cancer, AIDS and epidemics There are also two types of waivers. The facility-based waiver occurs when facilities waive fees for the provision of services (other than those listed above) to individuals who they determine cannot afford to pay. The community-base waiver refers to the preferred approach whereby communities identify poor households and provide membership cards to them free of charge. This preferable because the individual is not required to prove to a health provider that they cannot pay at the point of service, and the service provider cannot distinguish a "free" card from a membership card which has been paid for. Communities list the households each year to receive free cards, and the District Health Council makes a payment into the Fund the equivalent membership fees. There is an incentive for district councils to do so because these funds are included in calculating the matching funds. Since the CHF has started only in 42 (LGAs) out of 121 LGS, it is true that 80 LGAs have yet to introduce, changes beyond the district hospital. Services are still free at the time of use.

EXPERIENCE TO DATE

Contributing Towards Local Resources: Implementation has revealed increased capacity to raise additional financial resource into the health care system at local level. The existing evidence suggest that, from 1996 to December, 2004 the sum of Tshs.2.2. billion have been collected in aggregate and Igunga Council has cumulatively collected about 650 million Tanzania shillings since the introduction of the scheme in 1996. The experience from Igunga in revenue collection, show that an average of Tshs.40 million a year as a complementary resources has been collected. This reaches Tshs.80 million after the Matching Grant contributions; this amount is substantial in district resources flow. Igunga has around 44,000 households and a population of about 300,000. This population and level of enrollment enables the district to qualify for US$150,

000 from matching funds. Increasing the level of enrolment from 10% current status to 45% annually, would boost the revenue from 40,000,000/= to 99,000,000/= (members' contributions only) which, automatically is doubled by the matching grant to make 80 million and 198 million respectively. Although this is not a large share when compared to the total health sector budget, it is a significant amount for the district when compared with the other charges.

Strengthening Service Delivery: Cost-sharing at lower levels has contributed to quality of care through procurement of supplementary essential drugs, reducing stock-outs in CHF implementing councils; the rehabilitation of health facilities and electrical installation in many councils; training in management, planning and quality of care, which has contributed in the change of health providers behaviors and attitude.

Increasing Value and Ownership by Community: The scheme promotes community participation and empowerment through establishment of the Facility Health Committees and Council Health Boards to promote membership manage the CHF and decide on how to utilize revenues. The introduction of a price element in primary level has rationalized utilization by enhancing management of drug consumption[2]

Improving Equity: The implementation of community financing is a way to ensure that those who can afford to contribute towards health services do so. The Fund ensures that the poor are offered an improved waiver system -- as people who can not afford to pay are identified by the community themselves and are provided with membership cards (reducing constraints to care seeking that might relate to having to prove inability to pay at each visit and to unknown health providers)..

Relationship with Decentralization and the PRS: CHF is a tool of decentralization of decision-making and management of the health services beyond the district level. Under the Poverty Reduction Strategy (PRS), the rolling out of CHF to more districts is one of the indicators in the PRS policy matrix. Thus CHF Programme contributes substantially in the government's effort towards poverty reduction. It has shown a way forward for sustainable health care system at district level as such received recognition from Legislative authorities, Administrators, Managers, Community and Community Leaders.

Insufficient Enrollment: The share of households contributing to the Fund through pre-payment has not exceeded 30%. The ideal threshold would have been 60% of the households in the councils. The explanations for low coverage demand analysis. Possible explanations include:

i) Recognition by healthy households that it is a better "deal" to pay fee for service, as so many services are exempted and fees are minimal. Increasing fees, reducing exempted services or reducing membership premiums would thus increase enrollment.

[2] Community Health Financing in Tanzania; the views of the Communities in Igunga 2001.

ii) Lack of appreciation for risk mitigation ("I do not think my household will be sick" or "We did not use Tsh5,000 worth of services last year, so we should just pay user fees") and lack of trust in managing entities.

High drop-out rates at re-enrollment support the above two hypotheses.

iii) Lack of ability to pay premiums.

Remaining Challenges: There has been limited capacity in the MOH to support capacity building training, sensitization and effective advocacy. Out of 42 councils who have started, only 10 councils had been supported fully; in revenue targeting, financial management and basic principles of quality improvement. The MOH, Regions and Districts also need to be able to monitor and continually evaluate the CHF in order to respond to and disseminate lessons learned; address disbanded or non-functioning Boards and Committees; address low user fee collections; and conduct additional community mobilization and advocacy.