Practical experiences with scaling-up CHF enrollment and current challenges

Tanzanian German Programme to Support Health

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Development Cooperation

6th SEPTEMBER 2010

The Community Health Fund (CHF) in Tanzania

- Voluntary, district based scheme
- 2001: bill passed to establish CHF in all LGAs
- CHF entails pre-payment for health care and risk sharing
- Premiums/Contributions vary between Tsh 5,000 and Tsh 15,000 per year for a household (individual or family)
- Same amount is contributed by the government to the district ("matching grant")
- Exemption mechanism for poor and vulnerable groups (pro-poor mechanism) by districts

Main objectives of CHF

- Mobilize financial resources from the community for provision of health care services to its members
- Improve health care management in the communities through decentralization
- community ownership and empowerment

By year 2015, the CHF enrolment is expected to be 30% of the population (HSSP III)

GTZ/TGPSH experiences and best practices

- Sensitization activities, e.g. group enrolment to cover large groups within the informal sector, enrollment of CSOs
- Partnership with NHIF (PPP) on group enrolment in Tanga and Lindi Region

GTZ/TGPSH experiences and best practices

Exemplary group enrolment figures

- 5667 children with 10200 dependants making a total of 15,867 beneficiaries by AFRIWAG
- ca. 7,200 beneficiaries in Mponde
- 3084 vulnerable children by TOWREC
- 2,538 pro poor members paid by Institute of Culture
- 300 students from Usagara secondary school
- 72,000 members enrolled through CBHI Dodoma

GTZ/TGPSH experiences and best practices

- Alternative payment modalities supported, such as microfinance institutions as entry-points for CHF enrolment (e.g. SACCOS = Saving and Credit Cooperative Societies)
- e.g. 4,400 beneficiaries through 1 SACCOS (TCCIA)

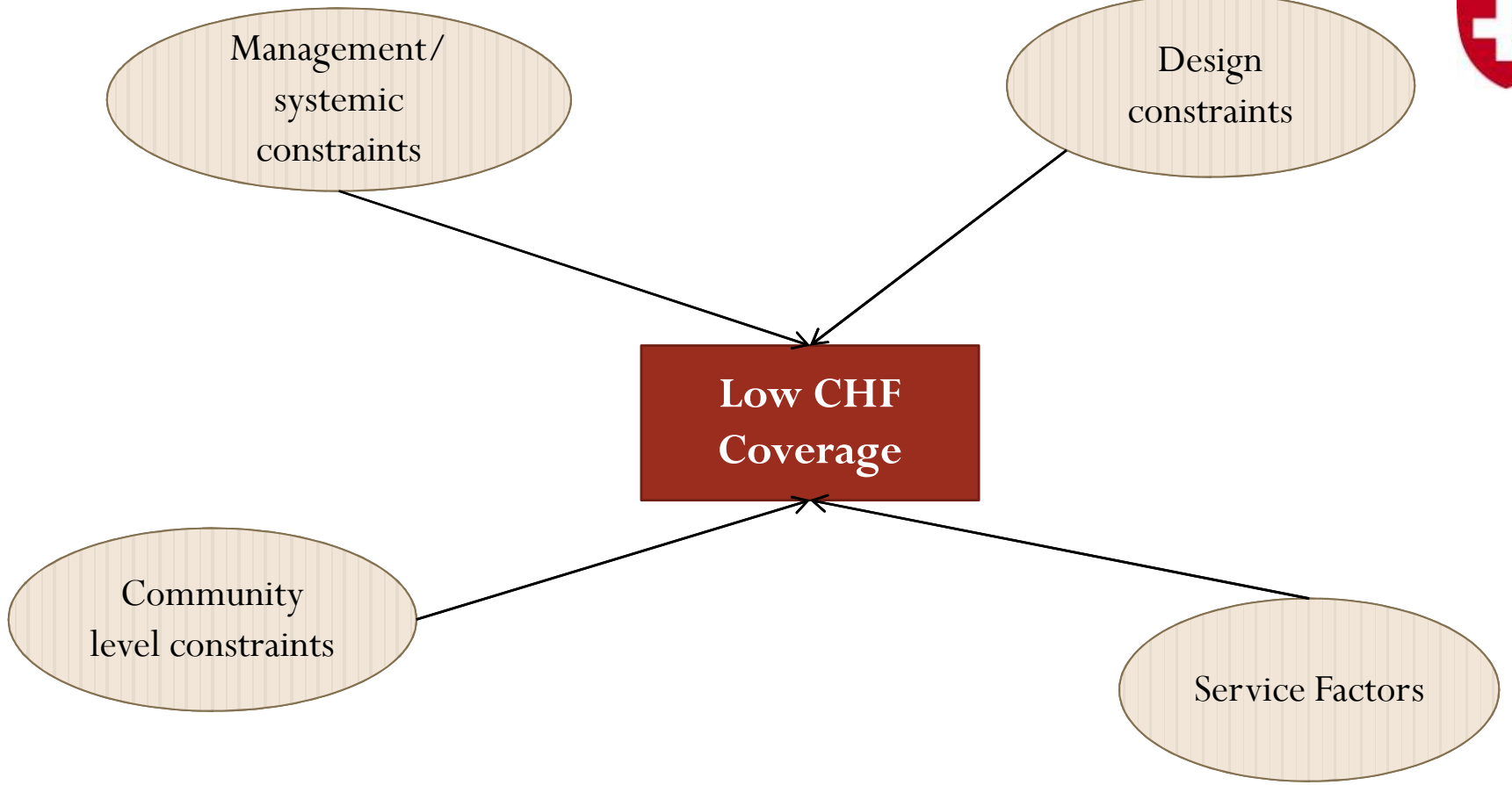
The Advantages of Collaboration for…

..the individual members of MFIs	..the MFI as an institution	..the CHF
✔ Free access to public health care facilities for them and up to five family members	Sick members cannot work	✔ More enrolled members
✔ Can save with the SACCOS for the premium	➳ No income	✔ ➳ more money coming into the fund ➳ better quality of care
✔ CHF money going back to health facilities	➳ Might be forced to sell assets to pay health care facility or use the loan of the SACCOS	✔ Sensitization can be done at group meetings
➳ Improved quality of care, drugs available	➳ Difficulties paying back the loan!	✔ Members who would not be able to pay the premium at once can save with the SACCOS and also join
	✔ When insured: Repayment of loan better secured	

GTZ/TGPSH experiences and best practices

- Establishment of district drug buffer stocks for supplementary drug supply (financed through cost sharing funds)
- Establishment of bank accounts at health facility level and allocation mechanism established (currently GTZ pilot on-going)
- Pro-poor funding mechanism supported within districts in order to enroll vulnerable groups
- Establishing CHF Competence Center at the Regional level (CHIC approach)

Major challenges for scaling up CHF



Major challenges (1/3)

Design constraints	Possible way forward
•Unclear financial sustainability and incentives for districts to promote CHF •Weak CHF Management structure	•De-linkage of CHF Management and service providers in order to professionalize CHF Management (professional CHF administration and overseeing board at district level, or support of administrative functions by NHIF) •Costing to be done, and cost-sharing mechanism to be revised •Office bearers to be full-time professionals for CHF, back-up through Regional Coordinators
Only basic benefit package	•Possibility about enlargement of benefit package to be considered (experiences with CHF plus benefit package for services in hospitals) •HIV/AIDS Workplace programmes can enlarge the offered services (e.g. through PPPs)
Portability of insurance	Harmonized reimbursement system (precondition: costing to be done) CHF to be included into Service Agreement with FBOs in areas where these are the fist options for many potential CHF members

Major challenges (2/3)

Management constraints	Possible way forward
Health Facilities are not reimbursed for (part) the costs, linked with poor quality of services	Health Facilities to be reimbursed (precondition: establishment of bank accounts)
Inconsistent matching grant disbursement	Better transparency of procedures (deadlines, application processes)
Data tracking/management not transparent enough and problems regarding data collection at lower level	•Improvement of data collection trough professional CHF coordinator (incentive system?), back-up through Regional CHF coordinator •Establishment of country-wide database, CHF tracking system
Problems with membership card issuance	Membership cards to be registered and available in all districts, design to be harmonized(NHIF support)

Major challenges (3/3)

Community level constraints	Possible way forward
Enrolment of the vulnerable groups unclear/insufficient	Targeting and subsidization mechanisms for the poorest to be identified and implemented
Poor health insurance literacy and slow enrollment	Advocacy, group enrollment, sensitization (best-practices available)
Ability to pay (of the poorest, as well as during years of crop failure etc.)	Mechanisms to be established for different payment procedures
Adverse selection (especially already sick people join the scheme)	Waiting time between application for CHF membership and access to services

Way forward

- Experiences and planned activities should be shared between stakeholders
- Steering mechanism should be in place to work on the different issues and challenges CHF is facing (systematic and managerial), involving stakeholders that can give technical advice
- Increase of transparency of information and decision-making process
- Implementation should be guided, different stakeholders can step in

Asanteni sana!