

# iCHF

How a public-private partnership can help make healthcare work in Northern Tanzania



PharmAccess  
FOUNDATION

Health  
Insurance  
Fund



Safe Care  
BASIC HEALTHCARE STANDARDS

PHARMACCESSGROUP

Authors: Charlotte Wagenaar, Dr. Heri Marwa, Ewout Irrgang

Contact: [info@pharmaccess.org](mailto:info@pharmaccess.org) | [www.pharmaccess.org](http://www.pharmaccess.org) | [@PharmAccessOrg](https://twitter.com/PharmAccessOrg)

The PharmAccess Group is a dynamic international organization with a digital agenda dedicated to connecting more people to better healthcare in sub-Saharan Africa. We focus on innovations to serve patients and doctors through mobile technology, loans for doctors, health insurance, clinical standards and impact research.

This document is for informational purposes only. No right can be obtained from information provided in this document.

**iCHF**

**HOW A PUBLIC-PRIVATE PARTNERSHIP CAN HELP MAKE  
HEALTHCARE WORK IN NORTHERN TANZANIA**

September 2016  
Amsterdam, The Netherlands





At Charlotte Health Centre in Siha district, Sister Yusta Kiria takes care of baby Angela who was diagnosed with pneumonia

# Introduction

Many solutions for better access to healthcare are available right now. The challenge is to get them implemented on a larger scale. One promising approach is currently underway in Northern Tanzania, where PharmAccess is working with the National Health Insurance Fund (NHIF) and the district councils (local government) to roll out a public-private health insurance scheme for low-income people in the informal sector. If successful, Tanzania could become the one of the first countries in Africa to make the health system work for everyone, rich and poor.

## iCHF at a glance

The ‘improved CHF’ or iCHF, is a voluntary, district-owned health insurance scheme that aims to increase access to quality healthcare for people in rural and low-income groups. It offers affordable access to both private and public care, and emphasizes quality improvement through training, equipment provision and infrastructure upgrading. iCHF was built by a strong partnership between NHIF, the district councils, public and private healthcare facilities, and PharmAccess. It was introduced at the end of 2014. By September 2016, more than 100,000 people had enrolled. The aim is to enroll at least 30% of the population in each of the districts of the Northern Zone’s Kilimanjaro, Arusha and Manyara regions: at least 713,292 people by 2021.

iCHF invests in quality as a first step to increasing demand. In addition to a limited upgrading budget, the capitation model ensures positive incentives for both public and private healthcare providers to improve their services in order to attract more patients. iCHF is steadily building enrollment through active and tailor-made marketing strategies. Enrollees pay 50% of the premium, promoting a sense of ownership and encouraging enrollees to demand better healthcare at the healthcare provider of their choice. Consequently iCHF is empowering consumers, especially low-income groups, to become active healthcare consumers rather than voiceless recipients.

Program design was done in partnership with the implementing partners in Tanzania, ensuring that it is firmly rooted in the healthcare system. Using the unique utilization data from extensive experience in other health insurance schemes like the former KNCU health plan in Kilimanjaro, PharmAccess performed actuarial analysis to calculate a realistic premium. As a result the insurance premium, which is 100% locally funded, was raised significantly to ensure effective financing of the scheme. Increased enrollment is generating transparent financial flows for healthcare providers. The flows are based on objectively measurable enrollment data, and as funds are no longer channeled through the district’s offices, healthcare providers are in control of their own budgets.

The combination of these elements is setting in motion an upward spiral of trust, investments, quality and availability of health services. While it is still early days, this approach shows great promise and the scheme continues to build momentum.

This paper provides an insight into the workings of iCHF. It highlights the unique elements contributing to its success, the numerous paradigm changes it is making, as well as the challenges that still remain.

## Introducing the PharmAccess Group

**The PharmAccess Group is a dynamic international organization dedicated to connecting more people to better healthcare in sub-Saharan Africa. PharmAccess focuses on innovations to serve patients and doctors through digital technology, loans to doctors, clinical and business standards, health insurance and impact research. We work closely with leading local and international partners to leverage donor contributions to increase trust throughout the health system, reduce risks, and pave the way for investments.**

PharmAccess was one of the first non-profit organizations in healthcare to act on the enormous untapped potential of the private sector and recognize the need for capital investments in healthcare delivery. The approach is based on their FT/IFC prize-winning new paradigm for health, which argues that health markets in Africa are stuck in a vicious cycle of low investments, low quality supply and low solvent demand.

The vicious cycle covers various interlocking elements:

- As a (semi-)public good, healthcare requires large government intervention, but many countries suffer from limited state capabilities and poor institutions. As a result many people rely on the private health sector and, since insurance is virtually non-existent, pay for healthcare out-of-pocket.
- Despite its important role, the private sector is often weakly regulated and highly fragmented. Due to the high investment risk healthcare providers have limited or no access to the capital required for quality improvement and expansion of their services. And low quality in the clinics means low trust among patients and low willingness to prepay through health insurance.
- The high proportion of out-of-pocket spending and the lack of trust in healthcare provision leads to low and unpredictable income for healthcare providers. This limits their options for investing in the quality, scope and scale of their services even further.
- Healthcare markets, especially at the base of the pyramid, are stuck in this vicious cycle of low and unpredictable demand, low and uncertain quality of supply and totally inadequate investments, both public and private. And the absence of health insurance leads to catastrophic healthcare spending, sending millions into deeper poverty every year.

Reversing this vicious cycle into a virtuous one is key to achieving inclusive healthcare.

### PharmAccess in Tanzania

PharmAccess has been facilitating public-private partnerships for health and testing innovative financing mechanisms including health insurance for more than 10 years, in different countries in Sub-Saharan Africa. The Dutch government is a long-term supporter and committed donor of its work. The lessons learned in Tanzania and other countries, combined with the thinking behind the PharmAccess paradigm, have been instrumental in the design of iCHF.

In Tanzania, the organization has been active since 2003, working on HIV/AIDS workplace programs for the military and the police as well as health insurance, quality improvement through the SafeCare standards and access to loans for healthcare providers through the Medical Credit Fund. PharmAccess has signed a memorandum of understanding with the Ministry of Health and Social Welfare to provide technical assistance to introduce a nationwide step-wise accreditation system for all healthcare facilities in Tanzania, based on the SafeCare methodology. As of 2011, PharmAccess supported the KNCU health insurance scheme, the success of which prompted NHIF to seek out a partnership with PharmAccess to revamp Tanzania's Community Health Fund.

In 2016, PharmAccess and GFA won a tender from the German development bank KfW for phase two of a program to improve access to healthcare for low-income pregnant woman in five other regions of Tanzania. This insurance program reaches an estimated 265,000 people. Both programs have the potential to increase access to better healthcare and help turn around the vicious cycle that forms the basis of the PharmAccess paradigm.

# Table of Contents

Introduction.....	5
1 Healthcare in Tanzania.....	9
2 A public-private partnership to make health markets work in Northern Tanzania .....	15
3 Investing in quality as a first step to increasing demand .....	19
4 Empowering patients to make informed healthcare choices.....	23
5 Reliable administration and a functioning payment system .....	25
6 A wealth of data to further improve healthcare delivery .....	28
7 Kick-starting enrollment through active marketing .....	31
8 The road ahead for iCHF .....	35
9 References .....	37





Sister Denaïke Daniel weighs baby Neilat with her mother Khadija Burhani looking on at Lyamungo Health Centre's postnatal wing



# 1 Healthcare in Tanzania

Tanzania boasts one of the fastest growing economies in East and sub-Saharan Africa. Nevertheless, it struggles with a range of challenges when it comes to meeting the growing healthcare demands of its people.

## KNCU Health Plan

PharmAccess has been working in Tanzania since 2003, with activities ranging from HIV/AIDS workplace programs for the military as well as the police to working towards a nation-wide quality improvement system using the SafeCare standards. Applying experience from setting up insurance programs in other sub-Saharan countries, PharmAccess started supporting a health insurance scheme for the coffee farmers of Africa's oldest co-operative, the Kilimanjaro Native Cooperation Union (KNCU), in April 2011. This scheme, operational in four districts of the Kilimanjaro region and administered by MicroEnsure, came to serve as a proof of concept. It ran almost exclusively in faith-based private facilities. On average, families paid 40% of the Tsh 50,000 (USD 25) annual insurance premium. The Health Insurance Fund, funded by the Dutch Ministry of Foreign Affairs, covered the remainder.

### TANZANIA AT A GLANCE

**50 million**  
population

**6.6%**  
enrolled in NHIF

**7.2%**  
enrolled in CHF

**80% of Tanzanians**  
uninsured for health

In accordance with the PharmAccess approach of addressing both the demand and the supply side, investing in quality was a key aspect from the start. All facilities underwent extensive upgrading based on a tailor-made renovation and training plan. In most cases, the whole building was renovated – from the floor to the roof, and from painting to extending the building to ensure that, for example, the laboratory had its own room separate from the dispensary. Also, the facilities were equipped with all the necessary basic equipment, ranging from a thermometer to an ultrasound, as appropriate. In addition, staff received monthly training from visiting specialists, for example on how to best treat and prevent chronic conditions. The scope of the training depended on the needs of the facilities as identified based on the claims forms as well as consultations with the staff. All facilities entered a quality improvement program based on the internationally accredited SafeCare standards and received regular visits to stimulate, support and monitor progress.

On the demand side, the KNCU Health Plan introduced a waiting period and started house-to-house sensitization. The benefit package of the scheme consisted of outpatient services, including chronic conditions, and (inpatient) maternity care. Enrollees could choose a facility for healthcare delivery, which in turn benefitted from a steady income: a capitation fee for every registered household. The premium was actuarially calculated, ensuring it was high enough to cover costs.

The KNCU health insurance scheme addressed most of the constraints that were hampering enrollment into the CHF. Enrollment benefited from the inclusion of private facilities and the investment in quality. The premium was higher than that of the CHF yet more people enrolled into the KNCU program. By September 2013, the KNCU health plan had more than 15,000 enrollees, representing a 25% coverage of the total target group. In some KNCU primary societies, enrollment was as high as 60%<sup>2</sup>. In short, this health insurance scheme was providing a strong and welcome contrast to the situation in the rest of the country.

.....  
2 [http://www.pharmaccess.org/kncu\\_dashboard\\_sept2013/](http://www.pharmaccess.org/kncu_dashboard_sept2013/)

## Tanzania's health market

About a third of the population in Tanzania lives below the national poverty line and income inequality continues to rise. These socio-economic challenges result in limited access to healthcare for the majority of the Tanzanian population. Out-of-pocket spending, which often plunges people into even deeper poverty, constitutes 27% of the nation's total health expenditure. Because healthcare providers are dependent on low and unpredictable out-of-pocket-payments, there is very little room for investment in quality improvement. The Catch-22 is that the low quality of healthcare services and poor access to medicines are important obstacles to increasing enrollment in insurance schemes. It is difficult enough to convince people with very low incomes of the benefits of health insurance, but if the quality is below par and there are no medicines or doctors in the hospitals, it becomes close to impossible. Therefore, a vicious circle of low quality, low trust and low enrollment perpetuates itself.

As part of its strategy to achieve universal access to healthcare, the Tanzanian government has introduced various insurance programs over the years aimed at reducing the financial risk of healthcare costs for households:

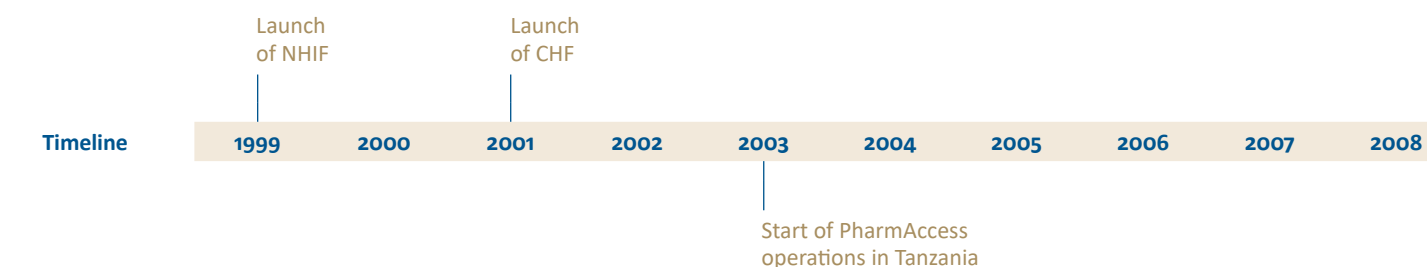
- In 1999, it set up the National Health Insurance Fund (NHIF), a country-wide mandatory health insurance scheme for civil servants which is also open to other formal sector groups on a voluntary basis.
- In 2001, this was followed by the establishment of the Community Health Fund (CHF), a voluntary, district-run insurance scheme for the informal sector, mostly rural and low-income groups. Only open to public clinics.

The CHF experienced disappointing enrollment rates and Tanzania's Ministry of Health signed an agreement with the NHIF in 2009, mandating the NHIF to oversee and support the operations of the CHF.

## Enrollment targets

Despite this national commitment to expand insurance coverage, enrollment continued to lag behind the 30% government target for the end of 2015<sup>3</sup>. In June 2013, 6.6% of the total population was enrolled in the NHIF and 7.2% in the CHF. An additional 1% (in 2011) was covered by other health insurance schemes. Although coverage has increased in the last few years, recent estimates suggest that close to 80% of the population is still not covered for healthcare costs.

The NHIF deducts the premium from the salaries of government employees. As a mandatory health insurance scheme, it covers most of its civil servant target group. What is less known, however, is that several years ago the NHIF expanded its mandate, allowing private companies to join and sign up their employees. So far, the NHIF has not attracted the private sector into the scheme on a large scale, possibly due to limited marketing efforts. As a result, health insurance coverage remains low.



3 National Health sector strategic Plan number three, (NHSSP III 2009-2015)

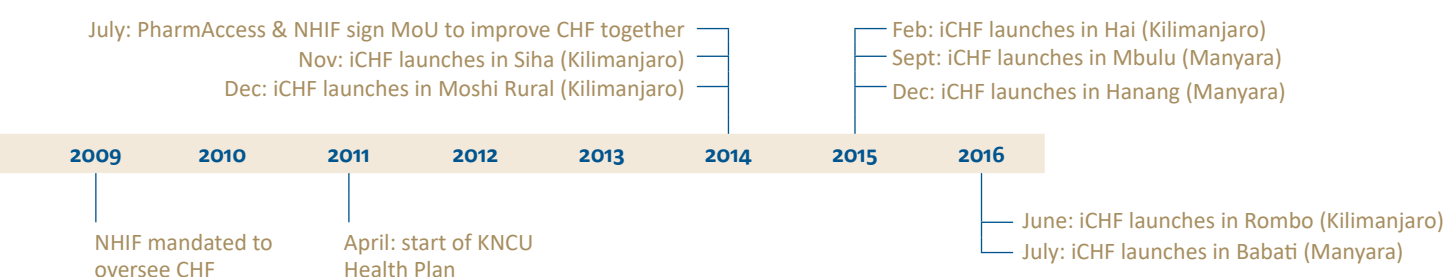
Enrollment into the CHF also continues to pose a challenge. On the demand side, it is hampered by the passive enrollment approach. Enrollment takes place at healthcare facilities. There is no incentive to enroll before falling ill, as there is no waiting period – people can receive treatment immediately upon enrollment. In turn, there is also little incentive for facilities to enroll their patients, as they send the premium to the district without any guarantee that the money would ever flow back to the facility. Reimbursement of healthcare providers is based on the perceived need by district health officers, not on provider expenditure on CHF members. Also, the user fees are generally so low that many people prefer to pay a small cash amount for a single visit than invest ten times that amount for a year of insurance that they are not sure they are going to need. This passive enrollment system limits the amount of people joining, and on top of that it leads to adverse selection and an unhealthy risk pool.

What is perhaps even more important is the aspect of quality of care on the supply side. When the quality of healthcare services is low, people are less inclined to pay ahead for care at such a facility. Quality issues can range from unfriendly staff to unreliable drug stocks, lack of equipment and insufficient infrastructure. The height of the premium is based on social and political acceptability, not on actuarial calculations based on risk and provider costs. As the premium amount (Tsh 10,000, or USD 5) is very low, CHF does not generate enough funds to cover costs. Many of the facilities in rural areas were built in the 1970s, when Tanzania's population was less than half<sup>4</sup> of what it is today. While they were built as health posts, today's health burden calls for facilities with more comprehensive services. Upgrading these facilities will require a considerable investment. In addition to funding challenges, quality also suffers from a lack of standards and benchmarks. Even if healthcare providers are motivated to improve, they do not know where to start.

In addition to constraints on demand and supply side, the CHF office is overburdened. It only has one person in the council health management team (CHMT) responsible for all CHF activities and operations in the district. The fact that the CHF is managed by local district councils creates double roles whereby the district is both 'provider' and 'purchaser', since they are the owners of the primary public health facilities. The lack of insurance management information systems further limits the effective implementation of the CHF.

### CHF: Need for a new way forward

District, regional and national leaders were looking for a way to revamp CHF in order to improve access to healthcare for Tanzanians. In light of the expertise gained by PharmAccess with the KNCU health plan, the NHIF had been discussing a possible partnership with PharmAccess for some time. They noticed that a part of their target group in parts of Kilimanjaro was choosing to enroll in KNCU instead of CHF and expressed the wish that this scheme should be available for the whole population instead of only to the coffee farmers. In July 2014, NHIF signed a MoU with PharmAccess to work together with local governments to improve enrollment into the existing CHF. During an NHIF meeting in 2014, an NHIF Director argued that



4 <https://knoema.com/search?query=population%20tanzania>



“We cannot continue doing the same thing and expect different results.”

Former NHIF Director Mr Rehani Athumani

it was time for a new way forward: ‘We cannot continue doing the same thing and expect different results.’ He advocated for a redesign of the CHF, using successful elements from the KNCU health plan including the use of private healthcare providers in addition to public ones.

PharmAccess and the NHIF agreed that the way forward must be to redesign the CHF to address most of the challenges that hindered enrollment into the ‘ordinary’ CHF and rebrand it as iCHF, the improved CHF. At the Prime Minister Office permanent secretary’s recommendation, this would extend beyond KNCU’s original realm in the Kilimanjaro region and include districts of the Arusha and Manyara regions of Tanzania’s Northern Zone.

## Introducing iCHF

It was clear that iCHF should address constraints on both the supply and the demand side of the health-care market. To stimulate quality health service in the program, contracted facilities would work on quality improvement using the SafeCare standards. Council Health Management Team members, who are responsible for the quality of facilities at the district level, would be trained regarding the SafeCare principles. Financial investment in infrastructure was a key aspect of the approach in the KNCU Health Plan. Healthcare providers should get paid for the services they provide to iCHF enrollees. The premium should be actuarially calculated to ensure both public and private healthcare providers can sustainably provide care for enrollees. It should have a smooth administration system run by a third party administrator (in this case the NHIF) to facilitate payments and reduce the burden on the district health office. The use of a third party administrator will also separate the double role of provider and purchaser which the district council played, and facilitates having both public and private facilities in the scheme. And finally, there should be an active enrollment system that would leverage the availability of community health workers.



Tanzania has six zones: Northern, Coastal, Central, Lake, Southern Highlands and Zanzibar

The Northern Zone has four regions: Arusha, Kilimanjaro, Manyara and Tanga.

Total population Northern Zone: 4,759,528

1. **Kilimanjaro** region has six district councils. iCHF has been rolled out in three: Hai (population 210,533), Moshi rural (population 466,737) Siha (population 116,313) and Rombo (260,963)

2. **Manyara** region has five district councils. iCHF has been rolled out in Mbulu (population 320,279), Hanang (population 275,990) and Babati (405,500)

3. **Arusha** region has seven district councils. iCHF will be rolled out here in 2017

## iCHF at a glance

The table below illustrates the main differences between the CHF and iCHF. These themes are further explored throughout the rest of this paper.

	From CHF..	.. to iCHF
<b>Improving access to health services</b>		
<b>Access to public and private healthcare providers</b>	Public healthcare facilities only	Private and faith-based healthcare facilities included. According to 2015 data, 72% of enrollees in Kilimanjaro choose to access healthcare services through a private (faith-based) provider.
<b>More extensive coverage for enrollees</b>	Benefits: out-patient only (in most cases)	Benefits: out-patient (including chronic conditions) and in-patient (including minor and major surgery, limited to 5 days), maternity, investigations, drug costs.
<b>Active marketing</b>	Effectively only one person per district (district medical officer) available to promote and manage CHF, contributing to low enrollment	Large teams of trained community health workers and volunteers to sensitize community, collect premiums and issue receipt for those who wish to join – leading to higher enrollment.
<b>Setting and raising quality standards</b>		
<b>Improving quality</b>	Quality improvement element not included	Quality improvement integral aspect – providers working with SafeCare to improve their quality. Council Health Management Team (CHMT) receive SafeCare training.
<b>Investments</b>	No investment in upgrading facilities	Selected facilities also receive some support for renovation of their buildings and essential medical equipment.
<b>Increasing financial resources, pre-payment and risk equalization</b>		
<b>Predictable income</b>	<ul style="list-style-type: none"> <li>Healthcare providers don't get reimbursed – funds not based on utilization</li> <li>Public healthcare providers don't receive funds, district medical officers manage their finances</li> <li>For this reason, public providers sometimes 'keep' the Tsh 10,000 premium as a sort of capitation payment when people enroll at their facility</li> </ul>	<ul style="list-style-type: none"> <li>Healthcare providers get monthly reimbursements depending on utilization, i.e. number of people enrolled at their facility (capitation), resulting in a stable stream of revenue.</li> <li>Public and private providers must set up own bank account in order to join the iCHF – are in control of their own budget.</li> </ul>
<b>Transparency and accountability</b>	<ul style="list-style-type: none"> <li>Limited transparency on allocation of funds</li> <li>Allocation of funds based on decisions of district council – no incentive to improve quality</li> </ul>	<ul style="list-style-type: none"> <li>Financial flows are transparent.</li> <li>Allocation of funds based on performance – positive incentives to improve quality.</li> </ul>
<b>Realistic premium</b>	<ul style="list-style-type: none"> <li>Premium: Tsh 5,000-15,000 Premium based on social acceptability – unable to cover actual costs</li> <li>Premium does not cover marketing &amp; admin costs</li> <li>Despite low premium – very limited enrollment, suggesting decision not led by cost</li> <li>Insufficient funds for healthcare</li> </ul>	<ul style="list-style-type: none"> <li>Co-premium: 30,000</li> <li>Premium based on actuarial calculations – financially sustainable</li> <li>Premium includes marketing &amp; admin costs – leading to heightened marketing efforts and data gathering</li> <li>Higher premium – high enrollment, due in part to improved quality, more comprehensive benefits package, option to choose private provider, etc.</li> <li>Much more funds raised for healthcare due to higher enrollment numbers and a high premium (double dividend).</li> </ul>
<b>Empowering patients</b>	No feedback mechanism for clients	Toll-free phone number
<b>Risk mitigation</b>	<ul style="list-style-type: none"> <li>No waiting period</li> <li>Patients could go straight to district hospitals</li> </ul>	<ul style="list-style-type: none"> <li>14 day waiting period</li> <li>All services start at primary level facilities</li> </ul>
<b>Cross-subsidization and risk equalization</b>		
<b>Local ownership</b>	Little input from district councils	Program design in partnership with district councils – more ownership. NHIF has a more active role as implementing partner (incl. marketing & admin).
<b>Risk pooling</b>	Enrollment at healthcare facilities, i.e. no risk pool	Enrollment at household level, i.e. healthier risk pool. Up to household size of 6.
<b>Risk distribution</b>	Healthcare facilities carry the risk of excess medical costs	The NHIF carries the risk of excess medical costs.
<b>Premium 100% covered by enrollees and the Tanzanian government</b>	The CHF and iCHF have the same basic premium structure. Under CHF however many districts didn't receive their matching fund due to poor administration.	Enrollees pay 50%, the central government (through the NHIF) pays the other half. iCHF is thus financed locally.

By implementing the abovementioned changes, iCHF aims to increase access to improved quality and affordability services, especially in rural areas and in the informal sector. iCHF objectives are to:

1. Establish a financially sustainable CHF structure which can be replicated in other districts in Tanzania;
2. Improve the quality of facilities and increase access to quality health services, especially for women and children;
3. Increase uptake into the 'improved' CHF. The target is to reach at least 30% enrollment in 5 years;
4. Reduce out-of-pocket expenditure on health;
5. Facilitate public-private partnerships;
6. Increase capacity at the district councils to strengthen existing healthcare structures and to be able to self-manage the scheme more effectively and sustainably.

By providing proof of principle before going to scale, iCHF is building political will to fulfill its long-term potential for helping to make healthcare work in Tanzania. The iCHF approach is unique in its kind in that it addresses access and quality issues simultaneously. It is stimulating effective cooperation between national, regional and district authorities and the model has considerable support for being rolled out in other regions. Undeniably something remarkable is unfolding – iCHF has already convinced more than 100,000 people on low incomes to pay in advance for health. But although it shows great promise, iCHF still covers only a little over 5% of the population in the districts where it is available, and the challenges ahead are daunting.



## 2 A public-private partnership to make health markets work in Northern Tanzania

iCHF builds on a strong public private partnership whereby the Tanzanian government is working with the private healthcare sector to help achieve national targets for increasing health insurance coverage in the Northern Zone. An important catalyst has been local ownership on the community, district, regional and national level. This encompasses replacing the CHF in several regions and promoting iCHF, providing a matching fund and allowing the private healthcare sector to do its part in delivering quality healthcare services to the local population.

iCHF's governance structure is distinctly Tanzanian. The NHIF not only initiated the partnership with PharmAccess to adapt the successful elements of the KNCU health plan into an improved CHF: with the local governments, the NHIF has been in the driver's seat of this public private partnership from the very beginning.

### **Roles and responsibilities**

The districts are owners of iCHF, the NHIF is responsible for administration and marketing and carries the medical insurance risk, the public and private providers deliver the healthcare services, and the enrollees pay half of the insurance premium. From the onset of iCHF, the Tanzanian government, through the NHIF, has provided the other half of the premium through the so-called matching funds. While the KNCU health plan received funding for premium subsidy from the Dutch Ministry of Foreign Affairs, the iCHF premium is 100% locally funded. Enrollees pay 50% and the Tanzanian government pays the other half through the NHIF. This public private partnership thus represents a scale-up of a program initially developed and implemented with international development aid.

PharmAccess is involved in an advisory capacity, sharing best practices and providing technical assistance. While PharmAccess applies its expertise to develop and test models for improving access to healthcare, it is up to local partners to adopt the successful models and take them to scale. The idea is to build an approach that is scalable in other regions and by other partners.

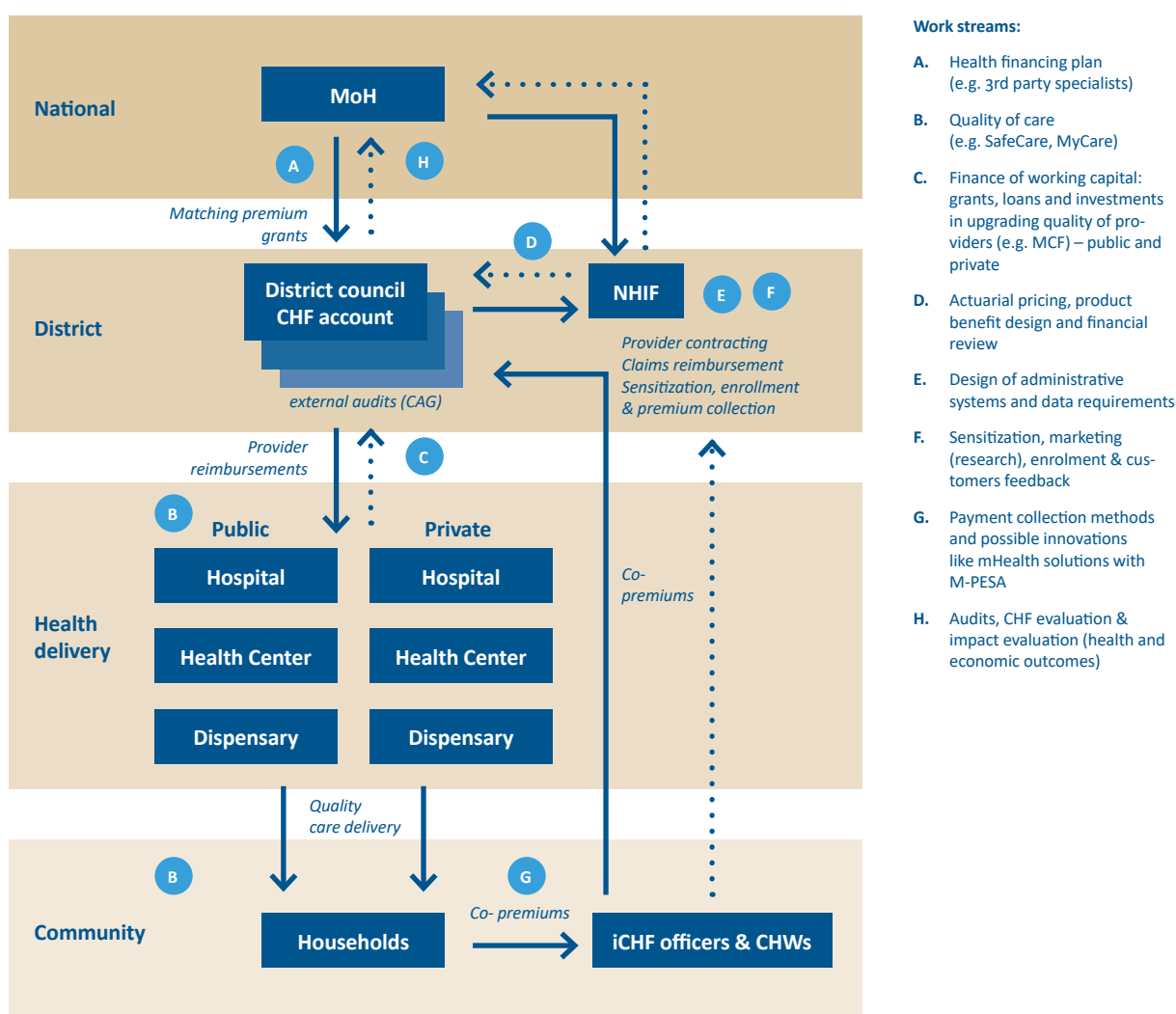
### **Political breakthrough for a financially sustainable structure**

One of the political breakthroughs in iCHF is the admittance of private healthcare facilities into a public scheme. As the administrator of iCHF, the NHIF reimburses both public and private healthcare facilities per enrolled household. On top of that, the capitation fee for private providers is 50% higher compared to public providers. This is a compensation for the fact that public providers receive government support to cover fixed costs like rent or staff salaries. iCHF thus represents a system that both public and private providers can participate in. Without this compensation, private providers would not be able to sustain their business, leading to less access to care, especially in remote areas. The solidarity principle behind this approach means they are protected from possible future scenarios of under-compensation. The logic of differentiation of compensation is well-embedded in iCHF's governance structure.

### **Increasing insurance uptake, reducing out-of-pocket expenditure, facilitating PPPs and increasing capacity**

On the community level, trained community health workers and other volunteers are working to develop awareness of health insurance principles. They go from household to household to sensitize the community so people are better equipped to make decisions on health-related matters. As part of an incentive-based approach, they receive a percentage of the co-premium for each household they enroll into iCHF.

Figure 1 An optimized CHF health system



The district councils are closely involved in the design of the scheme. District-employed iCHF officers are provided with motorbikes to oversee the activities of the volunteers and receive the claims from providers. The CHF coordinator, who is also employed by the district, supervises all iCHF officers. The Council Health Service Board, made of appointed community members, oversees all activities at the district level.

On a regional level, NHIF is responsible for the implementation of iCHF. Under the CHF, there was essentially no administration or marketing and NHIF staff thus had no experience in this area. For this reason, PharmAccess has seconded staff to build capacity at NHIF as part of an agreed upon transition phase. NHIF and the Ministry of Health are willing to invest in building a separate IT system for iCHF to ensure effective data collection. The collected premiums are sent to the NHIF regional office's bank account. The NHIF then reimburses the healthcare providers directly using the capitation system, depending on the number of enrollees they have managed to attract. Provider payments are strictly monitored.

Nationally, iCHF is under supervision of the NHIF which in turn reports to the Ministry of Health. While iCHF is currently only running in several districts of two regions, the NHIF is an organization with regional offices nationwide and as such has the ability to scale.

## Changes ahead

The solid political buy-in, combined with the success of the private healthcare sector in delivering health-care in Northern Tanzania, and iCHF's architecture and sustainability elements, suggests that iCHF has all the ingredients to contribute to achieving universal health coverage in Tanzania. In order to live up to its promise, iCHF will have to move out of the above-mentioned transition phase by 2019. As scheme administrator, the NHIF must take the lead in all operations, including staffing. PharmAccess is currently building capacity at NHIF in terms of scheme operations such as marketing and administration, and the NHIF has committed to provide human resources to take over all aspects of implementation. Also, the NHIF will have to make headway in building a separate IT system for the administration of iCHF.

A fully functioning IT system is especially relevant in view of planned expansion. Expansion provides advantages such as economies of scale, allowing for administration costs to be fully shared at a regional level. It will also fully shift pooling from the district level to the regional level, helping to increase cross-subsidization. iCHF has already taken big steps in terms of regionalization. Expanding into the few remaining districts within Kilimanjaro and Manyara will elevate iCHF's profile as a truly regional program, fully shifting the risk pool to the regional level. This will help to build even stronger political support from the NHIF as well as the Ministry of Health. It will also increase the likelihood of the 'PharmAccess model' being replicated and taken to scale in other regions where PharmAccess is not active.

### HOW iCHF HAS CHANGED THE POWER STRUCTURE INTO A PERFORMANCE-BASED SYSTEM

Under the CHF, district medical officers (DMOs) collected the co-premiums and matching fund from NHIF to distribute among the public facilities in their district according to the judgment of the Health Management Team. Under iCHF, financial flows are based on objectively measurable enrollment data and funds are no longer channeled through the district's offices with sometimes competing priorities. Furthermore, the premium was raised significantly based on actuarial analysis, to allow for enough funding to be able to pay healthcare providers for delivering services. Political will played a significant role in implementing this systemic change.

iCHF has shifted the power structure. From a funding perspective, DMOs may have had to sacrifice some influence. At the same time, one of iCHF's strengths is precisely the fact that it has de-politicized healthcare. 'Introducing the idea of channeling the funds differently was done through top management,' says NHIF Regional Manager Isaya Shekifu. 'It took some getting used to the idea, but at the end of the day we are all committed to the same goal of making sure our citizens gain access to good quality healthcare.'

#### Purchaser-provider split

This different funding structure results in another key systemic change: the so-called purchaser-provider split. In the former CHF, the districts were not only owners of the public primary care providers – they also purchased their healthcare services through the CHF. In the new iCHF set-up, the district remains the owner of public primary care providers but their services are now being purchased by the NHIF which has contracted those providers and is paying them on their bank accounts.

DMOs have generally welcomed the implementation of a system that actually works. Before, they were often frustrated that their allocated budget wasn't nearly enough to provide adequate care within their district. The iCHF model generates far more funds for healthcare. And ultimately, a smoothly functioning healthcare system will reflect positively on the DMO.

iCHF has also strengthened the position of DMOs. Now, their portfolio also includes private and faith-based providers in addition to public facilities.

Finally, the fact that data is now being collected on enrollment and utilization is generating a wealth of information that can help DMOs to better coordinate care, develop effective policies and support the providers in their district.





Sister Lucyanna Edward explains how the pharmacy at Charlotte Health Centre was improved using an upgrading budget and the SafeCare standards

### 3 Investing in quality as a first step to increasing demand

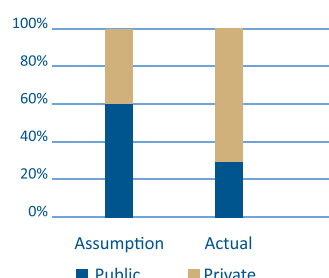
The *need* for healthcare services doesn't necessarily translate into an actual demand for services. Low-income groups are often unable or unwilling to pre-pay for an uncertain level of care. iCHF emphasizes improving quality on the supply side in order to actively increase demand.

According to iCHF scheme administrator Lameck Stephen, quality is the main determinant when it comes to enrollment decisions. 'In general, people are not so worried about paying the premium. They're more worried about the services, or lack of them. Once they trust the quality, they have more confidence in taking out health insurance.'

The co-premium for the former CHF varied per district, but averaged Tsh 10,000 (USD 5) per year. The co-premium for iCHF is three times that amount. However, the perception of its value as opposed to the cost has risen.

#### Opting for private care

Enrollees can opt for a private faith-based healthcare facility as their preferred provider. This makes iCHF much more attractive, as people tend to perceive the quality of services at private providers as higher than at public facilities. In the former CHF, which only offered access to public facilities, many enrollees visited private facilities and paid out-of-pocket for services they could have received free-of-charge at a public facility. iCHF is thus contributing to a reduction in out-of-pocket spending.



During the program design phase, actuarial analysis estimated a 60% to 40% ratio between public and private/faith-based providers in iCHF. In reality, the majority of enrollees opted for private care.

According to 2015 program data, 72% of enrollees in Kilimanjaro chose to access healthcare services through a private (faith-based) provider. In Manyara, 52% of people who enroll opt for a private preferred provider. These numbers are even more striking considering the fact that public facilities vastly outnumber private ones – more than 70% of the facilities in these rural areas are public. Enrollment is clearly driven by the preference for private faith-based providers.

"A Kanga, the colorful printed fabric traditionally worn by women in our region, costs about Tsh 30,000. During sensitization meetings I tell people that this one piece of clothing is just as expensive as the iCHF premium that covers their family's health expenses for a whole year. It makes them see that they cost the same but that iCHF is worth much more."

Sister Basilica Panga, Mbulu Catholic Diocese Health Secretary and a key figure in the Mbulu community

#### Changes ahead

In the KNCU Health Plan substantial amounts were invested in improving the quality of the healthcare providers in the program. iCHF was set up as a locally funded program. So far, it has not generated enough financial resources to continue the important upgrading work that started under KNCU. This hasn't significantly hindered enrollment, but it remains one of the main challenges in ensuring success.

## Changes that are being made:

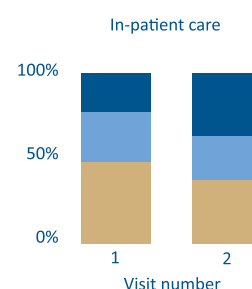
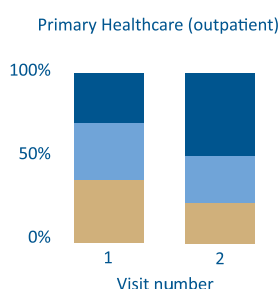
- **Integrated quality improvement:** Under the KNCU health plan, facilities underwent considerable renovations and were enrolled in SafeCare. Healthcare facilities selected to be part of iCHF must continuously work on improving the level of quality. The objective is for all facilities to join PharmAccess' quality improvement program and start working with the SafeCare standards, an internationally accredited quality improvement methodology for resource-restricted settings. This gives healthcare providers positive incentives to move steadily upwards in quality. Of all the iCHF healthcare providers that have been working with the SafeCare standards and that have received at least two SafeCare assessments, 100% showed a significant improvement in their SafeCare score. So far, however, limited financial and human resources means that SafeCare can only work with up to 40 providers a year.
- **Refurbishment:** In addition to improving their quality through SafeCare, selected facilities receive some support in upgrading their quality. This includes ensuring the availability of drugs, equipment and limited refurbishments, but also training on skills, attitude, processes, management, etc. The budget can fluctuate depending on the condition of the facilities, the amount of funding available and the range of equipment available. In Manyara region, for example, many facilities are so remote that they are not connected to the national electricity grid. For such facilities, refurbishment can include installing solar electricity power. The combination of capacity building through SafeCare and the upgrading budget enables healthcare providers to invest in their facilities and improve the quality of their services.
- **Increase in healthcare staff:** Another aspect of quality is the scarcity of healthcare staff. However, DMOs have helped to provide laboratory staff in cases where PharmAccess helped to upgrade or expand the laboratory. This is another way in which iCHF has leveraged donor funding.
- **More extensive coverage:** CHF covered outpatient services in most cases only, whereas iCHF has a much more comprehensive benefits package which among others includes inpatient services up to five days. Currently, the benefit package is being expanded to include referral to regional hospitals.
- **More incentive for investment:** The fact that iCHF has both public and private facilities competing to attract enrollees is an extra incentive for facilities to work on improving their quality. This also benefits healthcare consumers not enrolled in iCHF.

Investing in quality is a key aspect of the PharmAccess approach. If iCHF is to reach its full potential, it will need considerable investments in improving quality at healthcare facilities.

**'After joining iCHF, we made structural changes to the facility such as repairing the water supply system to ensure water is available in all sinks, toilets and showers, adding a consultation room, expanding the laboratory and adding shelves to the pharmacy. We also pay more attention to diagnostics, taking time for examinations before prescribing drugs.'**

John Ware, clinician at faith-based Bashay Dispensary in Mbulu district

All healthcare providers working with the SafeCare standards have improved the quality of their services. These charts depict a selection of the available data and how providers that have received at least two visits from SafeCare assessors are working towards full compliance with the standards.





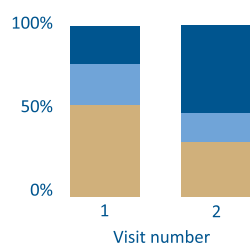


### ICHF ENROLLEE AT CHARLOTTE HEALTH CENTRE

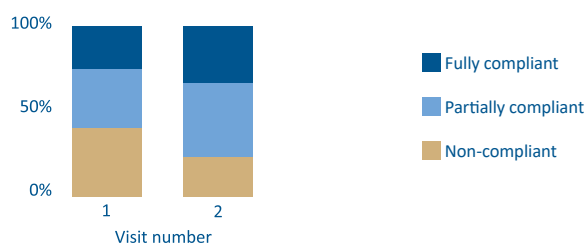
Agnes Tito is from a farming family and lives in a neighboring district. When she enrolled in iCHF she chose Charlotte Health Centre, a faith-based facility in Siha district even though she lives about 20 km away. She had heard about the good quality of care here, that the staff was caring and more attentive to patients. She received antenatal care at a public facility closer to home but travelled to Charlotte Health Centre when she went into labor.

iCHF is Agnes' first experience with insurance. She joined after a community health worker visited her family and explained the concept to them. She already had three children, all born outside of an insurance plan and without complications. This time, her delivery was very different. Due to fetal distress she had to have an emergency caesarian section. While an ordinary delivery costs around Tsh 10,000, this operation and the ensuing 7 days of hospitalization would have cost her family Tsh 250,000. Thankfully, Agnes was insured. She was able to recover in hospital and baby Jessica is doing very well.

Diagnostic imaging services



Patients rights & access to care





#### **INSTILLING A HEALTHY BUSINESS SENSE AT A PUBLIC HEALTHCARE FACILITY**

Levishi is a public dispensary in Siha district, Kilimanjaro region. It has drastically improved its services since joining the iCHF and entering into competition with private and faith-based healthcare facilities in the area. The facility underwent considerable renovations, set up a well-equipped laboratory and hired a certified lab attendant.

Dr. Peter Mselle: “Instead of referring patients, we can now do our own diagnostics in the lab. We do about 60 tests per week, ranging from malaria to HIV, urine, stool and urinary tract infections. We used to see about 300-400 patients per month, now we see up to 650.

We installed a water and drainage system, elbow-operated taps and also created different observation rooms for males and females. Since we built an extra consultation room and hired a second clinician, waiting times for our patients are also much shorter.”

## 4 Empowering patients to make informed healthcare choices

The old saying ‘beggars can’t be choosers’ is a daily reality for many people who lack access to quality healthcare. iCHF is changing this and empowering consumers, especially low-income groups. In Kilimanjaro, for example, people are voting with their feet and 72% of iCHF enrollees there have opted for a private (faith-based) provider.

iCHF brings better healthcare within reach of those who previously had little or no access, and not just because people can now also opt for private providers. The fact that enrollees pay 50% of the premium and the fact that this premium is three times as high as that of the CHF promotes a sense of ownership and encourages enrollees to demand better healthcare at the healthcare provider of their choice. They become active healthcare consumers rather than voiceless recipients.

### From ‘pay-for-non-performance’ to an incentives-driven system

The payment structure is now centered around patients. Previously, healthcare facilities were paid based on the district health management teams agenda rather than on utilization. Effectively, we can conclude that the CHF is not a form of health insurance but rather a health financing mechanism. Often, funds would be used to support healthcare facilities that weren’t functioning optimally, while facilities that were being run more efficiently would receive little to nothing because they already had more patients. In environments that work according to this public health budgeting approach, a vicious cycle is created where quality and availability of services are reduced and investments cannot be attracted.

Thus, there was not much incentive to improve quality, as poorly performing healthcare facilities were guaranteed a safety net while well-performing facilities were ‘punished’ with a smaller amount of funding relative to their number of patients. As a result, these providers could not invest in the expansion or quality of their services. Furthermore, the total amount of payment was generally not enough anyway because of the low CHF contribution and sometimes other competing priorities at the district level.

Now, healthcare facilities receive a capitation fee for every household that enrolls in iCHF. The money follows the patient, which incentivizes healthcare facilities to invest in their quality so they can attract more patients. Attracting more patients is also beneficial for healthcare staff. More patients translates to more income for the healthcare facility, leading to improvements like higher working standards and better equipment.

To further stimulate this process PharmAccess is currently in negotiations with iCHF stakeholders to reward providers who reach higher levels in the SafeCare standards with a higher capitation fee.

### Patient feedback

iCHF has introduced a toll-free number people can call to ask general questions or to complain if they haven’t received proper service. Every month, iCHF receives and follows up on an average of 150 calls per district. Under the CHF the only way to raise concerns was by using opinion boxes facilities, if they were available.

---

“In terms of utilization, the main confidence builder is having an insurance card. In many regions, people are told they’re ‘exempted from payment,’ but they don’t understand the language. With a card in their hands, they know they are covered for treatment.”

Deputy Permanent Secretary at the Prime Minister’s office Dr. Deo Mtasiwa

---





Sister Marcelina Remitarimo addresses healthcare staff at the Charlotte Health Centre



## 5 Reliable administration and a functioning payment system

Successfully implementing a system of health insurance payments as well as maintaining a reliable administration process is another major achievement within iCHF. While many healthcare facilities were initially hesitant to adopt a fixed capitation payment fee per enrolled household, the ensuing steady and sufficient cash flow and liquidity provides them with the financial leg room to invest in improving their quality. It also provides enrollees with freedom of choice when deciding on their healthcare needs.

High levels of out-of-pocket payments lead to uncertain income for healthcare providers. Stimulating pre-payment is an important first step to setting up a predictable payment system. And this generally only becomes possible once a committed and responsible payer like the NHIF enters the equation. In an uncertain environment of low trust and poorly functioning institutions, healthcare providers often prefer the security of the traditional and most widely used fee-for-service model, where they get paid per patient visit and type of treatment. However, reimbursement of insurance claims can take up to six months. Also, a large percentage of patients doesn't have health insurance and pays for services out-of-pocket. These patients are often unable to pay the full amount, adding to cash flow issues and financial stress at the healthcare facilities. Such unpredictable income is difficult to administrate and is not conducive to improving healthcare quality. When doctors do finally manage to generate a reliable income, they can finally invest in the future of their healthcare practice.

### Capitation payment

Healthcare facilities are often initially wary of capitation payment, whereby they receive a fixed fee at the beginning of the month for every patient that has registered at their facility, choosing it as their preferred provider for primary care before being referred if needed. Admittedly, the capitation model moves some of the burden of risk from payers to healthcare providers. Even though capitation ensures a steady cash flow and liquidity, many healthcare facilities are uneasy that the capitation model will result in deficits if patients end up using a lot of care. A great deal of time on PharmAccess' part was put into one-on-one sensitization of providers on the benefits and drawbacks of capitation.

The unfamiliarity of the concept of risk pooling is not just a hindrance in implementing capitation at the healthcare facility level: this limited awareness of risk pooling is also pervasive among the general population, contributing to slow enrollment into health insurance schemes.

Under the capitation model, enrollees have freedom of choice. They choose a single healthcare facility – public or private – as their main primary care provider, and a single referral center. If they are unsatisfied with the services, they can switch to another provider after three months. This switch is possible thanks to iCHF's administration system. In the former CHF, patients could only visit different public facilities and there was no effective way to switch providers.



**"Since joining iCHF, patient visits have grown from below 15 per day to about 40 per day. Before, we had almost no income. Now we earn up to Tsh 1 million per month. This has allowed us to go from 3 staff members to 16 and improve our services."**

**Dr. Amani Mariki, Lyamungo Health Center in the Moshi Rural district of Kilimanjaro region**

There are countless challenges on the road to achieving pre-payment. Many people are hesitant to pay in advance for healthcare they may not need, preferring to take their chances with out-of-pocket payments should they fall ill. They also often prefer traditional medicine or faith healers.

### **SIGN OF TRUST**

The fact that almost all private healthcare facilities decided to accept iCHF's capitation model of payment signifies a high level of trust. Interestingly, the readiness to join iCHF was considerably higher in Kilimanjaro region, where the success of the KNCU health plan over the years leading up to iCHF had built experience and confidence among healthcare providers.

### **Quality assurance**

Capitation in itself also stimulates providers to improve their quality and attract more patients. Inadequate care can cause iCHF members to decide to switch healthcare providers after three months. As such, doctors at private facilities have an incentive to keep patients satisfied. This includes making a correct diagnosis from the start, conducting proper tests and providing the right kind of medication if necessary, so that the patient hopefully gets better. Findings are that capitation fees stimulate a focus on patient satisfaction as well as patient satisfaction.

When patients pay out-of-pocket or are insured through another payment model whereby the doctor gets paid for every visit and treatment, there are also other incentives for the doctor. The doctor might over-treat the patient and ask him to come back, even when it's not really necessary. The capitation model eliminates any such incentive.

If a doctor decides to undertreat because of the fixed capitation payment model, this might work in the short run, but in the longer run those patients will likely choose another provider. Furthermore, capitation is easier to administer and does not require an extensive claim validation process at NHIF. Because there are no financial claims for every individual visit and/or service, capitation also means less room for fraud by healthcare providers.

Opting for a single provider has the advantage that doctors get to know their patients and can build records on them and their family's health, including their referral history. Ultimately, this enables healthcare facilities to foster relationships with their patients and to provide better care.

Finally, referral is also part of the capitation model of payment. iCHF members can access more specialized care at a district hospital when necessary, but only when they have been referred by their preferred primary care provider. Currently, district hospitals in Tanzania are usually overcrowded and overburdened because many people go there even for simple things like flu. A referral system like iCHF provides relief for district hospitals, allowing them to concentrate on patients in need of specialized care. As such, iCHF helps to keep overall healthcare costs down.

### **FINANCIAL FLOW**

When the enrollment officers enroll a new household they send the co-premium to the NHIF Regional Offices in Moshi and Babati where the application is reviewed. Regional offices request the matching funds from NHIF Headquarters every quarter.

Within two weeks after enrollment, the enrollment officer returns to the family to deliver their insurance card.

Every month, the regional NHIF office sends the capitation fee directly to the healthcare providers' bank accounts.

Possible delays in receiving matching grant from the NHIF due to bureaucratic limitations are mitigated by budgeting a buffer of about six months. The NHIF's double role as a matching grant provider and implementer also helps to speed up the process.

## Administration

In the districts where it is operational, iCHF has managed to reform the public healthcare system into a public-private system with less chance of leakage. A transparent administration process based on utilization and a shortening of the financial flows has been key.

Many healthcare facilities were pre-dominantly cash-based and did not have a bank account. As this was one of the conditions for joining iCHF and receiving the capitation fee, many healthcare facilities opened an account and now have more transparent financial flows.

In addition to the ensuing capacity building in learning the skills required to manage a bank account, moving away from an out-of-pocket, cash-based system is expected to reduce the chances of scarce resources being siphoned off. The iCHF model has created the conditions for more transparent operations.

The financing mechanism has been drastically shortened, as iCHF skips a large part of the chain. Channeling funds through the regional NHIF offices instead of through the district councils is a huge reform. The NHIF has also set up dedicated regional bank accounts for iCHF and is willing to invest in a separate IT administration system in order to provide even more insight into finances and operations.

Currently, iCHF is using the IT system developed as part of the KNCU health plan: a purpose-built interim system that was leased by MicroEnsure. However, this IT system cannot deal with much larger numbers of enrollees. For this reason, NHIF committed to design a new, separate IT system for iCHF, which will be crucial in ensuring smooth operations once the iCHF reaches scale. PharmAccess is involved in a consultative role.

For the time being, the interim iCHF system has not only become transparent for all parties involved, it has also been turned around to introduce accountability and reward good behavior. However, it is imperative that the NHIF fully takes over administration as originally envisioned. PharmAccess is investing in capacity building of NHIF staff to ensure this transition can occur smoothly.

.....

**“Our revenues have doubled. Previously we received about Tsh 250,000 per month, now we earn up to Tsh 500,000. Thanks to iCHF, we now have our own bank account. Before, all public health facilities had a single shared bank account, centralized under the district executive director. Now we have our own income and can decide how to spend it once our plans are approved by the DMO.”**

Dr. Peter Mselle of Levishi Dispensary, a public healthcare facility in Siha district, Kilimanjaro region

.....

## 6 A wealth of data to further improve healthcare delivery

**Gathering and analyzing data are integral aspects of iCHF, helping to improve decision-making and to further improve the health insurance model.**

Under the former CHF, administration was done at a district level by the facility in charge and the CHF coordinator. As the CHF office was overburdened, minimal administration and no data collection or analysis led to a lack of transparency on money flows, enrollment and utilization. Transparency on what little data was there was also not assured. Low enrollment, caused by the absence of an active marketing strategy but also by the poor quality of healthcare on offer, further minimized the CHF's chances of reaching scale.

The benefits of gathering more data are manifold. For example, in one district enrollment data showed that actual household sizes were larger than estimated. Also, data so far show that the number of people opting for private facilities over public facilities is much higher than initial projections. Having these data at hand makes it possible to re-evaluate premiums and fees and keep finances in balance, so that iCHF remains financially sustainable.

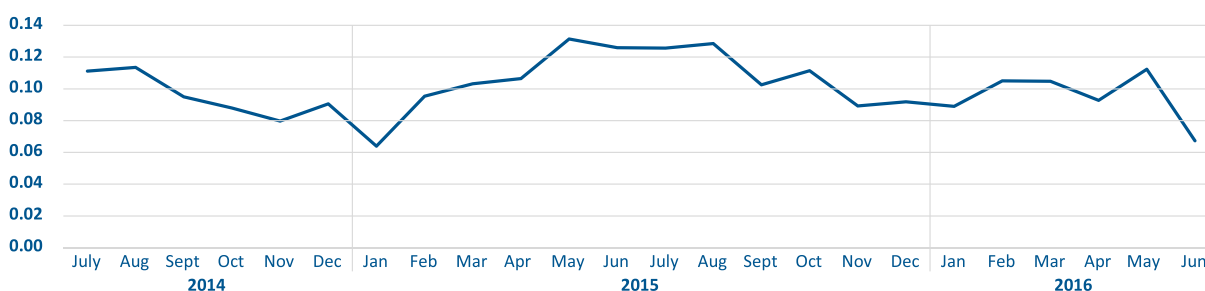
Before iCHF was introduced, the government had relatively limited amounts of data on the private health-care sector. The wealth of data being collected under iCHF is therefore of great value to both public and private stakeholders in the health sector.

### Premium based on actuarial analysis

Since the former CHF's payment mechanism was not based on utilization, it was less apparent that the premium was not realistic. The household contribution for the former CHF was determined by social and political acceptability rather than actuarial analysis, and the incoming premiums were therefore insufficient to cover the actual costs. This rendered the former CHF unsustainable from the start.

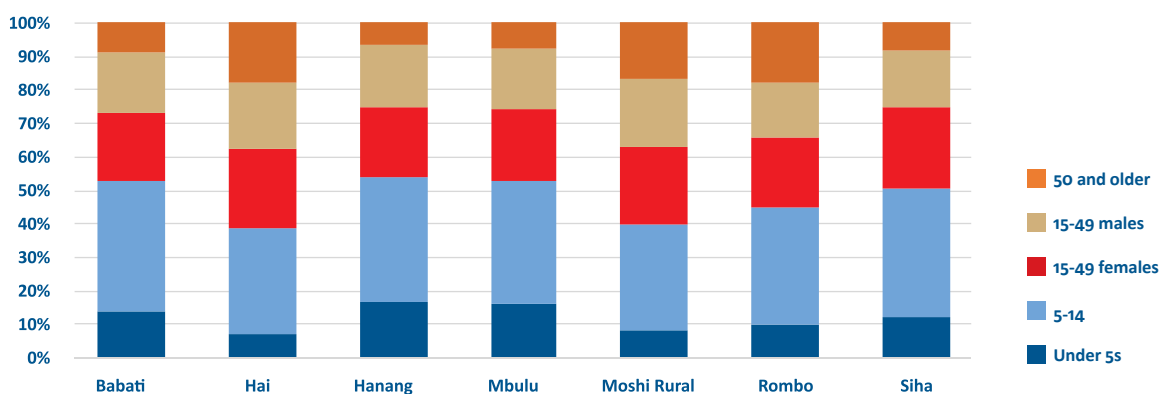
iCHF has a realistic premium and a much more reliable administration system. The lack of data from the former CHF made calculating a realistic insurance premium for iCHF a challenge. However, PharmAccess has a large amount of unique utilization data from extensive experience in other health insurance schemes, like the former KNCU health plan in Kilimanjaro. This provided a solid basis upon which to calculate estimated future costs, to set a premium based on actuarial design and to ensure sustainability of iCHF. The higher premium for iCHF, as calculated by PharmAccess actuaries, has proven to be fairly accurate. In fact, there was only one assumption which was clearly wrong: even PharmAccess greatly underestimated the extent to which iCHF members would choose private providers.

Average number of visits per iCHF enrollee

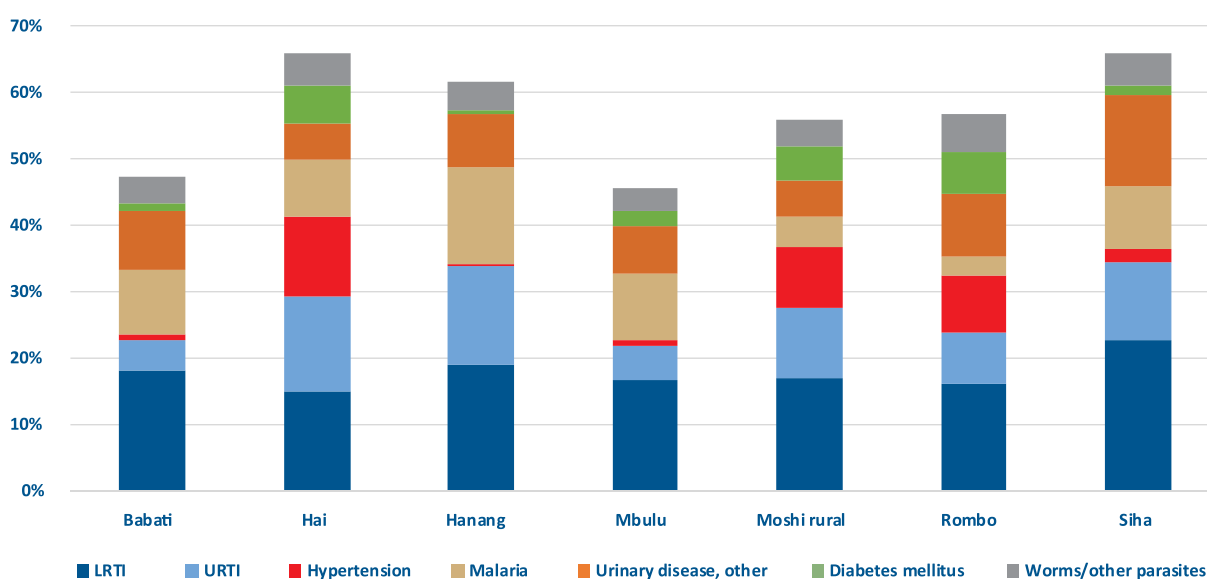




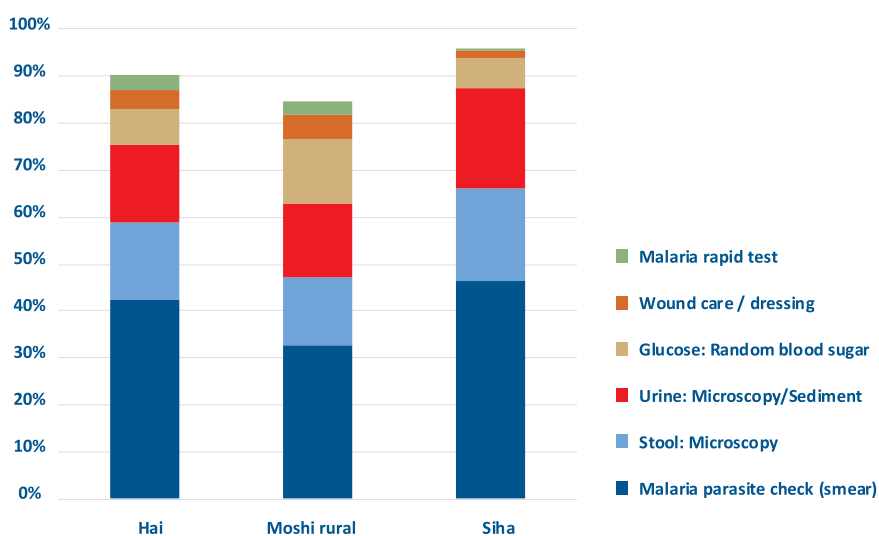
Age-distribution of the enrollees



Utilization: most common diagnoses



Utilization: most common investigations and procedures





Community health workers use motorcycles to expand their household visits

## 7 Kick-starting enrollment through active marketing

For a health insurance scheme that relies on voluntary enrollment in communities where the concept of insurance is new and where people may have had a less than satisfactory experience with insurance in the past, marketing, sensitization and education are essential. iCHF is steadily building enrollment through an active marketing strategy.

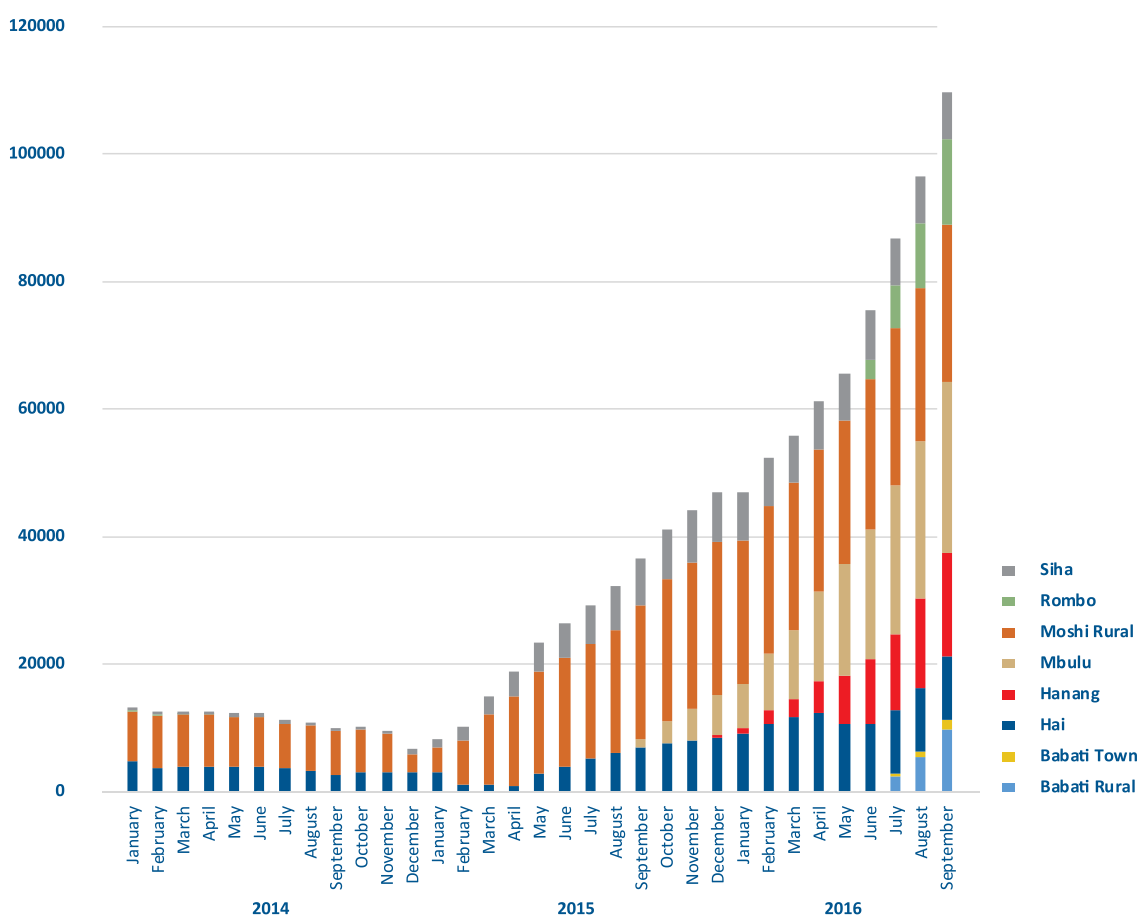
Within the former CHF, there was one designated person in every district covering all CHF-related issues. With such limited resources, marketing was virtually non-existent. There was no system in place to reward good performance in terms of enrollment numbers. Enrollment was done at healthcare facilities at the moment the potential enrollee needed care. As such, there was effectively no risk pooling in the program.

Now, enrollment is done at the household level – increasing the chance of a healthy risk pool. In the former CHF, there was no waiting period. This meant people could enroll in the hospital and get services immediately. In practice, this also means few people will enroll before they get sick. iCHF has a waiting period of 14 days to stimulate people to enroll before they get sick.



iCHF officer James registers new enrollees at the Lyamungu Primary Society office in Hai District, Kilimanjaro Region

### Enrollment in iCHF has exceeded expectations



### Active network

iCHF employs a very active marketing strategy, primarily through an intricate network of community health workers and volunteers. These people are incentivized by the payment structure: they are paid a percentage of the co-premium per signed and paid contract. They visit at least seven households per week and also pay return visits to families after they have enrolled, first to deliver their insurance card and later to enquire after their experience with iCHF.

The most successful community health workers are rewarded with further benefits. In Moshi Rural district, Mary Shao enrolled 124 households with 721 individuals in 2015. She received 10 bags of cement. In Siha District, Domicile Mvungi enrolled over 200 households in 2015. The Kilimanjaro Regional Commissioner Health Honorable Amos Makalla presented her with a brand new motorcycle. Mr. Makalla is fully on board with the iCHF: 'I ask all Village Executive Officers and Ward Executive Officers to incorporate the iCHF in their daily activities, from now I will measure your performances also by looking on iCHF enrollment.'



The iCHF model has introduced officers at each division of the district, responsible for supervision and support of the community health workers/volunteers. These iCHF officers are also responsible for sensitizing and enrolling people in groups e.g. schools, economic activities groups etc.

iCHF actively creates awareness in remote areas.

- Through village meetings, road shows and visits to churches and schools, the marketing team aims to reach a broad slice of the population.
- The iCHF has ample radio coverage thanks to contracts with local radio stations. Every week, the iCHF has a one-hour live radio show. Guests range from doctors, politicians and patients, including people who called the toll-free number with a complaint that was treated successfully.
- Radio shows are often followed up by sms campaigns.
- There is a catchy iCHF song written by one of the most popular bands in Moshi which is regularly played on the radio and at iCHF events.





## TAILOR-MADE MARKETING IN MBULU

Although iCHF is designed to work all over Tanzania, every district requires a slightly different approach. In Mbulu district in Manyara, for example, the population can be roughly divided into pastoralists and farmers.

The farmers are very successful in producing crops like onions, garlic, peas, tomatoes and capsicum. The whole family tends to work on the farm. During the harvest season in August and September, families are most likely to have extra cash to invest in an insurance plan. It is thus wise to ramp up marketing efforts in those months.

The pastoralists, mostly Masai, raise livestock and lead nomadic lives. This means that the capitation model causes some concern as they are less willing to commit to a single healthcare provider. They also have different family structures as they tend to live in extended families with up to 5 wives and 3-4 children per wife rather than in a more standard family. iCHF allows a maximum household size of 6. This target group requires extra marketing and sensitization through community leaders.

Manyara's NHIF Regional Manager Isaya Shekifu confirms the importance of intensive and targeted marketing. 'People in Mbulu are very trusting of their leaders. Endorsements from community leaders, churches, doctors, politicians and peers are crucial to iCHF's success. This is especially important because the concept of insurance is new and the culture here is quite resistant to change.'





Sister Lucyanna Edward at Charlotte Health Centre

## 8 The road ahead for iCHF

**iCHF has the potential to drive systemic change in the healthcare system in Tanzania. While it is still early days, it is showing that it is possible to make the healthcare system work better for low-income groups as well as those healthcare facilities serving low-income groups, and to unlock the potential of the private healthcare sector by expanding health insurance.**

This systemic change is only possible because iCHF has succeeded in building trust. This is crucial for all parties in this public private partnership who have to venture out of their comfort zone and take a risk they would otherwise not dare to take. The KNCU health plan, set up with support from the Dutch Ministry of Foreign Affairs, was an important precursor. Without this experience, and the trust created at healthcare providers and communities in Kilimanjaro, it would have been much more difficult, if not impossible, to successfully launch iCHF.

### **Trust across the board**

iCHF has a large network of people who help advocate it. From traditional local leaders to religious leaders in the church, and from politicians on a national level as well as a municipal level, these key figures are instrumental. Their faith in iCHF has built trust and played an important role in the high enrollment rates and the establishment of a healthy risk pool.

Both public and private healthcare providers have also displayed trust in iCHF, agreeing to adopt a new payment model, even though it shifts some risk to their side of the court. At the same time, they now enjoy much more financial security and benefits than they did under the former CHF. Every month, they know how much they will receive in their account, and they can more effectively manage their own finances as a result.

As for the future, iCHF will have to continue to prove itself. In an environment with such limited awareness of health insurance, first-time enrollment may be based largely on trust. Re-enrollment, however, is based on experience.

### **Quality and access**

Increasing quality and availability of medicines, especially at public healthcare facilities, will be crucial to the success of iCHF in the long run. When people place their faith in the quality of services by paying ahead, meeting their expectations is key.

Quality improvement on the supply side of the healthcare market is a key element of the PharmAccess approach. PharmAccess offers clinical as well as business training to healthcare providers. The quality levels at facilities participating in iCHF can vary greatly, as the CHF and the NHIF are required to work with all public facilities in the area.

Patients are now starting to come into their own as healthcare consumers who know that they can demand their money's worth. If they are unsatisfied with the treatment they receive at their chosen facility, they can opt to switch facilities at the end of the contract year. The fact that they can vote with their feet will help to keep the system in check.

### **Building capacity**

However, there is currently limited capacity to introduce the SafeCare quality standards and PharmAccess's quality improvement program at all contracted facilities. To mitigate this, PharmAccess is training district Council Health Management Team (CHMT) members as SafeCare facilitators and assessors so that they can



independently conduct quality assessments and support healthcare providers in executing their quality improvement plan. Political commitment to embed the SafeCare methodology into local government operations will be crucial to raising quality levels at the facilities.

Under iCHF, selected facilities receive limited support for upgrading of their facility. There is insufficient funding to provide this support for all contracted facilities, which puts some facilities at a disadvantage in terms of quality improvement. This funding would have to be budgeted for on a regional or even national level as iCHF grows to scale. An option on the private sector side would be to enlist the support of the Medical Credit Fund, which works with local banks to facilitate loans to private healthcare providers in Africa.

While not directly within iCHF's realm of influence, in future it will aim to build capacity with the CHMT to establish drug audits at (public) facilities as an effort to address stock outs. However, this will still require political commitment and reform on a national level.

### **Political will and local funding**

The new government has put health insurance high on the agenda. It is currently developing a reformed CHF for a nation-wide rollout as part of its policy to move towards universal healthcare coverage. Key elements of iCHF, like administration by the NHIF, a household contribution of Tsh 30,000 and involvement of private providers, are likely to be part of this reformed CHF. In this way, iCHF seems very well-positioned to be taken to scale.

Scaling up to other districts and regions will require a more institutional approach to capacity building. This may for example take the shape of a curriculum that could be taught at existing zonal training centers. In the long term, it may be prudent to bring vertical programs such as maternal and child care, malaria, TB and HIV/AIDS into iCHF. This would not only be more efficient, it could also be a solution for funding (for example so iCHF will also be able to cover the poorest of the poor) and a way to secure its future. Mobile technology can also play an important role in this respect, especially considering PharmAccess' extensive experience in Kenya.

The more successful iCHF becomes, the more funding it will require from the Tanzanian government and the NHIF – both in terms of the matching grant and the amount of human resources for administration and marketing. Such political and financial commitment will be key to ensuring iCHF reaches its full potential.

By improving the quality of healthcare providers and addressing the abovementioned issues, NHIF and PharmAccess aim to replicate this public private partnership in more districts, upgrade the majority of the healthcare providers in iCHF and achieve at least 30% health insurance coverage within five years.

By increasing both the quality of care and the level of enrollment, iCHF has the clear potential to effectively break the vicious circle of low quality, low trust and low enrollment and contribute to achieving universal health coverage in Tanzania.



## 9 References

- Kuwawenaruwa A & Borghi J. **Health insurance cover is increasing among the Tanzanian population but wealthier groups are more likely to benefit.** Ifakara Health Institute, spotlight issue 11, June 2012.
- **Lessons from Community Health Fund reform – A review of the past three years.** Ifakara Health Institute, spotlight issue 15, December 2012.
- **Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note September 2011.** Human Development Department, Africa Region, The World Bank
- Ministry of Health and Social Welfare. **National Health Sector Strategic plan III (2009 to 2015)-Partnership for delivering the MDG.**
- Mtei G, Makawia S, Ally M, Kuwawenaruwa A, Meheus F , Borghi J, **Who pays and who benefits from health care? An assessment of equity in health care financing and benefit distribution in Tanzania,** Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine, January 2012.
- Mtei G, Muligan J, **Community Health Funds in Tanzania- A literature review.** Consortium for research on equitable health systems, January 2007.
- National Health Insurance Fund (NHIF) data of September 2013
- Stoermer VM et al., **Building a sustainable financing mechanism for healthcare in the districts and municipalities: Transforming Community health Funds in Tanzania into viable social health insurance schemes-the challenge ahead.** Swiss TPH, September 2010.
- Von Manfred Stoermer & Ralf Radermacher and Mackenzie Vanderhyden , **Improving Access through Effective Health Financing** - Reader of the Swiss TPH's Spring Symposium 2011 in MMS Bulletin #120 June 2011
- Msuya, J. M., J. P. Jutting, et al. (2004). **Impacts of Community Health Insurance Schemes on Health Care Provision in Rural Tanzania.** ZEF.
- 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.
- 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.
- Shaw, R. P. (2002). **Tanzania's Community Health Fund: Prepayment as an Alternative to User Fees.**
- 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.
- Godfrey M. Mubyazi and Jan Borg, **Desirability, challenges and options for launching a community health fund scheme in Tanzania: interview-based views from community members and health managers in Kagera Region and review of lessons from other CHF implementing districts.** African Journal of Health Economics, 2012.

PharmAccess  
FOUNDATION

Health  
Insurance  
Fund



SafeCare  
BASIC HEALTHCARE STANDARDS

PharmAccess Group  
Trinity Building C  
Pietersbergweg 17  
1105 BM Amsterdam  
+31 (0)20 566 7158  
[www.pharmaccess.org](http://www.pharmaccess.org)

PHARMACCESSGROUP

