Spotlight

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Lessons from Community Health Fund reforms

A review of the past three years

Key Points

In 2009 the National Health Insurance Fund (NHIF) took over the management of the Community Health Fund (CHF) to increase insurance coverage, efficiency and supervision and access to services.

Key achievements include successful integration of CHF within the NHIF organisational structure, improved reporting systems and growing awareness of the reform since 2011.

Challenges in the implementation of the reform include top-level conception, delays in communication to lower levels, failure to secure all requested financing. There have also been no changes in district level CHF management.

Background

The National Health Insurance Fund (NHIF) is a compulsory insurance scheme for the formal sector offering extensive benefits to members. The Community Health Fund (CHF) is a voluntary scheme established by the Ministry of Health and Social Welfare (MoHSW) for the informal sector with premiums fixed at between TZS 5,000 to TZS 30,000 for care in public primary facilities. Both schemes have been in operation since 2001.

In June 2009, a Memorandum of Understanding (MOU) was signed among the NHIF, the MoHSW and the Prime Minister's Office for Regional Administration and Local Government (PMO-RALG) giving management responsibility for the CHF to the NHIF for a three-year period. The objectives were to:

- ☐ Harmonise NHIF and CHF management operations;
- ☐ Improve efficiency and supervision;
- ☐ Increase awareness of the CHF and increase coverage.

A study was carried out to assess the origins and rationale for the shift of management, referred to as 'the reform'; how it has affected CHF management and reporting structures; levels of awareness of the reform and acceptability.

In-depth interviews were carried out with six policy makers, 11 district managers; six facility in-charges and 16 facility governing committee members in two districts (an urban and a rural district from the same region). This brief reports on the findings of the study.

Origins of the reform

The objective of the reform was to increase national health insurance coverage (United Republic of Tanzania, 2008), address the limitations of CHF management, to synchronize the NHIF and CHF, and improve access to services by providing support to "*Mpango wa Maendeleo ya Afya ya Msingi" (*MMAM – improving access to primary health care). (Table 1). The fact that both the NHIF and the CHF report to the MOHSW also facilitated the process (Gilson et al., 2012).

"The government felt that the NHIF has strong experience in managing a health insurance scheme, it has experts and it has many zonal offices" (National level respondent).

The MoHSW was to cover the recurrent costs of managing the scheme along with the matching grant funds, which are government subsidies matching the level of CHF revenue collected by districts.

Reform implementation

Shortly after the MOU, the NHIF developed a three year action plan. An estimated USD 13.1 million were requested from the MoHSW to cover the costs of running the CHF for the period. Delays in approval of the action plan and failure to secure all of the requested funds in time delayed reform implementation. In 2011, a revised and more limited action plan was prepared. Later that year a national consultation meeting with CHF coordinators was held to introduce the reform and its objective and a nationwide information campaign was launched to expand CHF enrolment.

Table 1: Chronology of events preceding and following the reform

Date	Event
2007	Cabinet directive No 37/2007 to synchronise the NHIF and the CHF to support the implementation of the Primary Health Services Development Programme and provide technical and managerial support and extend CHF coverage.
31st January- 2nd February, 2007	CHF best practice workshop in Dar es Salaam funded by SDC and GTZ in collaboration with the MoHSW.
October, 2007	Ten year evaluation of the health sector recommending synchronization of NHIF and CHF operations conducted by an external consultant and commissioned by development partners and the Government of Tanzania.
March, 2008	Resolution by MoHSW management team that the NHIF should oversee CHF.
August, 2008	Regulatory framework feasibility study commissioned by the MoHSW which included a scenario on merging the NHIF and CHF funded by GIZ and SDC.
June, 2009	Signing of Memorandum of Understanding between the MoHSW, PMO-RALG and NHIF management. Secondment of MOHSW national CHF coordinator to the NHIF.
September, 2009	Country evaluation of the net worth of the CHF by the NHIF.
October, 2009	The CHF action plan 2009-2012 developed.
February, 2010	Appointment of staff to oversee CHF at the zonal/regional NHIF offices.
March, 2010	The NHIF began payment of matching funds to the districts.
September, 2011	CHF directorate created within the NHIF.
Late 2011	CHF action plan revised for remaining year.
December, 2011	Meeting of CHF coordinators from across the country to inform about the reform and set targets to meet 30% coverage nationally.
February-April, 2012	☐ National client days to gather opinions on CHF implementation; ☐ Printing and distribution of CHF leaflets and posters; ☐ Districts are instructed to budget for use of CHF cars that can be used to promote CHF, showing promotional films to communities.
June, 2012	NHIF and CHF management teams expected to report on 3 years experience and present plan for coming years to the MoHSW and PMOLARG.

Management structures Pre and Post reform

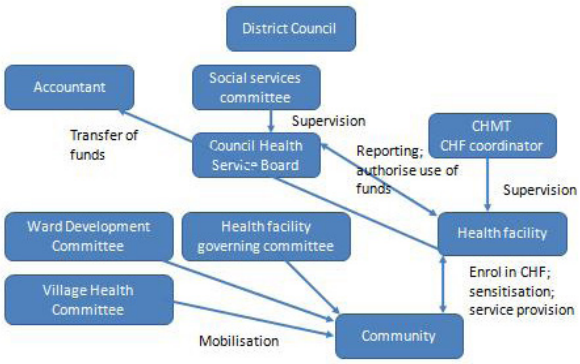
The reform has not led to any changes in district level structures defined by the CHF Act. These cannot be changed without a change in legislation, which was beyond the scope of the MOU. The CHF, at district level, remains under the management of the Council Health Service Board (CHSB) and a CHF coordinator (Figure 1). Ward Health Committee and the Health Facility Governing Committee along with health workers have the responsibility of mobilising people to join the CHF (Figure 1). The reform has, however, led to significant changes in national and zonal/regional level management systems.

Pre-reform national, zonal and regional structures

Prior to the reform, the national CHF coordination unit was headed by a coordinator and 2 assistants, who trained district managers on CHF, and oversaw the enactment of bylaws for the CHF which set out the CHF design for the district (premium level and benefits for members) (Figure 2).

Supervision of districts was done once per year and during annual regional management meetings where stronger CHF coordinators would support weaker ones. Matching fund requests were channeled through the district authorities to the national CHF coordinator, along with reports of membership/enrolment, which were often incomplete. There was no reliable national data on CHF coverage.

Figure 1: Overview of management structures from the district level down



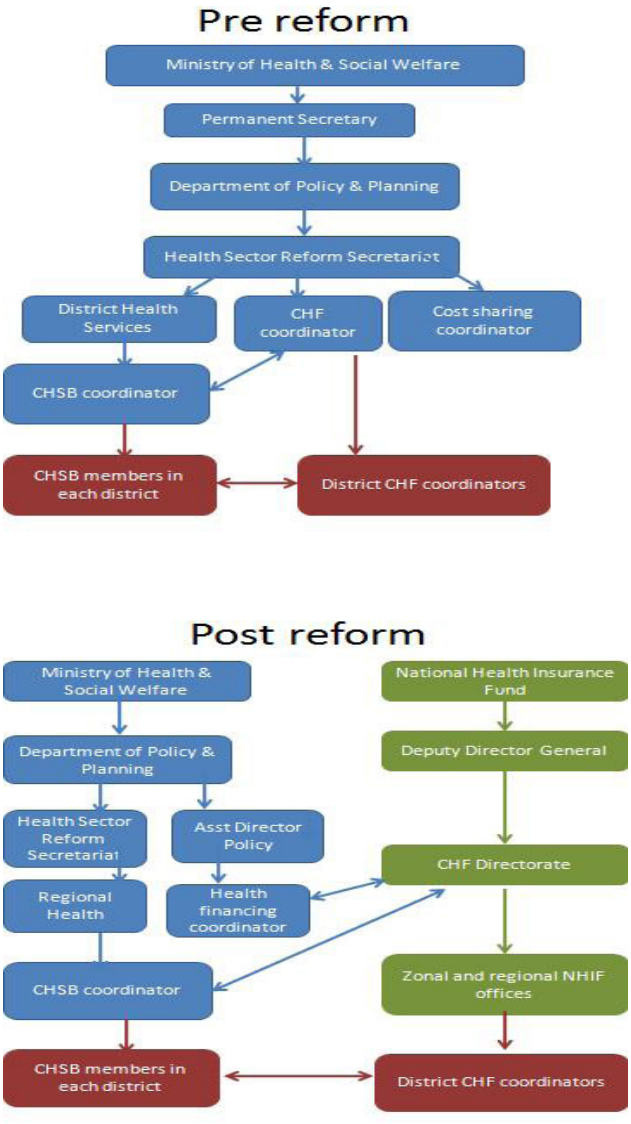
Post reform changes

Since the reform, a CHF Directorate within the NHIF headed by a CHF Director supported by a team of seven people oversees CHF operations centrally. The CHF Director also reports to the Health Financing Coordinator at the MoHSW (Figure 2). NHIF staff in 13 NHIF zonal and regional offices have been appointed to support district CHF coordinators across the country. Matching

fund requests and payments are managed by the NHIF zonal/regional offices, although funds themselves are still provided by the government.

The national CHF coordinator (pre-reform) and the CHF Director (post reform) work closely with the national CHSB coordinator who supports the establishment of the CHSB within districts, and the development of district by-laws. CHF supervision is integrated into the routine visits of NHIF staff which take place one a month or every two months.

Figure 2: Overview of management structures from the central to district level before and after the reform



The NHIF has modified the requirements for matching fund claims, to reduce the risk of fraud. District CHF coordinators must submit names of all CHF member household heads along with proof of revenue received. A computerised system is being prepared by the NHIF that will facilitate future data capture.

Communication & Awareness of the reform at district level

In February 2010, the MoHSW sent out a letter informing the districts that they should claim the matching grant.

"We were not involved in this discussion but we were only informed and when we went to claim the matching fund for the CHF we were told that we should claim it from the NHIF not from the Ministry of Health (District manager, rural district)

Generally, all stakeholder groups felt there had been insufficient information about the reform as of August 2011.

"Communication was not enough from the national or regional level to inform the district level about the reform" (District health manager, urban district)

There was a greater awareness of the reform within the district following the Morogoro meeting of CHF coordinators at the end of 2011.

Acceptability of the reform at the district level

Most district level respondents thought the reform would improve efficiency.

"Both are insurance schemes, I think they can support each other, for instance supervision can be done using NHIF zonal offices in one time and save money and time" (District manager, urban district.)

However, the new NHIF system for claiming matching funds has increased workload (and limited capacity to claim).

"The NHIF requires that when you are applying for matching fund you should attach receipts, a list of CHF members, bank statement, bank reconciliation etc.

This makes work very difficult and many people have failed to apply for matching fund" (District manager, rural district).

At the facility level, committee members expected CHF members would get access to a wider range of services like NHIF members.

"If they will be administered by a single organ it will be good because [...] they will try their best to improve health insurance [benefits], and not create differences [between schemes] of what we can get when we fall sick" (HFGC, urban district).

Community members interviewed had difficulty voicing opinions about the reform due to limited knowledge of the reform and the NHIF.

Health insurance coverage

The number of CHF districts increased from 92 to 111 between 2009 and 2011 (NHIF, 2011). At the end of 2009 about 43% of CHF districts had no members (United

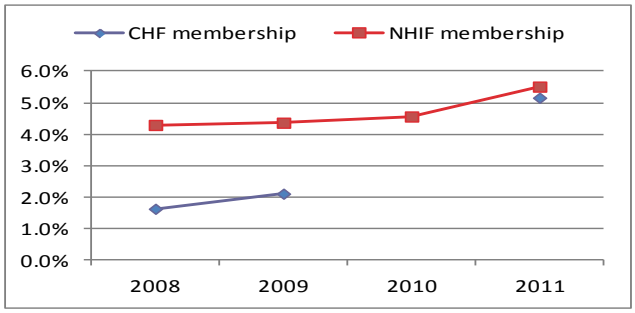
Republic of Tanzania, 2011), this had been reduced by half by 2011 (NHIF, 2011).

National CHF coverage increased from less than 2% to over 5% between 2008 and 2011 (Figure 3). While the reform has facilitated this process, independent district initiatives have also been influential. In the study districts the rural site significantly increased coverage as a result of such initiatives, whilst the urban district saw no change in coverage.

In June 2011, the NHIF released funds to pay for CHF cards for the poor in a number of districts across the country. It is expected this will further enhance coverage over the coming years.

In many districts, CHF funds are pooled at district level, allowing for cross subsidisation across health facilities. However, there has been no move to pool CHF funds at a higher level. A growing number of districts are introducing facility bank accounts which could reduce the size of the risk pool and limit cross-subsidisation.

Figure 3: Trends in health insurance coverage for the NHIF and CHF/TIKA between 2008 and 2011



Source: NHIF: Msambichaka & Humba. 2011; CHF (MOHSW, 2008, NHIF 2009-2011), using population projections based on 2002 census data.

Conclusions

The reform was conceived at the top and communication to lower levels was slow. Delays in approval of the action plan and failure to secure all of the requested funds in time delayed reform implementation. The reform has not led to any changes in district management structures and remains in the hands of individuals who are inexperienced in insurance management. However, the reform has resulted in substantial achievements:

- ☐ Successful integration of CHF within the NHIF organisational structure at national, zonal and regional levels, bringing more intensive and qualified supervision closer to the districts;
- ☐ Improved reporting systems leading to availability of national coverage and matching grant data;
- ☐ Growing awareness of the reform since 2011 and high levels of acceptability;
- ☐ National CHF membership has more than doubled.

Policy recommendations

- ☐ Full harmonisation between NHIF and CHF can only be achieved by changing CHF legislation and altering district management structures. It will be important to address this within the next phase of the reform.
- ☐ While changes to matching fund claiming procedures are well intended, it is important to monitor whether this delays fund disbursement, and review manageability of new reporting system over time.

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