PharmAccess' lessons learned on rolling out the iCHF health insurance scheme in Tanzania

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Introduction

All nations have agreed to achieve universal health coverage (UHC) by 2030, following the internationally adopted agenda of the Sustainable Development Goals (SDGs). This has stimulated many governments, including in Tanzania, to move toward health insurance for all.

PharmAccess actively supports the drive for UHC by helping the Tanzanian government strengthen primary care and provide technical assistance to develop and roll out sustainable health financing models. PharmAccess works with local and international partners in the public and private sectors to increase the funds channeled into the healthcare system and strengthen both the demand and supply side. To realize sustainable health financing and improvement, health insurance is key. Implemented well, insurance fundamentally changes how revenue for healthcare is raised and redistributes benefits across the population in an equitable way.

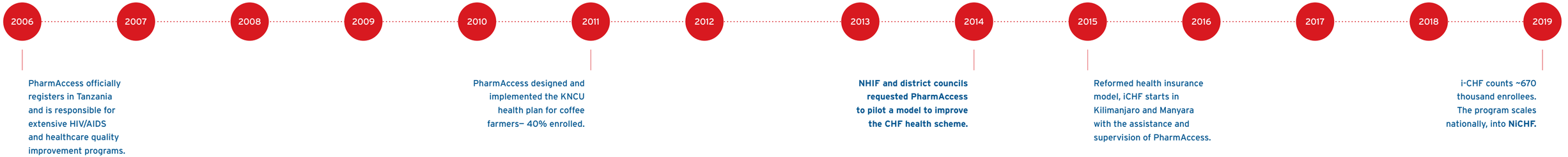
PharmAccess has been working in Tanzania since 2006, with activities ranging from extensive HIV/AIDS care and treatment programs to a nationwide quality improvement system using the PharmAccess' SafeCare quality standards. Applying our experience from setting up insurance programs in other sub-Saharan countries, PharmAccess supported Kilimanjaro Native Cooperative Union (KNCU) in designing and implementing a health insurance scheme for the coffee farmers of Africa's oldest cooperative, the Kilimanjaro Native Cooperation Union (KNCU), in April 2011. This scheme, operational in four districts in the Kilimanjaro region, enrolled up to 40 percent of eligible members.

Ten years earlier, the Tanzanian government founded two health schemes: National Health Insurance Fund (NHIF) and the Community Health Funds (CHF), the latter targeting the informal sector. In 2011, CHF enrollment in Kilimanjaro was less than 6 percent of the population. Local officials in Kilimanjaro noticed the growing KNCU enrollment rates and requested PharmAccess' support in improving CHF performance in their area.

After the governments' approval to pilot an improved scheme of CHF, the KNCU Health Plan, designed by PharmAccess, came to serve as the proof of concept for iCHF. iCHF is a health insurance reform piloted in Kilimanjaro and subsequently in Manyara from 2015 onwards. The iCHF scheme in these two regions provide a blueprint for the National improved CHF, which is currently being implemented. PharmAccess supported local governors in reforming and implementing the iCHF model by increasing its enrollment rates and improving the healthcare quality of providers connected to the scheme.

We would like to share our approach and the lessons learned from implementing the iCHF model, which grew to providing healthcare insurance coverage for more than 670 thousand people. Most of these people come from the region's lowest income groups. Without insurance, they are exposed to the risk of frequent, high out-of-pocket healthcare costs, pushing them further into poverty.

Under PharmAccess' supervision, in the regions of Kilimanjaro and Manyara, enrollment rates rose from less than 10% to respectively 18 to 22 percent of the total population. To identify the success factors of iCHF, we want to give voice to people in the field who have firsthand experience with the impact of insurance: hospital staff, beneficiaries, community health workers and other key people in the communities of Manyara and Kilimanjaro.



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Rolling out health insurance for the informal sector: our approach

Under the right circumstances, people are willing to prepay for healthcare

Out-of-pocket payments for healthcare are globally driving about 100 million people into poverty each year. Prepayment and risk pooling schemes are mechanisms to finance access to quality healthcare, so that people can afford to get treated when they are ill without having to borrow or being pushed into poverty. Social health insurance schemes that mobilize both public and private resources enable equitable and sustainable health financing to achieve UHC.

For those unfamiliar with the concept insurances require a mind shift. The insurance premium must be paid even when health services are not used. From interventions with the communities in the region we learned that there is a willingness to prepay, even among low-income groups. Insurances provide much-needed financial security for poor families who experience a daily struggle to afford basic necessities.

Considering iCHF, this willingness to pay is even more noteworthy because of a significant rise in the premium compared to the previous scheme (old CHF scheme: 5-10.000 TZS per person to iCHF: 30.000 TZS per household). In an uncertain environment of low trust and poorly functioning institutions, people may be hesitant to join. But during iCHF healthcare providers were incentivized to invest in better quality care. By improving quality, trust is built and people will be more prepared to pre-pay.

From our interventions and research we also learned that enrollees perceive the services from private facilities as better than the public providers. When the private facilities are included in insurance schemes, they receive the majority of the members. According to 2015 program data, 72 percent of enrollees in Kilimanjaro opted for services through private (mostly faith-based) providers, in Manyara, 52 percent.

These numbers are even more striking as public facilities in these regions vastly outnumber private ones.

Extensive sensitization and awareness of health insurance and iCHF also play a key role in boosting the enrollment rate. The next pages will elaborate on quality, provider reimbursements, the inclusion of private facilities and the importance of community awareness.

"The reality is, life was hard before I had insurance. Without 'emergency money' you are in trouble. I usually bought paracetamol for me or my children to relieve the pain. I also tried to guess and got only one test from the lab for a disease, but left others, as it was too expensive. If I eventually had to go the hospital, I needed a loan and afterwards to sell a chicken, or two, but even that was often not enough. After talking to my husband we decided to join iCHF. Treating one child can cost more than we pay for the insurance for a whole year."

Anna Laurent (45) lives in Ngoni, Manyara. She is a farmer and a mother of five children. Her youngest is 10 years old, the oldest 24.

Rosi Pauli (48) is a farmer in Kibosho Otaruni village, Kilimanjaro. Sometimes she collects firewood in the forest, carries it on her head back home and tries to sell it to earn some additional income.

" The people from iCHF went around and I said: why wouldn't I join? Disease do not give you a warning. Before I had health insurance, I often tried to visit a facility and they told me the price. It usually meant coming back home without being consulted. You then start to look for money. If you can't find it, you might lose your life. You go with what you have: when I had 100 or 200 Schilling I would buy aspirin or tried some herbs. I usually waited long to see a doctor.

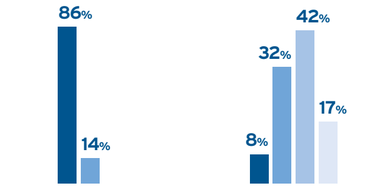
Only two months after joining the insurance my child had to get admitted with pneumonia. And shortly after, I needed to see a doctor. They even told me I had to get an abdominal operation which I did. I had to stay in the hospital for a couple of days. And all was paid for by iCHF!

"Disease does not give you a warning"

We are currently without insurance. I heard my neighbor, who joined the new scheme, did not get the services reimbursed at Kibosho, our preferred facility [which is private]. We are worried because we like the services there. I am waiting for information on the new scheme [N-iCHF]. In the meantime we are collecting the money for the premium and pray to God to not get sick.

If we need to go to the hospital now, it would affect the economic situation of the family. I would need to cut money on our expenses. I guess we would first stop eating meat. And then stop paying the school fees."

Improve and guarantee healthcare quality



SafeCare Baseline Levels

SafeCare Endline Levels

Level 1 2 3 4

Facilities under iCHF that have been working with SafeCare improved in quality.

Level 1= lowest, 5= highest level of quality. Data based on 59 clinics.

The need for healthcare services does not necessarily translate into an actual demand for services. It is challenging to convince people with low incomes to pre-pay for healthcare but if the quality of care is lower than expected, if medicines are out of stock and no doctors are available the task becomes impossible. Therefore, the design of iCHF improved quality on the supply side in order to actively increase demand.

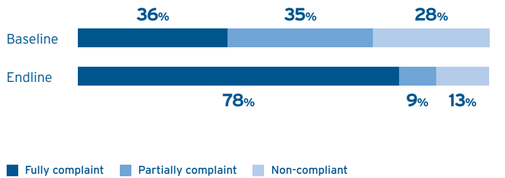
PharmAccess' SafeCare became an integral component of iCHF. From the start of iCHF in 2015 all facilities entered a quality improvement program based on the internationally accredited SafeCare standards.

SafeCare is a quality improvement methodology specially designed for health facilities in resource-restricted settings. Facilities receive regular visits and inspections to stimulate, support and monitor their progress. SafeCare equips providers with the tools and instruments to improve, step by step, and offer their patients better services. Facilities under iCHF that have been working with the SafeCare standards have demonstrated improvements in quality.

iCHF addresses access and healthcare quality issues simultaneously. The next chapter explains how facilities are continuously incentivized to improve their services by reimbursing them based on a capitation arrangement.

"In my supervising role, the SafeCare standards help me to teach others. The treatment procedures are now documented digitally so after I teach the juniors, they can do it without me.

We now have the three-bucket system to separate contaminated waste and a bucket for sharp waste, so we don't run the risk to cut ourselves. SafeCare also helps us to control infections. We brought our infection rates down and you can see that our patients can go home sooner."



Fully complaint Partially complaint Non-compliant

Facilities under iCHF that are compliant for maternal, newborn and child health, according to the SafeCare standards

Data based on 59 clinics.

Viridiana Gwandu is 55 years old and a registered Nurse at Dareda hospital. She works as a nurse for 28 years.

Dr Eileen Lirhunde (33), assistant medical officer at Kibosho hospital, Kilimanjaro.

" I have a passion for my job. But being a doctor in such a poor area is challenging too. Especially before iCHF. I used to write prescriptions but knew many could not afford the medicines. And in the meantime you see the complications progressing. Sometimes I looked into my own pocket, but the next day, they come again...

Fortunately our healthcare results have throughout the years improved so much, largely through SafeCare. I cannot compare our current situation with where we came from. Before SafeCare it was a mess here. SafeCare made the environment so clear and simple. It is now easier for us to offer the services without exposing ourselves or the patient to unnecessary risks.

Imagine earlier, you could have a seriously sick patient coming in. You check the [emergency drugs] cupboard and find out the medicine is not there. You rush to the pharmacy, and the medicine is out of stock because it wasn't ordered or there is simply no one there. Thanks to SafeCare everything is clearly labeled. You know medicines are available and tools are working. No matter which staff member you talk to, you speak the same language when it comes to quality.

"Before SafeCare, it was a mess here."

Kibosho hospital has improved from SafeCare standard 2 to 5 [the highest rate]. Despite the effort it takes, everyone works together to keep the rating high. This is great for the reputation of the hospital. And of course our results are better. Health results also improve as people come earlier to the facility now that they are insured. There is less chance for complications to become chronic. And at the maternal ward there are less cases of premature deaths, because women can get treated on time."

Select the right reimbursement model

There are several ways to manage the financial sustainability of health schemes and to deliver UHC. One approach includes the use of capitation fees, in which providers get fixed monthly reimbursements, based on the number of registered patients.

As part of iCHF, enrollees could choose a facility for primary healthcare services. This facility in turn benefits from a steady income; a capitation fee for every registered household. The money follows the patient, which incentivizes healthcare facilities to invest in their quality so they can attract more patients.

Instead of being reimbursed after treatment, providers receive a fixed fee at the beginning of the month, based on the number of people that selected the facility as their primary facility. Providers receive a more predictable stream of income from the insurance scheme. Also, it helps to reduce the administrative burden of the claims procedures.

As capitation fees are fixed per household, facilities tend to work towards prevention and decreasing their re-admission rates and focus more on prevention. In the maternal wards, facilities tend to encourage regular check-ups, leading to less complications in the longer run. After all, when no (additional) care is needed, the facility makes a profit.

Alana A. Mapunda is a mother of four and a patient at Kibosho Hospital. She visited the facility for an abdominal examination.

"I chose Kibosho hospital because of its services. Compared to other public hospitals close by, I know that services are not so easily accessible, and more administration is needed. Going to another hospital would mean I would be more worried."

John Materu (52) has worked for nine years as Medical Officer at Kibosho hospital, Kilimanjaro.

"Being at Kibosho hospital gives me an opportunity to deliver healthcare services to the small-scale farmers and villagers with low socio-economic status. They are the neediest population.

The iCHF capitation fees are a game changer for our hospital. Before iCHF it frequently happened that more clients come for treatment and their costs exceeded the reimbursement, so the hospital ended up with a loss. A year before iCHF we ended up with a loss of more than 6 million TZS ($ 2.6K). During iCHF we managed to realize a balance of about 1.8M TZS ($ 780).

This profit enables us to invest in better services and new activities within the hospital. One major improvement is the digitalization of our administration and guidelines. Now you can easily read procedures rather than having to know all steps by heart. Before that we had to write down each step for your colleague to continue the treatment. Digitalization makes it much less likely to make a mistake.

Digitalizing our medicine stock and supplies equally made a huge difference. You can see how supplies are moving and we are on time ordering new ones. It also improved our financial control. And last but no least, thanks to our improvements our staff works a lot better together. We connect with each other easily and ask for help, if needed.

"The iCHF capitation fees are a game changer for our hospital."

SafeCare helped us choosing where and how to improve which reduced the suffering of our patients. Our admission days have gone down, so people can go back home earlier to be united again with their beloved ones. But most important, you see the improvements coming back in the reduced number of complications and deaths. And I am proud that at this hospital we haven't had mothers dying during labor for a long time."

Include private health facilities into the scheme

Private facilities are needed to meet Tanzanian's demand for healthcare. In rural areas these clinics are often faith-based and perceived to provide better care. Some enrollees suggest they offer better specializations, hold a more adequate stock of drugs or require fewer bureaucratic procedures. For many living in remote areas being able to access private facilities means a significant reduction in travel costs. **According to 2015 data, 72 percent of enrollees in Kilimanjaro choose to access healthcare services through a private (faith-based) provider.**

The availability of private providers has boosted iCHF enrollment rates. For these facilities joining iCHF means that they benefit financially from the capitation payment model. Nearly all approached faith-based facilities joined iCHF signifying a high of level of trust in the organization of the scheme.

Private facilities receive a slightly higher share of the capitation fees as public providers already receive government subsidy to cover costs for medicines, medical supplies and staff salaries. iCHF thus represents a system that encourages both public and private provider participation. Without this compensation these private providers often experience trouble sustaining their businesses leading to less access to care, especially in remote areas.

"Previously, I had a nurse who helped me financially to cover my medical needs. But when she passed away, I knew my risks. I enrolled into the health insurance as soon as it was available. Being able to go to Kibosho hospital makes a big difference. The public facility around here lacks adequate equipment, the scope of investigations are limited, and staff are not enough. And, when I go for my medicines, they might send me away because they are out of stock. I am happy to go to Kibosho. It provides better care and I don't have to travel too far."

John Koyanga Temba is 80 years old and a hypertension patient. He lives with his wife in the highlands of Kibosho, and still carries out farming activities.

Dr Joseph Lorr (48) is Medical officer in charge at Hospital Dareda.

" We are a private hospital but we act like a district hospital. Workers, drugs and supplies are partly received through the district authorities.

But as a 'district hospital', we don't only serve people from the village. People also come from further afield, from Babati. They enjoy our services which are of good quality, thanks to '5S' [a quality improvement methodology]. We try and take good care of patient rights.

People in this village are very poor. When they come here, they see hope. Traveling further is too expensive. At the same time health demands are high: in this village it is common to see women having 10-14 children.

"People in this village are very poor. When they come here, they see hope."

Sometimes we don't receive enough supplies from the authorities. For example, we need a lot of intravenous fluids. These fluids help maintain adequate hydration and are often used during labor. That is why we decided to produce our own. I cannot let women die when the solution is available - I just need to make it myself.

Many people here are dependent on us, which comes with challenges. When seriously ill people come in, you need to treat them, regardless of their financial status. You cannot say: pay first. But after the treatment, when they are presented with the bill, they often run away. Only last weekend four patients from the female ward fled without paying, resulting in a loss of 800,000 Tsz ($350)."

Community involvement is key

PharmAccess helped train and coordinate community health workers (CHWs) and other volunteers to develop iCHF awareness and health insurance principles. For many insurance is a new concept. It requires time and dedication to educate people and build credibility.

The work of CHWs has been a key success factor. They are chosen by the community as trusted citizens and many have already built a record in volunteering and serving. CHWs go from household to household to sensitize the community and collect the premiums 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.

Community awareness during iCHF went beyond the work of CHWs. Residents learned about the scheme via radio, road shows, church and school visits that extended the scheme's marketing reach.

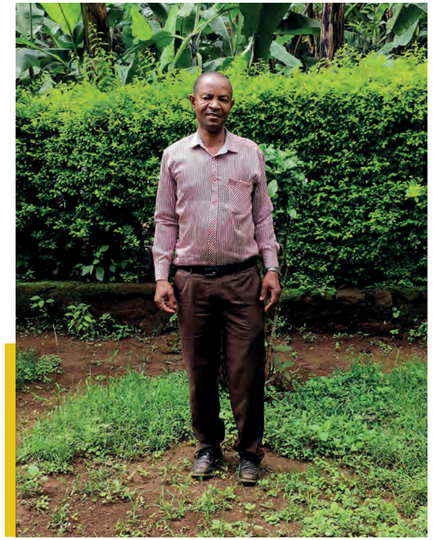
"Sensitization on insurance and iCHF was our biggest focus for a long time. We actively got out to the villages to educate people about iCHF. Once people joined the scheme, we would follow up a couple of months later to record a testimonial. As we have different tribes we would allow them to speak in their mother tongue, to build trust. People could also call in during the program. They asked all types of questions. For example on what medicines and treatment were covered and whether they could visit facilities in other regions. Now that iCHF comes to an end and leads into the new national scheme I haven't had a new request to promote the insurance."

Deo Moshi (41) is a radio presenter. His station, 'Redio Sauti ya Ijiri,' broadcasts in six Tanzanian provinces.

Mike Ngowi (58) has been one of the most productive iCHF Community Health Workers (CHW). Over 4.5 years, he has enrolled more than 10,000 households for health insurance, an average of 188 households per month. CHWs go from house to house to educate families on the value of health insurance and also to encourage and support them in saving for the premium.

" I have been volunteering in my community since I was young; and with that I have been able to build up trust. The work is not about salary, as you don't get much for it. But I believe God remembers you. Good things come back to me a in a different way.

I have been able to convince almost all families that I visited to sign up for iCHF by talking to both the father and the mother. Although the father may be the head of the household, the mother is the one who usually carries the burden to care for the sick. Sometimes I would even call their grownup children to help their parents paying their premium.



"I have been able to convince almost all families that I visited to sign up for iCHF, by talking to both the father and the mother."

One day, I went to a family with many sons. The family decided to join iCHF. In the meantime, one of the in-laws, a pregnant lady, listened quietly. When I walked away the lady followed me and told me she wanted to sign up as well. I enrolled her immediately.

A few months later she had to be admitted at the hospital. Fortunately, she eventually delivered healthy twins. The family in law celebrated the newborns when she came back home, and I was invited. For the occasion they planned to slaughter one of their goats. But as the father was about to start the slaughter the new mother stopped him and asked: what about we don't eat this goat but instead sell it, so we can pay for health insurance of our other in-laws? No one objected and I enrolled the new members soon after."

Digitalization to improve healthcare

From the beginning of iCHF, PharmAccess stimulated the use of IT in the healthcare sector. Digitalization has the potential to dramatically transform healthcare by improving efficiency, cost-effectiveness and generating data.

Many Tanzanian facilities made the first and major step in digitalization: the introduction of digital patient files. Up until a few years ago most providers only administered their patients and records on paper. Digital records allow medical staff to send patient files to other staff members, reducing overhead costs as well as the chance for errors. The facilities connected to the scheme made additional steps including the digitalization of their treatment protocols and laboratory investigations.

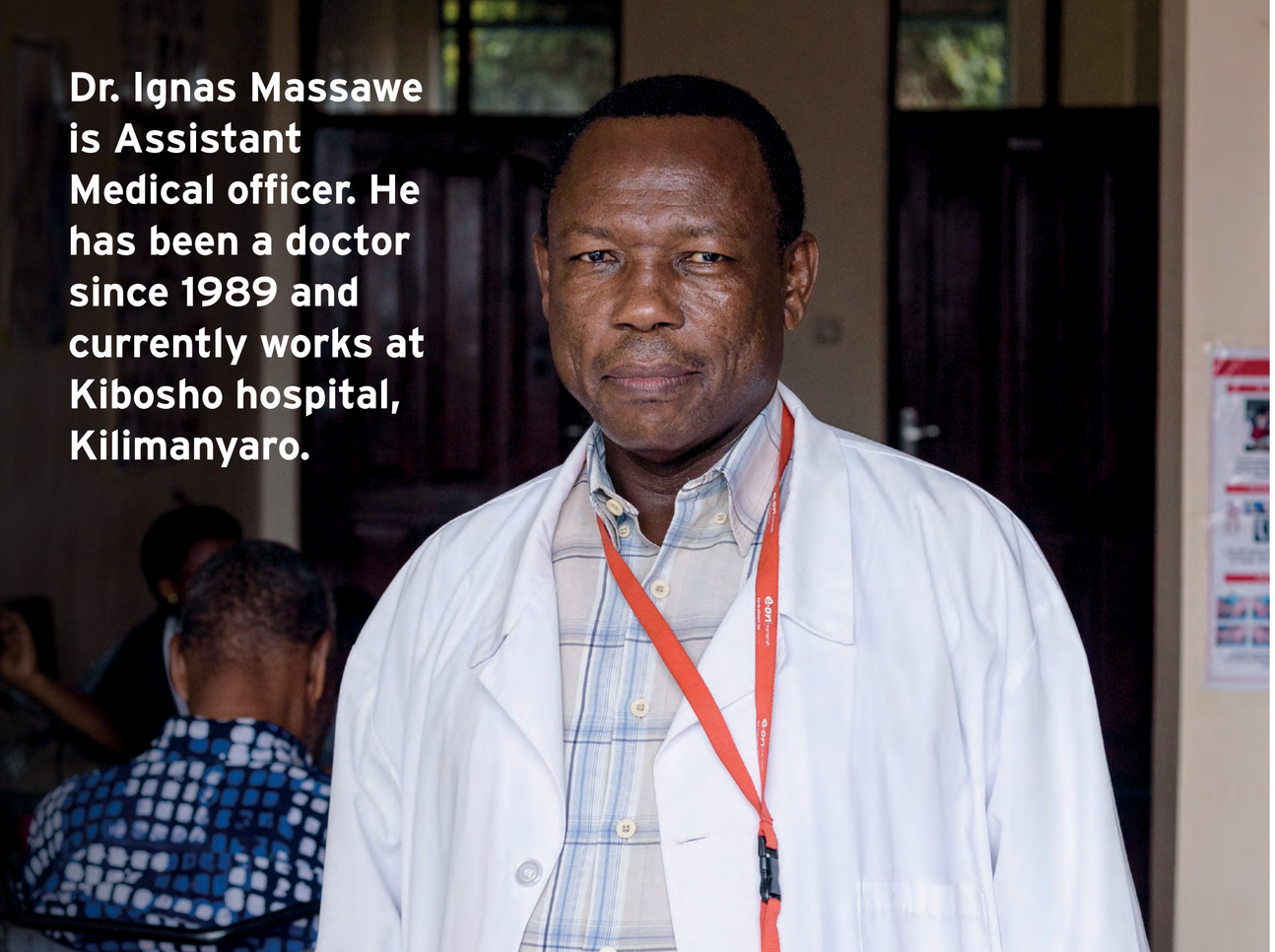
The emphasis on digitalization within iCHF has been notable in other areas too. CHWs enrolled members into iCHF via their mobile phone providing a user-friendly design that is less prone to errors. PharmAccess played a consultative role in designing an IT system, ensuring smooth enrollment, up-scaling and refining operations.

Future digitalization opportunities

By digitalizing the diagnostic process in a health facility new opportunities arise. A promising development is the introduction of alternate payment mechanisms for healthcare providers. In Kenya, PharmAccess ran a pilot and research project to make treatment of diseases like Malaria conditional on positive Malaria test results. This model can prevent further medicine resistance and at the same time, reduce healthcare costs.

"Thanks to our digital system, there is no more overflow of patients at the reception. It all runs a lot quicker. People are directed to where they need to go right after they come in. Before digitalization, I could find mistakes in a file and it would take me easily an hour to solve it. The communication between departments also has improved. You can now share and analyze the records easily. Sometimes I walk into the Medical Director's office and he tells me: 'Look, I am sitting here but I can see on my screen what is going on in the various departments and follow the patients, who has been admitted, who is still waiting."

Coleta Kimario is 47 years old and assistant Matron (a nurse) at Kibosho hospital. She works in this occupation since 1997.



Dr. Ignas Massawe is Assistant Medical officer. He has been a doctor since 1989 and currently works at Kibosho hospital, Kilimanyaro.

" Since three years our hospital is digitalized, which brought many improvements. Before that we used to have staff members constantly walking with patients through the hospital to carry their file. This was needed because as a patient you are not allowed to carry it yourself.

Until three years ago I had to go through paper patient files patient files first, before starting the treatment. It was complicated. When somebody has HIV, is a mother and had other complications...it means you need to go through many, many papers. And like that, things can get lost or misplaced. SafeCare did a lot of wonders to our hospital. It helped us to standardize and implement new guidelines. From radiology to the pharmacy to the maternal ward, everywhere we implemented improvements. The new guidelines for each and every department are digitalized - you can now find them in one place. It means less errors, better treatment and more motivated staff."

SafeCare and PharmAccess help and advise health facilities to work more efficiently by digitalizing records and procedures and by collecting and analyzing data.

Kibosho hospital went through a digital transformation that helped the staff not only to work more efficiently but also to monitor their progress in terms of quality.

"SafeCare helped us with new guidelines that are now all digitalized. It means fewer errors, better treatment and more motivated staff."

Further reflections

After four years of implementation, iCHF has proved to be a success. iCHF demonstrates that insurance can help protect the poor against catastrophic out-of-pocket healthcare costs. The reimbursement model also incentivizes healthcare providers to improve the quality of their services which in turn helps (potential) insurance enrollees trust the system. Better quality also leads to a higher willingness to pay for insurance which leads to a more financially sustainable healthcare system.

The model became a blueprint for developing the National iCHF (NiCHF), which is to be implemented in all 26 regions of Tanzania. The NiCHF began enrolling new members in May 2019. The new scheme adopted most features of iCHF. This brochure lists some of our learnings acquired during implementing iCHF in Manyara and Kilimanjaro, that can help accelerate the road to UHC in Tanzania and other sub-Saharan African countries. To conclude, some additional reflections can be made:

For a health scheme like iCHF to be successful on a national scale, a **continuing commitment from the central government is key.**
We have learned that iCHF be sustained without donor funding but does require engagement and full support from local leaders. Now that iCHF has been scaled a continuing commitment from the Tanzanian government is key to ensure the model reaches its full potential. Currently the Tanzanian government subsidizes 50% of the premium and the more successful the scheme, the more funding is required to subsidize the premiums, as well as to maintain human resources, equipment, medicines and the like.

Develop an attractive model for private facilities to join the scheme.
In Africa private health services account for approximately 50% of healthcare provision. Their services are used across all income groups. To utilize the role and capacity of the private sector, joining the scheme needs to be made attractive with a realistic reimbursement model, so providers can continue to improve their quality and increase their capacity.

Introduce targeted subsidies for the poorest of the poor.
Identifying the households that both can and cannot afford to contribute to their own health insurance costs is essential to designing sustainable schemes. Equipped with this data, the government and national health insurers can develop policies to ensure that subsidies and funds are channeled equitably to benefit the most vulnerable groups without crowding out contributions from those who can pay.

Integrated into a mobile registration tool, Pharmaccess deployed such a socioeconomic 'poverty mapping tool' to help assess socio-economic status of millions of households in Kenya. Such an exercise in Tanzania could help to make evidence-based decisions about developing targeted subsidies for low-income families.

Innovate to improve quality of health

From the experience of implementing health insurances, we also acquired lessons to use digitalization to innovate and further improve healthcare. For example, PharmAccess found that linking payment with quality of the care provided can ensure better results. We introduced a pilot for pregnant women in Kilimanjaro and Manyara called MomCare. In this first pilot, participating facilities already invest in better maternal healthcare services. Moreover, adherence to antenatal care visits has improved and women visit the facility earlier in their pregnancy.

PharmAccess is seeking new partnerships to scale and to establish new funding and cost-sharing collaborations.

At Dareda Hospital, the first group of mothers are tracked with MomCare. Those that are more vulnerable to complications, like teenagers and HIV patients, are automatically enrolled in the program.

"People in this town struggle financially and many expectant mothers skip check-ups. That is problematic as most have a poor diet and need iron supplements as well as de-worming medication. MomCare changes that. Thanks to better education and physical rewards such as pampers and Khangas [traditional fabrics], expectant mothers come in early and more women deliver at the hospital"

Dr Joseph Lorri (48), Medical Officer in charge at Dareda Hospital

Stakeholder glossary

Stakeholders	Roles and responsibilities	Activities
PharmAccess	Advisory role	Sharing best practices
	Technical Assistance	Design insurance package, costing and reimbursement model
	Capacity building	Upgrading facilities and improving quality in healthcare facilities (with SafeCare) Technical assistance for community sensitization, marketing and sales Advisory role on IT, data collection and analytics Capacity building at NHIF on admininistration and marketing
Tanzanian Government	Achieving national targets for increasing health insurance coverage	Provides 50% of the premium, through NHIF
	Owns NHIF	Covering fixed cost of public providers, like rent or staff salaries
NHIF	Implementation iCHF	Initiator of public-private partnership, as well as the partnership with PharmAccess
	Carries the medical insurance risk	Purchasing services of primary healthcare facilities Reimbursing public and private (faith-based) facilities per enrolled household, via their regional offices Administration and marketing for iCHF
The district councils	Owns iCHF	Audits, CHF evaluation & impact evaluation (health and economic outcomes)
	Supervising iCHF officers	Co-designing the scheme, together with NHIF Employment CHF coordinators (supervising all iCHF officers)
iCHF	Activities Community Health Volunteers	Sensitizing and enrolling people in groups Coordinating and overseeing activities of Community Health Volunteers Claim collection from providers
CHVs	Sensitization	Door-to-door sensitization
	Enrollment	Household enrollment
	Collecting premiums	Collecting premiums
Enrollees		Choosing two preferred facilities Paying 50% of the premium

"When we had the iCHF insurance, my kids even liked going to the hospital. I just gave them the insurance card and they were ready to leave. Before the insurance that was very different. They didn't want to go and made up all kinds of excuses because they knew it meant that I had to beg for money to get them treated.

In practice it meant we just didn't see any doctor. Perhaps we would eventually visit a dispensary when somebody in the community helped us out. In the meantime somebody might have given us some Panadol for some temporary relief.

Our financial situation is difficult. My husband passed away a year ago. He used to carry luggage for other people but had problems with his legs and therefore changed his job and became a shoe polisher. I tried and used local oils to massage his legs but it did not help, the pain stayed.

"Without the insurance my kids did not wanted to go to the hospital. They knew it meant that I had to beg for money."

Faina Muhammed (44) is a mother 3 children between 9 and 17 years old. She lives in Babati, Manyara. Here she sits next to her lastborn.

I also have a disability and my kids need to help out. After school they beg on the road, sometimes they come home with a bag of maize or so for us to eat. Last year somebody supported us to get the insurance and it really helped us. My son got Typhoid and Amoeba and got treated. If I don't have to pay for treatment it means I can use the money to buy something at the shop, like some tea or sugar.

Now our insurance is expired. My plan is save up and register again for the insurance cover, so when my children get sick they can get treated and get better. I really have that plan. But I first need to save for a matrass because sleeping is also a priority. After that, I want to set money aside for the insurance."

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Health Insurance Fund

MEDICAL CREDIT FUND AFRICA

SafeCare HEALTHCARE STANDARDS