ANALYSIS OF THE LEGAL FRAMEWORK ON HEALTH CARE FINANCING IN TANZANIA WITH SPECIAL FOCUS ON COMMUNITY HEALTH FUND

Ferdinand Marcel Temba[408*]

Abstract

This article is an analysis of health financing in Tanzania by reflecting the position of social health insurance through Community Health Fund (CHF). It links the concepts of national budget, pooling and allocation of health funds with health care financing. Various forms of health financing such as taxation, user fees and health insurance are discussed and a conclusion is made to the effect that financing of health sector by taxation has failed leading to introduction of other forms such as user fees and health insurance. As part of health insurance, the article categorically holds the view that adoption of CHF aimed at realising universal health coverage. The article reveals that there are many challenges facing CHF in its efforts to provide health insurance to local communities.

Key words*: Health Care, Health Care Financing, Community Health Fund*

1.0 Introduction

This article seeks to explore the position of health care financing by way of Community Health Fund (CHF) in Tanzania. It starts by providing a glimpse of health care system in Tanzania by setting its historical development and later links it with the requirements of international instruments on the accessibility of the right to health. Informed by history, the article posits that, Tanzania health care system dates back from the pre-colonial period in which, the societies practiced traditional health care practices. The study further understands the role played by several missionary organizations, who for the first time introduced formal health care services in the country.[409] The health care provision in the country was later developed by the colonialists i.e. Germans and British who colonised the country in different periods. Generally, colonial administration in East Africa established health care facilities in urban and raw material producing areas. Colonial health system aimed to first preserve health of the European Community, second, to keep the African and Asiatic labour force in good working condition, and third, to prevent the spread of tropical diseases.[410]

Immediately after independence the government concentrated on the establishment of public health sector by adopting development plans geared towards bringing health care services within easy walking distance of the entire population. However, the economic crisis which hit the country's economy in 1980s led to the establishment of private health sector. This was caused by the government's implementation of the IMF and World Bank austerity measures

408 * Lecturer, Faculty of Law, Mzumbe University.

409 J. S.Benson, 'The impact of privatization on access in Tanzania,' 52 *Social Science and Medicine* 2001, (1903–1915) at p.1904.

410 Kimalu, P.K., et al, *A Review of the Health Sector in Kenya*, Kenya Institute for Public Policy Research and Analysis(KIPPRA) Working Paper No. 11, 2004, at p. 23.

which forced it to play a minimal role in the provision of health care services. The government decided to transfer part of the cost to the users through various mechanisms including the introduction of user fees. Government provided limited resources in the health system and by 1991 limitation imposed on the provision of health services by the private sector were lifted. The structure also features traditional health sector which has been practiced in Tanzania for a long time even before independence.

This article reveals that, Tanzania as the State party to international and regional human rights instruments such as the ICESCR and ACHPR undertakes to provide health care services to its people. Thus, Tanzania is obliged to implement obligations arising from international instruments, in good faith, and to refrain from any act likely to defeat the aim of these instruments. The article, nonetheless, finds that the right to health, which is the subject of this study, is not explicitly stipulated in the 1977 Constitution of the United Republic of Tanzania (Constitution). The right to health can, however, be implied under Article 11 (1) in which the Government has a duty to ensure realization of the right to social welfare at times of sickness. Article 11 (1) provides that:

> "The state authority shall make appropriate provisions for the realisation of a person's right to work, to self education and social welfare at times of old age, sickness or disability and in other cases of incapacity, without prejudice to those rights, the state authority shall make provisions to ensure that every person earns his livelihood".

The article further takes note that, Article 11 falls in Fundamental Objectives and Directive Principles of State Policy (FODPSP) hence unenforceable before the court. Article 7 (2) of the Constitution categorically provides that the provisions which fall under FODPSP are not enforceable by any court; and bars any court from determining 'the question whether or not any action or omission by any person or any court, or any law or judgment complies with the provisions of this Part of this Chapter.'

That notwithstanding, by virtue of Article 9(f) of the Constitution, '… the state authority and all its agencies are obliged to direct their policies and programmes towards ensuring - that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights.' Thus social economic rights covered under the UDHR, such as the right to health is equally protected under the unjusticiable FODPSP.[411] Wambali arguably states that since the Universal Declaration is in fact the original source of social economic rights, the derogation thereof has to be questioned under the machinery provided anywhere in the Constitution, including that under the Bill of Rights.[412]

411 T. Ackson, 'Justiciability of Socio-Economic Rights in Tanzania,' 23 *African Journal of International and Comparative Law,* 3 (2015), pp. 359-382 at p.364.

412 Wambali, M. K. B., *Democracy and Human Rights in Tanzania Mainland: The Bill of Rights in the Context of Constitutional Developments and the History of Institutions of Governance*, Unpublished PhD Thesis Submitted to the School of Law, Faculty of Social Studies of the University of Warwick March, 1996 and Resubmitted in August, 1997 at pp. 174-176.

From the basis of this constitutional requirement on the right to health, this article sets to analyse the accessibility of the right to health, through health care financing by way of CHF to ascertain how the population access health care services under the set framework. The article starts by highlighting the understanding of health care financing. It later links health care financing and the national budget before addressing issues related to pooling and allocation of health funds and resources. As a matter of getting general understanding health financing, the article discusses different forms of health financing linking them with how they have been applied in Tanzania from independence. The article later centres its discussion on financing of health care services by CHF looking at its genesis of CHF in the country; its legal framework; the reforms undertaken by the government to make it more effective; and its challenges. Conclusion and recommendations form the last part of this article.

2.0 Understanding Health Care Financing

Health financing is a key component of the right to health and instrumental to full realization of the right to health.[413] Health financing in most parts of the world is constrained by inadequate coverage of health services and inadequate funding. Efforts have been taken at both international and national levels to establish policies and/or programmes intended at achieving universal health services in the health system. At the international level, to wit, Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) and General Comment 14 of the Economic Social and Cultural Rights Committee (the ESCR Committee) recognise the importance of health financing in the realisation of the right to health. Numerous other international and regional instruments, such as the Declaration of Alma-Ata adopted at the International Conference on Primary Health Care in 1978 and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, adopted by the African Union in 2001, recognise the centrality of health financing to the stability and effectiveness of health systems and meeting international development goals.[414] For instance, at the Alma-Ata Conference, universal coverage of health services received a substantial worldwide attention by the signatories of Alma-Ata Declaration who noted that Health for All would contribute both to a better quality of life and also to global peace and security.[415]

Since health financing is central in the realization of the right to health, States therefore have an obligation to ensure adequate, equitable and sustainable funding for health which ultimately will facilitate the realisation of the right to health.[416] Despite this international and national commitment on health system funding, there are still debates on how to adopt the best mix of health financing

413 United Nations General Assembly, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/67/302 at 4 para. 5.

414 *Ibid.*

415 World Health Organisation: World Health Report, *Health Systems Financing: The Path to Universal Coverage,* (Geneva: World Health Organisation, 2010), at ix.

416 United Nations General Assembly *op.cit fn 5* at 4 para 5.

which will achieve the protection by way of financing of all people, namely, those in the formal sector and those who are outside the formal employment sector. The World Health Report of 2010 insisted on extending affordable universal coverage and access of health services for all people on the basis of equity and solidarity.[417] It also urged that health financing systems should be developed in the manner which makes all people to have access to health care services and do not suffer financial hardship in paying for them.[418]

Universal health coverage aims at providing all people with access to prevention, promotion, and treatment as well as rehabilitation health services of sufficient quality to be effective. More importantly, universal health coverage will be successful if it ensures the use of health care services does not expose the user to financial hardship hence failing to realise the right to health. This article however, submits that in striving to achieve universal health coverage States are faced with three critical areas to address in health system financing, namely, raise sufficient money for health, remove financial barriers to access and reduce financial risks of illness and make better use of the available resources.[419] These challenges can only be overcome if the state's health system financing is designed in a way that considers the following issues as key in health financing, namely, that health financing should improve national budgets to health, develop equitable pooling schemes and fair allocation of health funds and resources in the country and adopt reforms geared towards improving forms of health financing.

2.1 The Nexus between Health Financing and the National Budgets

States have an obligation under the right to health to ensure that adequate funds are available for health and to prioritize financing for health in their budgets. That obligation is a necessary prerequisite to the realization of nearly every aspect of the right to health and requires States parties to the international instruments to make use of maximum available resources to ensure full realization of the right to health.[420] The enjoyment of the right to health entails, among others, sufficient funds and proper allocation of public funds in health financing particularly in the government budget.

The ESCR Committee of the ICESCR has rightly stated that insufficient expenditure or misallocation of public resources may result in the lack of enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized, and amount to a violation of the State's obligation to fulfil the right to health.[421] Budget prioritization requires States to set aside a significant portion of general government expenditures towards spending on health and prioritize health alongside other core funding commitments, such as spending on education, social security and defence.[422] The obligation to prioritize

417 World Health Organisation: World Health Report *op.cit fn 7* at ix.
418 *Ibid.*
419 *Ibid.*
420 UN Committee on Economic, Social and Cultural Rights: General Comment No. 14*, the Right to the Highest Attainable Standard of Health*, UN Doc.E/C.12/2000/4 at para. 33.
421 *Ibid*., para. 52.
422 United Nations General Assembly *op.cit fn 5 at* 4, para 7.

funding on health in State budgets is closely linked to the principle of progressive realization, which establishes a specific and continuing obligation for States to move as expeditiously and effectively as possible towards the full realization of the right to health of all persons, without discrimination and taking into account constraints due to the limits of available resources.[423]

In order to facilitate progressive realization of the right to health for all persons, States should make use of the maximum available funds and resources to realize the right to health, which requires successful raising of funds and allocating such funds to health sector through budget prioritization.[424] States unwilling to utilize the maximum of their available resources towards realization of the right to health are in violation of their obligations under the right.[425] There have been efforts both at international and national levels to prioritise realisation of the right to health. These efforts include but not limited to September 2000, when 189 heads of state adopted the Millennium Declaration designed to improve social and economic conditions in the world's poorest countries by 2015. Drawings on the Millennium Declaration, a set of eight goals were devised, as a way of tracking progress.[426] Three of these relate specifically to health and two more have health components.[427] In the year 2015, the Millennium Development Goals (MDGs) were superseded by the Sustainable Development Goals (SDGs). Unlike MDGs, the SDGs' expanded scope by increasing the number of goals and targets from 8 goals and 21 targets of MDGs to 17 goals and 169 targets of SDGs.[428] Thus, under SDGs the international community set one goal to improve the development for health of both poor and rich countries, i.e., to 'ensure healthy lives and promote well-being for all at all ages'. This goal is articulated in 9 targets.[429] In the African region, in order to achieve Millennium Development Goals, in April 2001, African States under the auspices of the then Organisation of African Unity (OAU) met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector.[430]

423 UN Committee on Economic, Social and Cultural Rights: General Comment No. 14 *op.cit fn 12* paras. 30 and 31, and UN Committee on Economic, Social and Cultural Rights: General Comment No. 3, The Nature of States Parties' Obligations (art 2, para 1 of the Covenant) (5th Session, 1990) [UN Doc E/1991/23] at para. 9.

424 United Nations General Assembly *op.cit fn 5 at* 5, para 8.

425 UN Committee on Economic, Social and Cultural Rights: General Comment No. 14 *op.cit fn 12* para. 47.

426 World Health Organisation, *The Abuja Declaration: Ten Years On*, Available on http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf (Accessed on 21 April, 2016).

427 *Ibid.*

428 E. A. Friedman and L. O. Gostin, 'The United Nations Sustainable Development Goals: Achieving the Vision of Global Health with Justice', 21 *The Georgetown Public Policy Review*1 (spring 2016), pp.1-25 at 6. The SDGs encompass three dimensions i.e. Social Dimension, Environmental Dimension and Economic Dimension. Social Dimension focuses on ending poverty; improving health and education; and achieving gender equality. Environmental Dimension focuses on actions related and/or connected to climate change and protecting terrestrial and marine environments. Lastly, there is Economic Dimension which focuses on economic growth, full employment, and resilient infrastructures. Several goals encompass multiple dimensions, including reducing equality and building more peaceful, just, and inclusive societies.

429 K. Buse and S. Hawkes, 'Health in the Sustainable Development Goals: Ready for a Paradigm Shift?' 11 *Globalization and Health* 13 (2015), pp.1-8 at 2-3.

430 Organisation of African Unity, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases Abuja Nigeria, 24-27 April 2001, OAU/SPS/ABUJA/3 para. 26.

Tanzania was part of the UN States which adopted the MDGs and later SDGs. Also, Tanzania participated fully in the Abuja Declaration which set the commitment that, at least 15% of the State's budget should be directed towards the improvement of the health sector. This article, however, reveals that in as far as health financing from national budget is concerned, the budget of the health sector has been increasing considerably in recent years but still insufficient to meet increasing challenges that the sector faces, including growing population which requires the improvement of health facilities from the primary health care to the national level.[431] The budget allocated by the government for health sector from the financial year 2012/2013 to 2016/2017 has not reached the 15% as agreed by the Abuja Declaration despite increase in amount of money. There has been a variation in budget allocations in health sector which on the face of it reveals that, may be, the government decided to ignore the targets set in 2001 by Abuja Declaration. For instance, the 2012/2013 national budget to health sector was 10%. However, the following two financial years, i.e., 2013/2014 and 2014/2015 the government reduced the percentage of national budget allocated to health sector by allocating below 8.5% of the total budget. The only year when health budget reached above 10% was in the 2015/2016. In that year there was an allocation of 11.3% of the national budget to health sector.

Responding to its failure to meet the 15% commitment set in the Abuja Declaration, the government contends that:

> "Although the national budget to the health sector estimates by the government has not reached 15% as agreed in the Abuja Declaration, the government through its efforts to improve the provision of health care services in the country directed a lot of finances in the health sector. Thus, the funds collected by the public health care facilities through user fees charges and the contributions of the funds obtained from the health insurance schemes all adds to the budget of the health sector despite the fact that the same were not estimated in the national health sector budget. Public health care facilities therefore use funds obtained from user fee charges and health insurance to purchase essential medicines and medical facilities as well as payment of health care professionals."[432]

This article, while finding the argument by the government attractive, asserts that it is a misleading one. The Abuja Declaration required State Parties to the OAU (now AU) to increase their budget to health sector to 15% of the national budget. The funds collected from user fees, health insurance and taxation form part of the national budget estimates to the health sector. The government could not plan and then set the national budget with utter disregard of these sources of funds which contribute in improving health care facilities and the purchase of essential medicines, medical facilities and equipment.

431 Legal and Human Rights Centre, *Tanzania Human Rights Report 2014,* Legal and Human Rights Centre, 2015, at 140.

432 Interview conducted on 27 October 2016 to the Coordinator of Regional Health Services/ Advocacy of the Ministry of Health, Community Development, Gender, the Elderly and the Children.

The fifth phase President of the United Republic of Tanzania has shown a political will and commitment to improve health care provision in the country. During his surprise visit to the Muhimbili National Hospital a few days after he was elected and sworn in as the president of Tanzania, he terminated the service of the head of the Hospital and dissolved its governing board after finding that the main scanning and diagnostic machines were not working, the hospital was in poor conditions and patients were sleeping on the floor.[433]

That notwithstanding, this article finds that, in its first national budget, the fifth phase government set the budget, which was far from 15% as agreed in Abuja Declaration, an act which raised concerns from people interviewed regarding the budget set for health sector in the financial year 2016/2017. While some of the interviewees agreed that there is a need to increase the budget to at least 15%, there are those who argued that increasing the budget would not be enough; but the government should work on increasing professionalism, accountability, and transparency in dealing with funds directed in the health sector. Moreover, the government should ensure that it deals with complex networks which are alleged to be benefiting from the shortage of essential medicines, medical facilities and equipment in the public health care facilities through corrupt practices. They state that having addressed these corrupt practices and set the effective corrupt free health system then the government should turn to consider and address the percentage of budget set to the health sector by increasing the national budget to health sector to meet the commitment agreed in the Abuja Declaration.[434]

On the other side, increasing the national budget in the health sector to the agreed 15% will meet the demand of health professionals, especially those working in peripheral areas by improving their allowance. This would make the right to health easily accessible by the people living in the peripheral areas. Also this increase will lead to improvements in healthcare services through measures such as purchase of medicines, prevention of communicable and non-communicable diseases, vaccination of children, and construction of health care facilities (dispensaries, health centres and districts hospitals) in areas with shortage of health care facilities.[435]

It has been argued that budgetary deficit of the health sector caused by the failure to meet the 15% agreed target has particularly reduced funds for essential medicines and medical supplies leading to the Government's failure to meet its obligations and commitments under international law.[436] It is submitted that the roles and efforts of the government to establish accountable, transparent and corruption-free health system must go hand in hand with efforts geared towards improving the increase of funds in the health sector to ease the burden of its population in accessing health services, especially those in rural areas.

433 F. Ng'wanakilala, 'Tanzania's New President Sacks Hospital Chief after Surprise Inspection,' in *Reuters*, Tuesday 10 November 2015, 6:16am EST, Available on http://www.reuters.com/article/us-tanzania-politics-idUSKCN0SZ17T20151110; (Accessed on 29th June 2016).

434 *Ibid.*

435 *Ibid.*

436 Legal and Human Rights Centre, *Tanzania Human Rights Report 2015*, Legal and Human Rights Centre, 2016, at 108-109.

2.2 Pooling and Allocation of Health Funds and Resources

Pooling of funds and/or resources can be defined as 'accumulation of prepaid health care revenues on behalf of a population.'[437] Pooling of funds facilitates the pooling of financial risk across the population or across a defined group and subgroup of the population.[438] The introduction of compulsory and voluntary health insurance schemes which are 'organized separately from the direct hierarchical control of the public sector budgetary and financial management system' is said to be the major step towards the establishment of well organised pooling and allocation schemes in health financing.[439] Indeed, health care costs are unpredictable as individuals do not know the time they will fall ill; the type of health care services they will require and their costs.[440] Despite the fact that it is difficult for an individual to predict his/her future health care needs and costs, the system or scheme can be adopted which can draw on epidemiological and actuarial data to estimate the probable future of health care needs of a group by way of risk pooling in which individuals contribute on a regular basis to a pooled fund, so that when they fall ill, the fund covers their health care need and costs.[441]

States have an obligation under the right to health to ensure equitable allocation of health facilities, goods and services for all persons without discrimination.[442] Further, States are required under international obligation to provide its people the right to access good quality health facilities, goods and services on a non-discriminatory basis. There should be no discrimination against vulnerable or marginalized groups nor should there be discrimination on the basis of ethnic, racial, religious and sexual minority groups, women, children and the poor.[443]

Inequitable allocation of health funds and resources may lead to indirect discrimination within the state's health system. Vulnerable or marginalized members of the community who often lack the social and political means to challenge the inequitable allocation of public resources are the victims of unequal allocation of health resources.[444] To avoid these challenges, states should allocate health funds and resources towards ensuring that good quality health facilities, goods and services are available and easily accessible for the poor and marginalised urban, rural and remote populations. There is a significant disparity in health between rural or remote populations and their urban counterparts in many parts of Tanzania. This inequality is caused by a number of factors, such as inadequate investment in health infrastructure in rural areas which has resulted in having a few dispensaries, health centres and qualified hospitals. In addition, no health funds and resources are directed to the rural

437 E. Mossialos and A. Dixon, 'Funding Health Care: An Introduction', in *Funding Health Care: Options for Europe* eds. E. Mossialos, *et al,* (Buckingham: Open University Press, 2002), pp. 1-30 at 6; J. Kutzin, 'A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements', 56 *Health Policy* 3 (2001), 171–204.

438 E. Mossialos and A. Dixon *op cit fn 29* at 6.

439 J. Kutzin, *et al,* 'Reforms in the Pooling of Funds', in *Implementing Health Financing Reform,* eds. J. Kutzin, *et al,* (Copenhagen: WHO Regional Office for Europe, 2010) 119 at 121.

440 D. McIntyre, *Learning from Experience: Health Care Financing in Low- and Middle-Income Countries*, (Geneva: Global Forum for Health Research, 2007), at 25.

441 *Ibid.*

442 UN Committee on Economic, Social and Cultural Rights: General Comment No. 14 *op.cit fn 12* para. 43 (a).

443 United Nations General Assembly *op.cit fn 5* at 6 para. 10.

444 UN Committee on Economic, Social and Cultural Rights: General Comment No. 14, *op.cit fn 12* para. 19.

population. This has further impacted on health workers available in rural areas as qualified health workers cannot be posted to areas without qualified dispensaries, health centres and hospitals.[445] Additionally, the fact that rural and remote populations often comprise vulnerable or marginalized groups, such as the poor, ethnic and indigenous populations, who tend to be poorer than those in urban areas, compounds the problem of accessibility of the right to health.[446] It is recommended that national efforts geared at ensuring that health funds and resources are equitably allocated among rural, remote and urban areas to meet the right to health approach which requires the accessibility of the right to health without discrimination to all population be encouraged.

The introduction of pooling of health funds collected through prepayment schemes is one of the ways used by States to achieve equitable allocation of funds and resources for health. Pooling of health funds and resources allows for the cross-subsidization of financial risks associated with health care among different groups across large populations and the transfer of health funds from the rich to the poor and the healthy to the sick.[447] Cross-subsidization of financial risks thus protects vulnerable or marginalized groups, such as the poor, from catastrophic health expenditures and ensures access to good quality health facilities, goods and services that may otherwise be financially inaccessible.[448]

Efforts have been taken to achieve equitable allocation of health care resources through pooling of health funds through prepayment schemes. As part of health sector reforms which aimed at improving the provision of health care services especially after the country and the world community were affected by economic crisis in 1970s and early 1980s, the country proposed prepayment schemes by way of social health insurance which contributes towards pooling of health funds. Prepayment health insurance schemes such as statutory health insurance, community-based health insurance and private health insurance currently characterise the health care system financing in Tanzania and have to a large extent addressed problems brought by inequality in health services in the country.

3.0 Forms of Health Financing in Tanzania

Tanzania finances its health system using different forms. Immediately after independence the country adopted the system of health financing which was based on free health care services. Following economic crisis in the global economy which affected both developed and developing countries there was a need to adopt different forms of health financing as part of health sector reforms. This led to the adoption of health reforms in Tanzania which introduced other forms of health financing such as user fees and health insurance. Health care financing in Tanzania takes various forms including taxation which characterised Tanzania health financing after independence, user fees and health insurance which resulted from health sector reforms of late 1980s and early 1990s.

445 P. G. M. Mujinja and T. M. Kida, *Implications of Health Sector Reforms in Tanzania: Policies, Indicators and Accessibility to Health Services,* Background Paper No. 8, Economic and Social Research Foundation (ESRF) Discussion Paper 62, 2014 at 16.

446 World Health Organization, *World Health Statistics 2008*, (Geneva: WHO, 2001) at 92-95.

447 United Nations General Assembly *op.cit fn 5* at 6 para. 11.

448 *Ibid.*

3.1 Taxation

Taxation is a common method through which States raise public funds for health by prepayments, as opposed to out-of-pocket payments at the point of service delivery.[449] In the WHO Report of 2010 it was said that several States have achieved universal (or near universal) access to health facilities, goods and services through the utilization of tax revenue to finance health.[450] Taxation allows States to pool funds and spread financial risks associated with health care across the entire population.[451] Financing accessibility to the right to health by way of taxation operates in a system through which the population contributes indirectly via taxes which is later directed by the government to finance health care services. The other forms such as health insurance require households to pay through contributions based on salaries or income to a particular scheme which in turn pays the costs of health services.

In Tanzania, after independence health system was financed by tax revenues. Health care services were provided free of copayment.[452] Insufficient government resources led to the abolition of free health services as a result of the economic crisis, which occurred in the late 1970s and early 1980s. This economic crisis was caused by tremendous increase in oil prices, rising interest rates of external debts and falling prices of commodities, leaving African countries, Tanzania inclusive unable to repay mounting foreign debts financed by international Financial Institutions such as World bank and the International Monetary Fund (IMF).[453] To remedy the problem, African countries and other developing countries signed an agreement with the World Bank and IMF to adopt Structural Adjustment Programmes (SAP), which recommended cutbacks in government expenditure on social services including spending in the health sector.[454] As part of its austerity measures, the World Bank through SAP introduced cost recovery programmes. These measures recommended for health sector reforms which ultimately led to the introduction of other forms of health financing complementing direct and indirect taxes health financing which was a common form of health financing in Tanzania. A fully fledged tax-funded health financing system became impossible to be maintained at the time on the ground that there was lack of a robust tax base and a low institutional capacity to effectively collect taxes.[455]

There are other problems which affected health financing by way of taxation. These problems include a typically small tax base and the growing of large informal sector which made it difficult to be covered by the small economy of

449 United Nations General Assembly *op.cit fn 5*at 7 para 15.
450 World Health Organisation: World Health Report *op.cit fn 7* at. 6.
451 United Nations General Assembly *op.cit fn 5*at 7 para 15.
452 J. Hennig, 'The Community Health Fund (CHF) in Tanzania: Problems and Solutions via Collaboration with Microfinance Institutions', in *Handbook of Micro Health Insurance in Africa* eds. H.J. Rosner, *et al,* (Zurich: LIT VERLAG GmbH & Co. KG Wien, 2012), at 148.
453 A. Colgan, *Hazardous to Health: The World Bank and IMF in Africa*, Africa Action Position Paper, April, 2002 Available on https://www.africa.upenn.edu/Urgent_Action/apic041802.html (Accessed on 5 April 2016).
454 World Bank, *World Development Report 1993: Investing in Health, (*Oxford: Oxford University Press, 1993) at 7.
455 G. Carrin, *et al,* 'Community-Based Health Insurance in Developing Countries: A study of Its Contribution to the Performance of Health Financing Systems', 10 *Tropical Medicine and International Health* 8 (August 2005), pp. 799–811 at 799.

the country which by the late of 1970s and whole of 1980s was hit by economic crisis. Donor dependence, weak income and asset taxes, and high dependence on international trade, which however, was a one way traffic as it was characterised by importation of goods and technology from developed countries with low or no exportation on the part of Tanzania, compounded the problems thus making it difficult to achieve the financing of health services by way of taxation.[456] Health financing by taxation which was practiced by Tanzania after independence became impossible to be achieved due to the above problems. Thus, as part of Health Sector Reform which took place in the early 1990s, the government introduced other forms of health financing such as user fees payment/out-of-pocket payments and health insurance which included statutory health insurance and private health insurance.

3.2 User Fees Payment

Another form of health financing in Tanzania which complemented financing of health care by way of taxation is user fees payment. Introduced as part of health sector reforms of 1990s, user fee charges or out-of-pocket payment of health expenditure occurs when a patient or his immediate custodian, friend or family member pays the cost of health care services before or after receiving treatment. Financing health care services through user fee charges was introduced at public health care facilities in 1993.[457] User fees cover payment for consultation fee, investigation of the disease which includes laboratory and image department (X-rays and ultra sound) services and treatment which includes surgery and medicines. The motive behind introduction of user fees payment was to generate additional revenues to fill the gap in financing health system in public health care and to improve access to quality health care.[458] The funds collected under user fees system are used to finance health services in the particular health facility such as dispensary, health centre and hospital. This in turn improves the accessibility of the right to health.

It is submitted that introduction of user fees or out of pocket payment of health services did not go smoothly without challenges. Immediately after it was introduced the system was condemned because it denied the poor from accessing the right to health. The poor could not afford payment of health care services.[459] It was reported that after introduction of user fees payment in Tanzania utilization of outpatient services declined by 53.4%.[460] It is argued in this article that there

456 Interview conducted at Morogoro on 23 March 2016 between the researcher and a Lecturer from Department of Economics of Faculty of Social Science of Mzumbe University.

457 S. Bonu, *et al,* 'Using Willingness to Pay To Investigate Regressiveness of User Fees in Health Facilities in Tanzania, 18 *Health Policy and Planning* 4 (2003) pp. 370-382 at 370; D. Mushi, *Financing Public Health Care: Insurance, User Fees or Taxes?* Welfare Comparisons in Tanzania, REPOA, Research Report 07.2, Dar es Salaam, 2007, at 5.

458 M. Stoermer, Strengthening of Claiming, Reimbursement and Use of Funds of the National Health Insurance Fund: Experience from the Pilot Region (Tanga) and Suggestion to Further Rollout, n.p. 2008 at p. 5.

459 B. Abel-Smith, and P. Rawal, 'Can the Poor Afford "Free" Health Services? A Case Study of Tanzania', 7 Health Policy Plan 4 (1992), at 329-341.

460 A. K. Hussein, and P. G. M. Mujinja 'Impact of User Charges on Government Health Facilities in Tanzania', 74 East African Medical Journal 12 (1997), at 751-757.

were other factors which lead to decline of outpatient services. Introduction of SP, an anti-malaria drug which made some patients avoid attending hospitals for fear of allergy of the drugs which replaced chloroquine was one of the factors which lead to decline of outpatient services.[461]

That aside, the WHO reports on the general impact of the introduction of user fee charges on health care financing noted that, every year about 100 million people from poor communities became vulnerable to falling into destitution as a result of unaffordable health care services.[462] To that end user fees has become an impediment for the poor population to access the right to health. Besides, people started questioning the quality of health care services provided by the public health care facilities as they were paying for the health costs. Thus, after the introduction of user fee charges the population showed dissatisfaction towards the quality and quantity of curative services provided by public health systems arguing that it was deteriorating. This was caused by lack of qualified health professionals especially in primary health care facilities, shortage of essential medicines and ineffective diagnostic machinery such as health laboratories and image rooms (x-rays and ultra sounds). These challenges, complemented with the inability of a substantial proportion of the population to pay for private health care services halted the efforts to have universal health care coverage even after the country had introduced health sector reforms. Admittedly, the aforementioned challenges stimulated debate as to whether the right to health remains a basic right to all people or the government should adopt other options to finance the accessibility of health care services.

One option that countries, Tanzania inclusive, could adopt was to set up a national health service which provides health care as a right of all (or groups of) citizens, and is financed and organized by the government.[463] This option is not possible in Tanzania as the government has not enacted a provision on the right to health since the Bill of rights was enshrined in the Constitution in 1984. The right to health has remained a Fundamental Objectives and Directive Principle of State Policy rather than a basic human right that is capable of being enforced before the court.

The other option is statutory health insurance, mainly financed by (employers' and employees') contributions, supervised and often co-financed by the government, and managed by independent public or private institutions.[464] This option has received support in Tanzania and as part of health sector reforms in early 1990s the government resolved to introduce health insurance as a means of health financing of the health system so as to improve the declining health financing system by way of taxation.

461 G. Mubyazi, *et al*, *User Charges in Public Health Facilities in Tanzania: Effect on Revenues, Quality of Services and People's Health-Seeking Behaviour for Malaria Illnesses in Korogwe District*, Health Services Management Research, Health Services Management Centre 2005.

462 W. Van Ginneken, *Extending Social Security Coverage: Concepts, Approaches and Knowledge Gaps*, Technical Seminar on the Extension of Social Security Coverage, Geneva, 16 October 2008 at 11.

463 W. Van Ginneken, 'Extending Social Security: Policies for Developing Countries', 142 *International Labour Review* 3 (2003), pp. 277-294 at 284-285.

464 *Ibid* at 285.

3.3 Financing Health System through Health Insurance

Funding access to health care through social health insurance has its origins from Germany in the nineteenth century.[465] Sickness funds organized by the workers for mutual support often attracted support from employers, who saw benefits in their workers having access to better health care.[466] Thus, a model arose in which health insurance was provided for some or all the workers in a firm, with much of the control remaining with the workers but with some management and financial input from employers.[467] The early sickness funds varied in their structures and governance but were mainly based on mutual support (in which contributions were based on income) and provided access to care based on need. Germany became the oldest country to advocate for under social insurance system. Under Chancellor Bismarck, the sickness funds were formalized into a broader and more consistent system of health insurance through social protection legislation such as the Social Insurance Bill of 1883 and Accident Insurance Bill of 1884.[468] Thus, the Bismarckian approach on social security favoured social insurance through a mandatory health insurance scheme in which employers and workers were obliged to contribute to cover the cost of health care services of the members and their beneficiaries. The scheme required members to pay a premium to a social security (in this case social insurance scheme) or another (often non-profit) agency in exchange for an agreed entitlement to a defined package.[469]

Social health insurance has no uniformly valid definition, but two characteristics are crucial. Insured people pay a regular, usually wage-based contribution. Independent quasi-public bodies usually called health insurance schemes or funds, act as the major managing bodies of the system and as payers for health care.[470] Health insurance allows payments for services to be spread across time and between those insured and implies cross-subsidization between the healthy and the sick.[471]

Social health insurance can ensure that people are treated on time and with quality services.[472] It also provides a secure and cost-effective protection against the financial consequences of medical treatment and it greatly increases the predictability of household expenditure.[473] All these advantages have a direct and positive impact on the income-earning capacity of the household. As part of health system financing in Tanzania, health insurance is characterised by both statutory health insurance, private health insurance and community-based health insurance. The following section of this paper looks at the Community Health Fund established under the Community Health Fund Act, Cap. 400 [R.E. 2002].

465 C. Normand and R. Busse 'Social Health Insurance Financing', in *Funding Health Care*: *Options for Europe* eds. E. Mossialos, *et al,* (Buckingham: Open University Press, 2002) at 59.
466 *Ibid.*
467 *Ibid.*
468 *Ibid.*
469 W. Van Ginneken, *op. cit fn 54* at 11.
470 C. Normand and R. Busse *op cit fn 57* at 60.
471 W. Van Ginneken *op cit fn 54* at 11.
472 *Ibid.*
473 *Ibid.*

4.0 Health Care Financing through Community Health Fund

Community Health Fund (CHF) is a general term for voluntary health insurance schemes organized at community level. These schemes are alternatively known as mutual health organizations, medical aid societies, medical aid schemes or micro-insurance schemes.[474] The CHF is a form of voluntary health insurance, a pre-payment arrangement for health services in the event of illness.[475] Community Health Fund intends to respond to the goal of fairness in health care financing, whereby beneficiaries are asked to pay according to their means while guaranteeing them the right to health services according to need.[476]

Adoption of CHF is based on the thrust that health care expenditures put serious financial burden on low-income households in Tanzania. For the vast majority of people, formal risk sharing arrangements are barely accessible while health insurance products are usually not available.[477] Low profit has hindered the conventional health insurance companies to base their operations in urban areas with utter neglect of rural areas. This has led to micro insurance schemes such as CHF to be established. It aims to be flexible in that contributors are encouraged to pay at the time of harvest, with an option of paying in instalments for those with more regular incomes.[478]

In Tanzania CHF was for the first time introduced in Igunga District in December 1995 covering only 26 wards. From August 1996 the whole of Igunga District had adopted CHF model of health insurance.[479] The scheme was introduced as a possible mechanism granting access to the right to health to the excluded sectors in both rural and urban areas in the country.[480] Later in 2001, CHF scheme was incorporated into Community Health Fund Act, Cap. 400 [R.E. 2002] (the CHF Act). The scheme was first established in 10 councils listed in the first schedule to the Act as a pilot study. By the end of January 2008 the government reported that 92 local government councils had formulated regulations on the operation of CHF in their local government authorities.[481] Due to this achievement the government decided to design and promote extension of CHF to all councils and regions in the country.[482] In the municipal/town councils CHF operates as *Tiba kwa Kadi (TIKA)* while in the district councils it remains CHF. CHF members were required to pay a flat rate of Tshs. 5000 per annum per household for all services.[483]

---

474 B. Criel, *et al,* 'Community Health Insurance (CHI) in Sub-Saharan Africa: Researching the Context', 9 *Tropical Medicine and International Health* 10 (October 2004), at 1041.

475 G. K. Munishi, 'Intervening to Address Constraints through Health Sector Reforms in Tanzania: Some Gains and the Unfinished Business', 15 *Journal of International Development* 1 (2003), at 119.

476 G. Carrin *op. cit fn 47* at p. 799.

477 L. M. Oudraogo, *et al,* 'Introduction: Social Protection in Health through Micro Health Insurance in sub-Saharan Africa', in *Handbook of Micro Health Insurance in Africa* eds. H. J. Rosner, *et al,* (Zurich: LIT VERLAG GmbH & Co. KG Wien, 2012) at 3.

478 G. K. Munishi *op. cit fn 67* at 119.

479 G. Munishi, *Constraints to Scaling up Health Interventions: Tanzania,* Commission on Macroeconomics and Health, Paper No. WG5: 16, June 2001, at 17; Available *on* http://library.cphs.chula.ac.th/Ebooks/HealthCareFinancing/WorkingPaper_WG5/WG5_16.pdf (Accessed on 5th July 2017).

480 G. Mtei, *et al, An Assessment of the Health Financing System in Tanzania: Implications for Equity and Social Health Insurance: Report on Shield Work Package 1,* Ifakara Health Research and Development Centre - Ministry of Health and Social Welfare Tanzania - London School of Hygiene and Tropical Medicine, May 2007, at 32-33.

481 United Republic of Tanzania, *the Summary of the Speech by the Minister of Health and Social Welfare Honourable David Homeli Mwakyusa on the estimate of the budget for the Ministry of Health and Social Welfare in the* Financial *Year 2008/09* at 4.

482 J. Hennig *op. cit fn 44* at 148.

483 G. Munishi *op. cit fn 71* at 17.

4.1 Legal framework of the early CHF under the CHF Act

Initially a district Council after consultation with members of that community decided on the level of annual contributions to be paid by each household as members' contributions to CHF. Membership contributions differ depending on whether the contribution is for outpatient or, inpatient health care services.[484] Meanwhile, the level of annual contributions could be varied from time to time by the Council after consultations with the members of that community.[485] Also, the Government may through the respective Council, contribute to the Fund a specified amount of money.[486] The law further required members of the household to be entitled to medical services of their choice prepaid under CHF arrangements at a pre-selected health care facility within the respective district.[487]

Before CHF reforms, the law provided for no limit on the number of children who could be insured under the scheme. This made most of the families in rural areas with more than four children to be covered by health insurance.[488] Unlike NHIF, which is also a statutory insurance and compulsory, CHF is a voluntary health insurance.[489] The local government is required to determine membership contribution after considering the economic powers of the community making it easier for the households to pay.

4.2 Reforms in the Management of Community Health Fund

Community Health Fund was initially administered by the then Ministry of Health and Social Welfare (MOHSW) and Prime Minister's Office Ministry of Regional Administration and Local Government (PMO RALG) through local government councils. With time the government adopted reforms in the administration and operation of CHF. One of the notable reforms was adopted in July 2009 through a Cabinet decision Number 36/2007. Through this decision the Government entrusted and deputized its function and powers in the operation of the CHF to the National Health Insurance Fund (NHIF).[490] This Cabinet decision was preceded by a Memorandum of Understanding (MOU) which was signed by NHIF, the ministry of health, and the President's Office, Regional Administration and Local Government (PO-RALG) giving management responsibility of CHF to NHIF for a 3 year period.[491] The Government' decision was aimed at improving CHF operations and ensuring that it covers the majority of informal workers in Tanzanians thus increasing national health insurance coverage.[492] Generally, the government aimed at addressing the limitations of CHF management, to synchronize the NHIF and CHF and improve access to services by providing support to Primary Health Care Service Development Programme (PHCSDP).

---

484 The CHF Act, Section 8 (1).
485 *Ibid.*, Section 8(2).
486 *Ibid.*, Section 8(3).
487 *Ibid.*, Section 9.
488 T. Ackson, "Social Security Law and Policy Reform in Tanzania with Reflections to South Africa Experience," Unpublished PhD Thesis, University of Cape Town 2007, at 123.
489 CHF Act, Section 4.
490 See National Health Insurance Fund "Profile" Available on http://www.nhif.or.tz/index.php/about-us/profile (Accessed on 12 April 2016).
491 J. Borghi, *et al*, 'Promoting Universal Financial Protection: A Case Study of New Management of Community Health Insurance In Tanzania', 11 *Health Research Policy and Systems* 21 (2013), at 4.
492 National Health Insurance Fund *op. cit fn 82.*

This was achieved through improving access to Primary Health Care (PHC) since CHF was initially introduced to cover health care services costs at the PHC levels.[493]

Apart from the reform which found the delegation of CHF administration to NHIF, the government in collaboration with the Health Promotion and System Strengthening (HPSS) has adopted further reforms of CHF in three regions of Dodoma, Morogoro and Shinyanga leading to the so-called Improved Community Health Funds. Under the reform which is sponsored by the Swiss Agency for Development and Cooperation, CHF members are entitled to receive health care services in any of the health care facilities within the three regions including Regional Referral Hospitals.[494] In addition students and groups of entrepreneurs may join CHF. The hierarchical structure of CHF has also been improved in which the reform has introduced a CHF Manager based in the Council and who liaises with NHIF especially in collection of matching fund from the government. Also there is CHF coordinator, CHF Information Technology personnel and CHF accounting Officer who are based at the District level. They entrusted with functions of facilitating easy operation of the scheme as the reform depends much on network communication between CHF district officers and other cadres in the wards and the village levels. At the Ward level there is a CHF officer while in the village/street level there is a CHF enrolment officer.[495]

It follows that under the reformed CHF, the operation of the scheme starts from the village/street level where there is the enrolment officer with the functions of sensitising community members to join the scheme. The CHF enrolment officer is paid by the CHF officer 10% of the fund obtained from the number of members he has enrolled. The CHF Officer, who is the employee of the local government and in most cases, is the Ward Welfare Officer takes the funds received from enrolment officer to the CHF accounting officer who deposits the funds. Therefore, under this reform which is operating in Dodoma, Morogoro and Shinyanga health care facility or the council leaders such as councillors are not involved in enrolment of CHF members or collection of CHF funds. The study further reveals that, the health care facility under the improved CHF has the role of providing health care services to the CHF members and claim reimbursement of their costs through a phone connected in the Information Technology- system which uses Insurance Management Information System (IMIS).[496] There is no CHF account and register available in the health care facilities under the improved CHF operation in Morogoro, Dodoma and Shinyanga.

After introduction of the two reforms particularly placing management of CHF under NHIF, CHF has been effectively embedded within the NHIF organisational structure, bringing more intensive and qualified supervision closer to the district.[497]

493 Ifakara Health Institute, *Lessons from Community Health Fund Reforms: A review of the Past Three Years,* Spotlight Issue 15 December, 2012, Available on http://ihi.eprints.org/1800/1/Sportlight_issue_-15_final.pdf (Accessed on 18th April 2016).

494 Interview with the Morogoro District Council CHF Coordinator conducted on 21 June 2016.

495 *Ibid.*

496 *Ibid.*

497 J. Borghi *et al*, *op. cit fn 83* at 10.

Also, under the new arrangements NHIF performs the role of collecting data and information of every health facility such as dispensary or health centre which are later used to justify the matching fund (*tele kwa tele*) given to the health facility.[498] The reform has led to a tremendous increase of national membership of CHF. As of 31 June, 2015 the scheme had a total of 1,112,874 households that translated to 6,677,244 beneficiaries.[499] Statistically, CHF has been rolled over to 144 out of 168 councils operating under Local Government Authority.[500]

It is further submitted that, the improved supervision and reporting systems along with the national CHF information campaign introduced by NHIF has played a critical part in the increase of households covered by CHF nationwide.[501] Under the new arrangement every local government authority has a CHF coordinator who links it with the NHIF office.[502] Additionally, every dispensary, health centre or District hospital has a coordinator assigned for CHF.[503] A register is kept for membership containing information and data of CHF members for every month. These monthly data are later communicated to the NHIF headquarter office quarterly.[504] Meanwhile, the study has revealed that NHIF now offers some degree of quality assurance to CHF members. It also supports districts to contract with referral facilities and this support, in turn, promises to offer a wider range of services thus making the scheme more attractive to prospective members.[505]

Before the reform, in most local government authorities CHF members were required to get health services in the dispensary, health centre or district hospital where they were registered for the first time. This move was justified by the fact that every health facility such as a dispensary or health centre has accounts for CHF membership and it is from the funds of that account the facility orders medicines and other medical facilities. On top of that the matching fund which under the current arrangement is collected by NHIF from the central government to top members' contribution to the CHF is taken to the facility where the member is registered and has contributed.[506] However, the reform has opened the door for CHF or TIKA members to receive health services within the council.[507]

5.0 Challenges of CHF in Tanzania

In Tanzania one of the most pressing issues for CHF is the low enrolment rate and early drop outs in membership.[508] One of the factors which leading to low enrolment of the households in CHF is that many people prefer, and are used to, financing their health care services through user fees payment. It has been

498 Interview conducted in Morogoro NHIF office between the researcher and NHIF Quality Assurance Officer Morogoro and NHIF Quality Assurance Officer Njombe on 4 May 2016.
499 National Health Insurance Fund *op. cit fn 82*
500 *Ibid.*
501 J. Borghi *et al op. cit fn 83* at 10.
502 Interview with the Morogoro District Council CHF Coordinator conducted on 21 June 2016.
503 *Ibid*
504 *Ibid.*
505 J. Borghi *et al op. cit fn 83* at 10.
506 Interview conducted in Morogoro NHIF office between the researcher and NHIF Quality Assurance Officer Morogoro and NHIF Quality Assurance Officer Njombe on 4 May 2016.
507 Interview conducted at Mzumbe University between the researcher and the CHF Coordinator of Moshi Municipal Council on 11 May 2016.
508 G. Mtei *et al op. cit fn 72*at 33.

shown that in most local government authorities CHF cost per year is set at 10,000/= shillings covering the contributor, the spouse and six other members of the household. That aside, with user fees at 1000 Tanzania shillings per visit at a Dispensary, 2000 shillings at a health centre and 10,000 shillings at the hospital many community members are more willing to pay the user fee rather than pay the higher CHF premium because if, for instance, the health facility does not have medicines they may visit another health facility.[509]

The inability to pay membership contributions is another factor which contributes to poor enrolment. Some Local Government Councils have set high CHF membership fees which have also contributed to poor enrolment.[510] When Act No 1 of 2001 was enacted, the issue of inability to contribute by members due to their poverty was taken into account and Ward Health Committee was vested with the power to issue exemptions for payment of the Community Health Fund annual contribution to any person after receiving recommendations from the Village Council.[511] When an exemption order was issued by the council, the exempting authority had to seek alternative means of compensating the Fund.[512] Despite the fact that the exemption policy was made by the government and was operationalized by an Act of Parliament to the effect that poor people could be exempted from the annual contribution of membership of CHF, District and ward managers indicated a negative attitude towards exemption.[513]

Another challenge is related to information and awareness the members of the community have on the operation of CHF. The study has revealed that CHF was introduced without sufficient awareness campaign to sensitize the population.[514] A large number of Tanzanians are not familiar with the concept of risk pooling, and they are consequently confused when they do not receive refunds for unused health care services.[515] Out of 5 people interviewed by the researcher in Mvomero District in Morogoro only 2 knew the existence of CHF and its operations while the remaining 3 were not aware of the whole concept of health insurance let alone CHF. Despite the fact that the interview was carried out with a few interviewees in Mvomero this research submits that lack of sufficient information of the existence and operation of CHF is the problem and this affects enrolment of membership of CHF.

CHF was introduced by the government and it operates in public health facilities. The same problems which the government health system faces, such as low quality of health care, are also faced by CHF. The study has identified four

509 Interview conducted in Morogoro NHIF office between the researcher and NHIF Quality Assurance Officer Morogoro and NHIF Quality Assurance Officer Njombe on 4 May 2016.

510 G. Mtei *et al op. cit fn 72* at 33.

511 The CHF Act, Section 10 (1).

512 *Ibid.*, Section 10 (2).

513 P. Kamuzora, and L. Gilson, 'Factors Influencing Implementation of the Community Health Fund in Tanzania', 22 *Health Policy and Planning* (2007) 95–102 at 98.

514 G. M. Mubyazi, *et al*, 'Community Views on Health Sector Reform and their Participation in Health Priority Setting: Case of Lushoto and Muheza Districts, Tanzania,' 29 *Journal of Public Health Advance Access* 2 (April, 2007), pp 1-10 at 5.

515 P. Shaw, 'Tanzania Community Health Fund, Prepayment as an Alternative to User Fees, Forthcoming, World Bank Institute, Flagship Online Journal in Health Sector Reforms and Sustainable Financing, 2002, at p.5; A. Kiwara, 'Group Premiums in Micro Health Insurance Experience from Tanzania', 4 *East Africa Journal of Public Health* 1 (2007) 28-32 at 31.

main problems linked with the quality of services, namely, shortage of essential medicines and medical facilities; inappropriate diagnosis due to lack of diagnostic equipment, particularly laboratory equipment; staff-related problems especially shortage of health professionals and limited range of services provided and lack of possibility to use health facilities of members' choice, coupled with referral problems.[516] With these problems those who registered initially into the scheme dropped out as the quality of health services provided under the scheme could not meet their expectations.[517] Since CHF operates at the local government level whose effectiveness depends on the financial and other resources' capacity of the particular local government.[518]

Insurance requires a high amount of trust in the company providing the insurance, as clients pay in advance for a possible future benefit.[519] This is not the case with CHF as there is a lack of trust in CHF managers which has led to its ineffectiveness.[520] It has been observed that ward leaderships are accused of corruption, lack of transparency and sensitisation of the public by giving information about the general operations of CHF at the district level in general.[521] On the same footing the CHF leaders at the district level are accused to have failed to supervise the ward-level CHF managers and health facility staff.[522] There is insufficient sensitisation/ education on the community on the importance of community insurance funds. It was further revealed that the fact that government-initiated CHF might have negatively affect trust. The research conducted has shown that people have lost trust in the community-based initiatives. Collapse of cooperative societies, mismanagement of populations contributions to village dispensaries and schools were cited as the reasons people lost trust in government initiatives.[523] Even after the introduction of the improved CHF in 2015, there is lack of trust on the part of CHF enrolment officers who fail to take the funds collected from the community members at the village/street to the CHF officers.[524]

The average and wealthy groups generally argued that many people in the community did not see the reason why they should pay before they fell sick often linking this to little knowledge about the benefits of the CHF.[525] To take care of this problem the government is supposed to give public education on the need of the society to join the CHF.

Lack of capacity and experience in community mobilisation and financial management are among the factors that are cited as hindering the implementation

516 P. Kamuzora and L. Gilson *op. cit fn 105* at 99.
517 Interview conducted at Mzumbe University between the researcher and the CHF Coordinator of Moshi Municipal Council on 11 May 2016.
518 Interview conducted in Morogoro NHIF office between the researcher and NHIF Quality Assurance Officer Morogoro and NHIF Quality Assurance Officer Njombe on 4 May 2016.
519 W. Brown and C. F. Churchill, Insurance Provision in Low-Income Communities Part II: Initial Lessons from Micro-Insurance Experiments for the Poor, (Bethesda: Microenterprise Best Practices Project – USAID, 2000) at 91.
520 P. Kamuzora and L. Gilson *op. cit fn 105* at p. 99.
521 *Ibid.*
522 *Ibid.*
523 J. Hennig *op. cit fn 44* at 154.
524 Interview with the Morogoro District Council CHF Coordinator conducted on 21 June 2016.
525 P. Kamuzora and L. Gilson *op. cit fn 105* at 100.

of CHF in councils.[526] Districts are not conversant with CHF management rules and procedures and it was reported that there was mismanagement of CHF funds and in some other instances it was found that CHF funds were not utilised at the district level.[527]

According to the CHF Act, the the Council Health Service Board (Board) is vested function of the management and administration of CHF at the District level. The Board is duty bound to keep proper accounts and other records in relation to the operation of the scheme and has to prepare in respect of each financial year of the Council statement of accounts as the Council may direct.[528] The CHF Act further requires the accounts of the Fund to be audited by competent and qualified auditors in accordance with regulations governing auditing of Council's accounts.[529] Also the Board has the duty after the end of each financial year of the Council to prepare as soon as practicable a full report on the performance of its functions during that financial year. One copy each of such report together with a copy of the audited accounts has to be submitted to the Council and the Ministry responsible for health.[530] Despite these requirements of the law, in 2003 an assessment by the Ministry of Health showed that not all councils conducted regular audits or reported to community members.[531]

There is lack of motivation and sensitisation of households to join CHF. The research has found that village chairpersons and ward councillors may motivate in either negative or positive way depending on their understanding of the scheme. For instance, districts of Morogoro, Ulanga and Kilombero were found to be amongst the areas with a large degree of understanding of the importance of health financing through CHF.[532] Poor motivation and sensitisation is said to be caused by lack of capacity and experience in community mobilisation. Also, the study has found that where the ward and village leaders were totally ignored from involvement in financial management of CHF they developed a negative attitude towards the operation of the CHF.[533] It has been reported that where there is no involvement of village and ward political and executive leaders CHF enrolment officers and CHF officers receive low cooperation from these leaders.[534]

Efforts to solve the challenge of lack of capacity and experience in community mobilisation and financial management at the council level have been made by merging CHF and NHIF. Merging of the two insurance schemes which was aimed at reducing administrative costs has not realized the aim as summarized below:

> [D]ue to the limited national level management systems prior to the reform, there is no evidence that the reform has in fact so far reduced administrative costs. Rather, the reform has, for the time

526 G. Mtei *et al op. cit fn 72* at 35.
527 *Ibid.*
528 The CHF Act, Section 25 (1).
529 *Ibid.*, Section 25 (2).
530 *Ibid.*, Section 25 (3).
531 G. Mtei *et al op. cit fn 72* at 36.
532 Interview conducted in Morogoro NHIF office between the researcher and NHIF Quality Assurance Officer Morogoro and NHIF Quality Assurance Officer Njombe on 4 May 2016.
533 *Ibid.*
534 Interview with the Morogoro District Council CHF Coordinator conducted on 21 June 2016.

> being, resulted in the introduction of another level of administration (regional/zonal and national level), a larger number of national level management staff, and more intensive reporting requirements at district level. NHIF are also encouraging districts to employ full time CHF coordinators.[535]

Therefore, despite the positive effects of merging the two insurance schemes i.e. CHF and NHIF it is revealed that administrative costs have also increased.

CHF operates at the local government level with the aim to realise the accessibility of the right to health especially PHC. The requirement of every health facility to have an account has not resolved the problem of centralising funds as there is still a very tight control from the central government on the operation of such accounts.

According to this study there is lack of cross subsidisation between the two funds, i.e., NHIF and CHF which has posed a big problem. There is lack of solidarity in the health care insurance schemes leading to failure to realize comprehensive social security which entails the presence of solidarity in the society. Solidarity describes the presence of systems of mutual dependencies, responsibilities and entitlements within a defined group of people or a community.[536] Solidarity is one of the important aspects of social security, and even more for the adequacy of social security benefits.[537] The practice of solidarity can take place following different principles like reciprocity, mutual aid and redistribution.[538] Solidarity can be defined as a complex system for the transfer of goods and services that serves people's lives and tries to improve their general situation and standard of life.[539] Lack of solidarity has been witnessed as between the operation of NHIF and CHF.

The benefit packages for members of CHF are limited by the ability of the members to contribute. Where the income of the members is just enough to provide for subsistence, making it difficult to meet their immediate needs one cannot dream of paying contributions to social insurance schemes for their future protection. For the population who are engaged in informal sector such as small agricultural and livestock income activities, contribution to CHF is more limited compared with the formally employed population who are members of NHIF. That is the position even though NHIF recognises cross subsidisation and solidarity among its members.[540] Thus the benefit package of CHF with members who have irregular and low income is smaller than the package provided by NHIF for public servants. It is submitted that benefits that can be provided by health funds are restricted by the limited financial resources of its members. Moreover, the size and quality of the benefit package depend on the pre-paid amounts of contribution; there is

535 J. Borghi *et al op. cit fn 83* at 11.

536 L. Steinwachs, *Extending Health Protection in Tanzania, Networking between Health Financing Mechanisms, ESS Extension of Social Security* ESS Paper No 7, Social Security Policy and Development Branch, International Labour Office, Geneva 2002 at 5.

537 T. Ackson *op. cit fn 80* at 177.

538 Steinwachs *op. cit fn 128* at 5.

539 *Ibid.*

540 *Ibid.*

no form of redistribution yet among these two schemes hence lack of solidarity.[541] And, indeed, there is no element yet of cross subsidization.

Other challenges include the problem of network system for the phones for those using Insurance Management Information system (IMIS) under the improved CHF. There is also the problem of poor transport system from the villages to the wards where CHF enrolment officers stay. After collecting the funds from the community members poor transport system makes it difficult for the officers to send the funds to the district offices and thus tempting them to use the funds. . Where there is loss of phones by health care facility heads proper record of members of CHF attended by a particular health care facility cannot be maintained.[542]

6.0 Conclusion

This study has found that the government has adopted various forms in financing health system, CHF inclusive. It has shown that immediately after independence, the government adopted a system of health financing through taxation which nonetheless could not be sustained due to the economic crisis which hit the world economy in late 1970s and 1980s. This economic crisis forced the government to embark on health sector reforms which introduced other forms of health care financing.

As part of health care financing reforms, the State adopted user fees/out of pocket payment in which individuals who initially received free health services financed by taxation had to pay for the cost of health care services. The assessment of the effectiveness of user fees a few years after its inception revealed that many people were without the means to access the right to health as they could not afford health care expenses through user fees that were charged.

Apart from the introduction of user fees as part of health sector reform in 1993 the government introduced health insurance to finance its health system. The access to health care through health insurance in Tanzania is a recent development and efforts by the government to achieve it are yet to be appreciated due to former system of free health care services. One of the insurance schemes for accessing health care has been the community health fund (CHF).

CHF was primarily introduced to cover health insurance for people in the informal sector. The scheme which was introduced in 1996, has not performed well since it has not covered all districts of the country; and where the fund was introduced it has been attended by many problems ranging from lack of information by members, failure to pay membership fees and despite the fact that the law gives the council the power to give exemption to indigent families the district and ward managers were reported to be against the exemption. The ministry responsible for health may wish to consider addressing these challenges. The study has further found that CHF members cannot benefit from health services at the referral level where costs are higher; it is at this level that services are needed most. Where a

541 *Ibid.*

542 Interview with the Morogoro District Council CHF Coordinator conducted on 21 June 2016.

member has contributed to the CHF and registered at the dispensary then such member cannot receive health services in the health centre or a district hospital. With most PHC there is the problem of funds to finance health services and hence poor quality of services at lower levels (dispensaries and health centres). Failure to access health care services at referral levels discourages community members who can afford to contribute to the fund. Community members choose to access services from other institutions rather than PHC. The Government may wish to reconsider its CHF scheme in order to make community members appreciate and make use of it. Some of the CHF challenges have been addressed by the reformed CHF which resulted in the administration and management CHF by NHIF. Under the reformed CHF, management of the fund has been put under NHIF making CHF to be imbedded in the NHIF structure. Members can now receive health services in any health facility in the council he/she has contributed and registered. This achievement however is not complete as members cannot receive referral level beyond district hospital. The reformed CHF must cover referral within the councils and where possible in the future CHF should consider introducing referral system for its members to at least Regional referral Hospitals.

After the above analysis, the study has the following recommendations. First, the government through CHF and local government should provide public education on the need of the members of the society to join CHF. This must go hand in hand with awareness raising seminars to be given to the members of the society on the existence of CHF and its importance in achieving universal health coverage.

Secondly, there should be efforts for capacity building for the officials of the CHF, those attached to the NHIF and workers working under the hierarchy of the CHF coordinator in the LGAs. Capacity building should involve proper management of the funds collected from the general public in the peripheral areas, keeping of records of the number of people enrolled by the CHF enrolment officers in the villages and streets and giving Identity Cards to the enrolled members on time to enable them benefit from their CHF insurance.

Thirdly, LGAs should set affordable cost which will enable many members of the society to be enrolled to the CHF. Setting high cost for the members of the society to join CHF undermines the intention of the government to introduce health insurance which was meant to support its efforts in health care financing after the failure of other forms of health financing.

Fourthly, the government should address general challenges facing the health sector. For a sustainable health care financing by CHF, the government should consider addressing issues related to, shortage of essential medicines and medical facilities; inappropriate diagnosis due to lack of diagnostic equipment, particularly laboratory equipment; staff-related problems especially shortage of health professionals; limited range of services provided and lack of possibility to use health facilities of members' choice, coupled with referral problems.

Fifthly, CHF should improve its benefits. Members of CHF are excluded from vital health insurance benefits. For instance, most of the diseases, medicines of certain quality or diagnostic procedures which members could get from the hospital are

not obtainable under CHF scheme. Due to these exclusion members of CHF pay health care services while they are at the same time paying for insurance. Thus it is recommended that, CHF should realise that universal health coverage for their members is achieved through health insurance and not partly health insurance and partly user fees. By improving its benefits, members of the society, even those from the rich class, which shun away from enrolment under CHF, will be attracted to join as they will be assured of proper health care coverage for themselves and their beneficiaries.

Sixthly, CHF is urged to increase its referral ladder. In most LGAs apart from regions operating under Improved CHF i.e. Morogoro, Dodoma and Shinyanga members can use their CHF Cards up to the level of District Hospitals. This is unlike other health insurance schemes such as NHIF and NSSF in which their members can be treated through referral or directly at the National Hospital.

Seventhly, efforts should be taken by the government through NHIF which is entrusted with the duty of managing the affairs of CHF to achieve solidarity in health insurance schemes. Measures should be taken to improve CHF so that those insured under the scheme receive more qualified health services as their counterparts in the NHIF.