

Community-Based Health Insurance: Experiences and Lessons Learned from East Africa

August 1999

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Partnerships
for Health
Reform

PHR



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Abstract

The annexes in this volume examine the strengths and limitations of community-based health insurance (CBHI) schemes currently operating to meet basic health care needs of rural populations in East and Southern Africa. These CBHI operations have achieved limited successes in designing and implementing affordable, participatory, and sustainable health care financing mechanisms for populations with limited resources but great need for health services. The scheme information presented here focuses on “lessons learned” from these operations, and recommendations derived from these lessons learned are designed to assist the rural communities interested in establishing similar, workable risk-sharing and financing mechanisms. These types of health care financing systems offer promising alternatives to centralized health care system and promote community ownership in health care.

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Acronyms

AIDS/HIV	Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus
APHIA	AIDS, Population and Health Integrated Assistance
CBHC	Community-Based Health Care
CBHI	Community-Based Health Insurance
CHAK	Christian Health Association of Kenya
CHF	Community Health Fund
CHIS	Chogoria Hospital Insurance Schemes
DfID	Department for International Development (U.K.)
DHB	District Health Boards
DHMT	District Health Management Teams
DISH	Delivery of Improved Services for Health Project
DMO	District Medical Officer
DRC	Democratic Republic of Congo
EDP	Essential Drugs Program
ESA	East and Southern Africa
GDP	Gross Domestic Product
ILO	International Labor Organization
IPD	Inpatient Department
KHHS	Kisiizi Hospital Health Society
MCH	Maternal and Child Health
MHO	Mutual Health Organization
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund
OPD	Outpatient Department
PHR	Partnerships for Health Reform
REDSO	Regional Economic Development Support Office
SSMECA	Strengthening Small and Micro Enterprises and their Cooperatives/Associations
STEP	Strategies and Tools Against Social Exclusion and Poverty
TB	Tuberculosis

TEC	Tanzania Episcopal Church
TFNC	Tanzania Food and Nutrition Project
USAID	United States Agency for International Development
WCA	West and Central Africa
WEO	Ward Executive Officer

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Executive Summary

Background

This study of community-based health insurance (CBHI) schemes in East Africa was conducted in the spring of 1999. Its goal was to contribute to the improvement of health care financing mechanisms, including the improved design and implementation of alternative models of financing and service delivery, especially for rural populations. This is a subject in the health care reform agenda of most countries in eastern and southern Africa. The study compiles the experiences and lessons learned from the CBHI schemes with a view to:

- ▲ Documenting progress and achievement to date;
- ▲ Identifying problematic areas and documenting solutions used to address them;
- ▲ Identifying ways to improve health care financing models;
- ▲ Providing both general and scheme-specific information which can be used for monitoring and improving CBHI schemes; and
- ▲ Providing information that can be used to design technical assistance strategies and programs.

In the last 10 years or so, each of the three East African countries included in this study has expanded considerably the use of user charges as a means of financing health care. Apart from cost sharing programs, there have also been other initiatives to finance health care by encouraging the private sector, particularly the not-for-profit health care providers to participate more actively in the provision of health care.

The motivation for the introduction of community-based health insurance schemes has come from both the public and private not-for-profit health care providers. The governments of Uganda and Tanzania have actively participated in the design and implementation of some of the CBHI schemes in those countries. In all three countries mission hospitals have played a key role in the formation of CBHI schemes. The primary motivation for the mission hospitals has been their recurrent problem of bad debts; patients leave the hospitals with debts they are unable or unwilling to pay.

Definition

The term “community-based health insurance” is used in this study to refer to any non-profit health financing scheme. It covers any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of an ethic of mutual aid and the collective pooling of health risks, and in which the members participate in its management. In addition, as noted below under “General Observations,” the study expanded this definition of insurance to include prepayment schemes. In other words, the objective has been the analysis and improvement of health financing mechanisms, including new alternatives, focusing on but necessarily limited to, health insurance.

Scheme Selection

Schemes were chosen based on their ability to provide lessons learned to help improve their own performance and to provide guidance to new schemes in the design and implementation of their schemes. As such, they were selected based upon duration of operating history and availability of data for analysis. Some younger schemes were also included because of their different approach which, it was decided, would enrich the study. Included in the study were the following schemes: Community Health Fund (Tanzania); Chogoria Hospital Insurance Scheme (Kenya); Kisiizi Hospital Health Society (Uganda); Ishaka Hospital Health Plan (Uganda); Atiman Insurance Scheme (Tanzania) and Mburahati Health Trust Fund (Tanzania).

Assessment Criteria

The performance of each scheme in the study was assessed under the following criteria: efficiency, equity, quality, community participation, solution strategies, and sustainability and replicability. These criteria were chosen because firstly, they focus attention on areas that are of concern to governments and donors in the Eastern and Southern Africa region. Secondly, they provide the opportunity to compare experiences in Eastern and Southern Africa with West and Central Africa where a similar study was conducted in 1998¹ using similar criteria.

Key Lessons Learned

- ▲ Community participation is important to the success of a community-based health insurance scheme. Such participation does need to be active so that the community has a say in decision making.
- ▲ Failure in risk management is one of the greatest threats to the viability of the CBHI schemes.
- ▲ Provider staff require training in order to appreciate the need for the scheme so that they may handle the client/patient with the respect they deserve.
- ▲ Marketing to the community by the scheme is very important. This should go on throughout the life of the scheme to insure that membership levels expand during start-up and are kept high.
- ▲ Underwriting of the initial losses by the government can help the scheme set low rates at the beginning but may also give a false sense of affordability to the potential clients.
- ▲ It is important to set realistic premiums at the beginning of the scheme and to periodically review and adjust them.
- ▲ Schemes need to adopt a business culture in their management styles.

¹ Atim, Dr. Chris. 1998. *The Contribution of Mutual Health Organizations (MHOs) to Financing, Delivery, and Access to Health Care in West and Central Africa*. Technical Report 18. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

General Observations

The CBHI schemes studied were introduced with inadequate management training in the critical aspects of an insurance business, such as risk management and marketing. Some of the earlier design problems have been corrected but serious financial management issues still remain to be addressed. External assistance has helped most of the schemes to stay on track but there is need for internal capacity to be built up to deal with issues as they arise. Community awareness of the schemes has not led to wide membership as other external economic factors have also had a negative impact, e.g., famine in the region has made it difficult for many to spare the lump sum required to join the schemes.

As noted above, all the schemes are not strictly health insurance schemes; some (for example, the CHF and Atiman schemes) are more like prepayment schemes. In general, an insurance scheme would be expected to deal with high cost but low probability health care needs. A prepayment scheme, on the other hand, would normally cover high probability low cost events. Despite these differences, both types of schemes can serve a useful purpose and can also be affected by similar problems that may be remedied through similar solutions.

General Conclusions

The schemes can be sustainable in the long term only if serious attention is paid to their design and management. Their current failure is not, however, a failure of the concept of health insurance or prepayment and its applicability to low-income communities, but rather, a failure in the design and implementation of individual schemes.

Enrollment has been low and it is worth investigating the reasons why. The presence of public health facilities that charge nominal fees and can take care of less serious disease conditions may be a deterrent to membership in schemes not based at public facilities. People know that they only need insurance cover (which they self-insure) for the more serious illnesses that may not be cured in a public hospital or for which they may choose admission into a mission hospital.

General Recommendation

The schemes studied have quite serious problems in their design, and management should address them before the schemes expand to include more members. Marketing should take place after the schemes have dealt with the fundamental issues of risk management and financial management. The schemes need to re-examine their designs on an ongoing basis so that they can be continuously improved.

Governments in the region have an important role to play in the development and future sustainability of community-based health schemes. In particular they should provide:

- ▲ The policy framework within which schemes can be formed. They should make the necessary amendments to the existing laws, if necessary, so that CBHI schemes can be formed without fear of conflict with other insurance laws.
- ▲ The regulatory framework for schemes to ensure that members' interests are protected.
- ▲ Technical support to those wishing to form new schemes.

Donors

Donors could support CBHI initiatives by providing targeted technical assistance to strengthen the managerial capacity within the schemes to run insurance businesses.

Areas Which Would Benefit from Technical Assistance and Training

- ▲ Training in management of an insurance scheme.
- ▲ Training in the use of treatment guidelines/protocols as well as in the assessment of existing guidelines for cost effectiveness.
- ▲ Cost analysis to establish benefits packages and set premiums based on actual costs so that the value of any subsidies/discounts given are clearly identified.
- ▲ Development of guidelines for setting up CBHI schemes, including tools for management information, taking into account existing materials.

Possible Areas for Further Investigation

- ▲ Health care financing reforms affect patient access to necessary health care. The impact on the poorer members of the community and alternatives to address negative impacts have not been fully investigated.

There also is a need to examine factors affecting demand for health insurance. Does competition from public-sector health service delivery impact the ability of mission or private hospital-based schemes to recruit members and, if so, how? It has been speculated that this impact could partly be due to the low prices of public-sector services. Other factors could include the package of benefits and quality of health care offered at public facilities.

Scheme Recommendations

Kisiizi Hospital Health Society (Uganda)

- ▲ The financial viability of the scheme requires urgent attention. Premiums must be based upon good cost analysis and sound assumptions regarding use of hospital services by scheme members.
- ▲ Risk management techniques require strengthening. It is vital that the scheme controls the use of services by members. At the same time the hospital should adopt the most cost-effective treatment methods in order to keep costs down.
- ▲ The scheme needs to be run under sound business principles to ensure its sustainability. Financial management indicators and procedures should be designed to monitor the scheme's performance.
- ▲ The scheme requires more aggressive marketing to keep existing members and recruit new groups to join.

Chogoria Hospital Insurance Scheme (Kenya)

- ▲ The hospital is in the process of relaunching the scheme under a new name, but with a similar benefit structure as before. The question of staff capacity should be addressed in order for the scheme to be run more professionally, in terms of day-to-day management and marketing.
- ▲ The “new” scheme also will require more aggressive marketing—including more attractive marketing of the benefits package—than the staff can probably handle on their own. In a recent market survey, only 12 percent of the people in the catchment interviewed were aware of the scheme. The use of outsiders (insurance agents) to help in marketing is worth considering.
- ▲ The failure to involve the community may be one of the reasons for the low popularity of the scheme. Ways need to be found to involve the community in the decision-making processes of the scheme.

Community Health Fund (Tanzania)

- ▲ Data management is going to become a major problem if not addressed; the volume of data is such that manual processing is not longer feasible.
- ▲ Risk management of the scheme requires urgent attention. Currently members are over-utilizing the health facilities. The possibilities of facility staff misusing drugs in the name of CHF members exists due to the absence of proper internal controls to prevent this.
- ▲ There are indications that some poor people are being denied necessary health care due to the introduction of user fees and the CHF. Evidence of this is the seriousness of illnesses now presenting at the health facilities. A study should be conducted to examine the state of health of people in the community.
- ▲ There is a need to investigate the level of user fees versus CHF premiums and make adjustments as indicated so that more people may receive health care.

1. Introduction

As part of broader health care reform efforts aimed at generating more revenue for health services and decentralization, a number of community-based health insurance (CBHI) schemes have been established in several East African countries. This report describes a study of five of those schemes, carried out by the Partnerships for Health Reform (PHR), a USAID-funded project. This chapter describes study objectives, background, and methodology. Following chapters set out findings, lessons learned, conclusions, and recommendations to resolve problems that threaten the schemes' viability and sustainability. Five annexes discuss the schemes in detail.

1.1 Goal and Objectives of the Study

Goal

To contribute to the improvement of health care financing mechanisms, including the improved design and implementation of alternative models of financing and service delivery, especially for rural populations

Objective

To compile the experiences and lessons learned with community-based health insurance (CBHI) schemes in East and Southern Africa (ESA) with a view to:

- ▲ Documenting progress and achievement to date;
- ▲ Identifying problematic areas and possible solutions to address them;
- ▲ Identifying ways to improve health care financing models;
- ▲ Providing both general and scheme-specific information that can be used for monitoring and improving CBHI schemes; and,
- ▲ Providing information that can be used to design technical assistance strategies and programs.

1.2 General Context

1.2.1 Health Care Reform and Financing Policies in East and Southern Africa

Most countries in Africa are grappling with the problems of a rapidly expanding population for whom they need to provide reasonable quality health care. The challenges facing these governments have been made more severe by the spread of HIV/AIDS. Nevertheless, overall progress has been made in reducing rates of infant mortality and preventable diseases. Several countries have made great strides in improving the health status of the majority of their population. In all of these countries, governments and international donors are working together to implement health sector and health financing reforms in an effort to improve national health status. To ensure that this progress is achieved and/or sustained for growing populations, further resources will need to be mobilized or reallocated, and alternate health financing schemes will need to be considered (McEuen 1997).

Currently, most countries in East and Southern Africa are going through some form of health sector reform, including steps related to decentralization of management functions; health care financing, especially the introduction of user fees and health insurance; and staff rationalizations and retrenchment.

The World Bank, in its policy study *Financing Health Services in Developing Countries: An Agenda for Action* (Akin 1987), calls for reforms in four areas:

- ▲ *User fees* in government health facilities, especially for drugs and curative care.
- ▲ *Health insurance or other risk coverage* by encouraging well-designed health insurance programs to help mobilize resources for the health sector while simultaneously protecting households from large financial losses.
- ▲ *More effective use of non-governmental resources* by encouraging the non-governmental sector to provide health services for which consumers are willing to pay.
- ▲ *Decentralized planning, budgeting, and purchasing* of government health services, especially those services offering private benefit for which users are charged.

1.2.2 Health Care Financing Strategies in East and Southern Africa

In the last 10 years or so, each of the three East African countries included in this study has considerably expanded the use of user charges as a means of financing health care. In Kenya, user fees have been charged in all public health facilities except dispensaries since 1989. All hospital employees are also required to join the National Hospital Insurance Fund, which pays for inpatient care, subject to hospital-specific per diem rates. In Tanzania, user fees were introduced in 1993. Services at rural health centers and dispensaries are still free of charge except in the districts that are implementing the Community Health Fund (CHF), where patients do pay a fee. In Uganda, the concept of user charges for health services was given official recognition in 1993 when the Local Council Bill (1993), which decentralized government authority and administrative powers to the districts, was passed. This Act gave the districts authority to charge for the services they offer if they wished to do so.

Apart from cost sharing programs, there have also been other initiatives to finance health care by encouraging the private sector, particularly the not-for-profit health care providers, to participate more actively in the provision of health care. Donors have been involved in providing technical and other assistance to strengthen the capacity of local health care providers to provide sustainable, quality services in order to help reduce the burden on the government.

Within the East Africa region, USAID/REDSO/ESA (the USAID regional office for East and Southern Africa), one of the key donors in the health sector, provides assistance focusing on activities aimed at facilitating the development and implementation of local, national, and regional strategies and initiatives to improve the availability, quality, and sustainability of health services through improved policies and mechanisms to finance those services. Focus areas include cost sharing programs, health insurance, health system decentralization including organizational and fiscal aspects, strengthening African health care financing consulting capacity, and supporting overall health care financing national strategy formulation.

The promotion of health insurance as a means of pooling risks as well as mobilizing resources for health care financing had for a long time been left almost entirely to the private sector. The current interest in community-based health insurance and prepayment schemes and the rapid growth in other forms of health insurance are testimony to the growing public interest in seeking alternative means of paying for their health care needs in an environment where cost recovery is necessary and government capacity to subsidize services is limited.

The decentralization of the public health planning and management functions to the districts, plus the inclusion of communities in the management of health services, is seen as a way of improving the decision-making process and of creating a higher sense of responsibility in the community for their own health needs. There is more autonomy at district level with the introduction of cost sharing in Kenya and Uganda, as district health managers are given authority to plan for and spend such funds.

1.2.3 Concerns Regarding Access to Quality Care and Efficiency of Health Care Delivery

The health care financing strategies that have been adopted do not only address the problem of inadequate funds. They also seek to correct the inefficiencies in the health care delivery system to make it more cost effective and able to provide better-quality services, increase efficiency in the allocation of available resources, and make health programs more equitable.

The ability of the poor in the community to gain access to the formal health care system has long been a concern of African governments. In East Africa, free health care for all was offered as one of the fruits of independence until, in the 1980s, it began to dawn on governments that they may not actually have the means to pay for such a promise. Due to inadequate financing, the quantity and quality of health care the public could receive was very limited; it was free but not available. User fees were introduced, gradually starting with the non-essential services, until most services are now covered. With the introduction of user fees, there were fears that the poor were being denied necessary health care. Policies for exempting the poor from paying user fees, relying on some form of means testing, have been in place in all three countries since the introduction of the user fee programs. Similarly, some illnesses (e.g., HIV/AIDS, tuberculosis [TB] and other communicable diseases) are treated free of charge irrespective of ability to pay due to public health considerations. Maternal and child health and family planning services also tend to be provided free of charge in all three countries.

Public health care delivery systems have had the reputation of being very inefficient. Demand-side problems have been made worse by a number of factors: The low fees charged at all facilities (primary, secondary, tertiary) do not encourage patients to use the lowest-level facilities first. In addition, the district or regional hospital may be the only health facility that is geographically accessible to the local community. Finally, insufficient funding for the more cost-effective primary health care facilities lowers the quality of service they can provide, which also discourages use. For example, an adequate supply of drugs occurs only infrequently; it is quickly depleted as both the well and the ill scramble for the limited supply. All these factors undermine the referral system and increase expenditures at the more expensive secondary and tertiary health institutions.

1.2.4 Rise of CBHI Schemes and the Potential for Risk Sharing

Community-based health insurance and prepayment schemes have arisen in many communities in East and Southern Africa in response to the economic problems that make them unable to pay for health care when they need it. Many rural people have irregular farm incomes and can only afford to pay for their health care seasonally. When they are unable to pay, they pass on the problem to the local public or mission hospital by presenting themselves at the facility too ill to be denied health care. Others are forced to sell their means of livelihood, e.g., cattle or land, to pay their medical bills.

Social solidarity in various forms has long played an important role in the financing of health care in eastern African communities. In southwestern Uganda, the existence of Engozi societies,² to which about 96 percent of the population belong, provided a ready structure for Kisiizi Hospital to work with in establishing a health insurance scheme whose membership would be drawn from these groups. In Kenya, the concept of “harambee” (which means “let’s pull together”) has been used to raise funds for community projects, higher education for children from poor families, and to pay for hospital bills. The cooperative societies for marketing agricultural and other products are a form of self-help economic solidarity among rural communities. The Chogoria scheme aimed to recruit members of cooperative societies, as groups, into the insurance scheme. In Tanzania, the local (district) government’s administrative structure makes it possible for the idea of pooling resources to pay for health care to be acceptable to the community. The present structures, developed during the socialist policies of the 1960s and 1970s, seem to encourage a stronger sense of community solidarity than one would find in either Kenya or Uganda. Indeed, “it has been suggested that strong traditions of community initiative and management, or very cohesive communities, may also encourage the development of community-based insurance schemes” (Bennett, Creese, and Monasch 1988).

Mission hospitals, traditionally more reliant on user fees than are public hospitals, struggle with the problem of bad debts, which are borne by the hospital as part of its administration overheads. Many seek external donations to help offset the debts. Government subsidies ease the burden but are rare and come mainly in the form of financial support and personnel. Where present, these subsidies are declining. In Uganda and Tanzania, the government still provides some support to mission hospitals, but in Kenya, subsidies have ceased altogether. This lack of financing among the mission hospitals has been part of the motivation to start the CBHI in Chogoria and Kisiizi. The inadequate financial allocations to health facilities in Tanzania, which led to constant shortages of drugs and medical supplies and ill-maintained facilities, motivated the Ministry of Health (MOH) to investigate the feasibility of CBHI in Igunga district, aiming to only bridge the financing gap.

² The “Engozi” is a hand-carried stretcher. It can be owned by an organized group/society or by an individual. The Engozi society covers burials and transport of ill members; many have a loan scheme or income-generating projects.

Experience with community- and employment-based health insurance schemes has been better developed and documented in West and Central Africa (WCA). The term that is commonly accepted in WCA is the mutual health organization (MHO). In a recent study in West and Central Africa by Dr. Chris Atim, the MHO is defined as “a voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and the collective pooling of health risks, in which the members participate effectively in its management and functioning” (Atim 1998).

In this East Africa study, the term that has been used to describe the health insurance schemes that have been formed outside of the formal health insurance sector is community-based health insurance. The term “community-based” does not necessarily mean that the scheme is operated strictly outside the setting of a health care provider. As was noted in the workshop held to design this study, “some of the large mission hospitals tend to be the hub of a wide community outreach health program and are considered to be part of the community. They also consider themselves, in a sense, as community centers which deal with a wide variety of issues, having a greater reach than community health” (McGaugh 1999). In this sense the schemes based in these facilities are “community-based.” However, they are not community derived nor generated schemes in the same way that many in West and Central Africa are. For purposes of this study, therefore, and until a more suitable term can be agreed on, we have attempted a definition of CBHI based on that for MHOs: “A CBHI scheme is a not-for-profit health insurance scheme for the informal sector, formed on the basis of an ethic of mutual aid and the collective pooling of health risks, in which the members participate in its management.”

“What is the difference between mutual self-help and solidarity?”

It is possible to distinguish between solidarity and mutual self-help: mutual self-help is based on the principle of reciprocity, i.e., the reciprocal obligation expected from the recipient of aid towards the giver, whereas solidarity is an expression of empathy with the more disadvantaged, without expectation of a direct reciprocal obligation from the recipient. However, solidarity is not the same thing as charity, because the former takes place within a complex social system of mutual *rights and obligations*, where the recipient is considered to be entitled to assistance as of right, and the obligations on them may be *indirect* ones (towards the whole community, for instance, rather than towards the individuals who give).

Mutual self-help and solidarity are expressed in various ways within traditional African society: through work, financial assistance, etc. The individual or family that is faced with unexpected expenditures—e.g., in connection with a new birth, marriage, sickness, death—can call upon the extended family for help. These forms of mutual self-help and solidarity often take place at the level of the clan, lineage or even village.” (Solidarité Mondial 1996)

1.2.5 Need for this Study

The overall purpose of this study is to provide information and technical guidance to CBHI schemes and to policymakers and communities in the East and Southern Africa region to help improve the performance of schemes and their contributions to health sector financing, and access to and quality of services. The method is to conduct a review of community-based health insurance focusing on experiences and lessons learned in East Africa. Follow-on activities will build upon the results of this study. Such activities include the development of a “how-to” manual and tool kit to provide guidance for the design and implementation of CBHI schemes. Additional opportunities for follow-up technical assistance to support improvements in CBHI schemes and in the policy environment in the three study countries and in the region will also be explored.

This document chronicles and compares the experiences of schemes in Kenya, Tanzania, Uganda, and other countries, providing a resource to schemes, policymakers and community members as they examine health care financing options and opportunities.

1.2.6 Overview of Other Schemes in East and Southern Africa

The ESA region experience with CBHI schemes has not been widely studied or documented. Available information is sketchy and some of it outdated. The table below summarizes this information, including some schemes in the Democratic Republic of Congo (DRC) (Bennett, Creese, and Monasch 1998).

Table 1. Schemes in East and Southern Africa and Democratic Republic of Congo

Scheme	Country	Number of People Covered	% of target population covered
Chogoria	Kenya	1,400	0.3%
Kisiizi	Uganda	6,580	6.5%
Ishaka	Uganda	247	Not known
Community Health Fund	Tanzania	Approx. 32,000	5%
Atiman	Tanzania	27 families	85%
Mburahati	Tanzania	38,000	0.6%
Masisi	DRC	3,500	Not known
Bwamanda	DRC	80,000	66%
UMASIDA	Tanzania	6,000	< 1%
Kongolo	DRC	976	19.3%
Kasturba Hospital	DRC	19,450	74%

1.3 Methodology

1.3.1 Research Methods

The review was carried out through a combination of strategies including:

- ▲ Desk review of available documents
- ▲ Site visits to schemes
- ▲ Interviews with scheme/hospital management, members, non-members, member organizations/groups
- ▲ Analysis of costs and revenues for schemes and related facilities and,
- ▲ Analysis of services utilization trends and patterns

1.3.2 Selection of Schemes

Schemes were chosen based their ability to provide lessons learned that new schemes will find useful when designing and implementing their schemes. As such, three main schemes were selected based upon duration of operating history and availability of sufficient data for analysis. Some younger schemes, located in Tanzania, were also included because of their different approach which, it was decided, would enrich the study. These Atiman schemes, made up of two sub-schemes, or units, receive technical assistance from the International Labor Organization (ILO) under the STEP (Strategies and Tools against Social Exclusion and Poverty) Project. They tend to be more “community-based” than the other schemes in the study and one of them involves contracting with a health care provider. Another recent scheme that was included in the study is the Ishaka Hospital Health Plan because it was easily accessible and because, while it is still in its early months of implementation, it could benefit from the visit by the study team. The three main schemes studied were:

Chogoria Hospital Health Insurance Scheme

This scheme is the oldest of those in the study. It was started in 1991 by the Chogoria Hospital in collaboration with the Apollo Insurance Company. The Chogoria Hospital is a mission hospital in Kenya, sponsored by the Presbyterian Church of East Africa. The hospital entered into a contract with the insurance company to provide a defined range of health services to members of the scheme who would be enrolled from the community. The hospital and its community-based clinics were the designated service providers. The contract with the insurance company was terminated in February 1998 and the hospital now self-insures.

Kisiizi Hospital Health Scheme

This provider-based scheme in southwestern Uganda is administered by the Kisiizi Hospital, a mission hospital sponsored by the Church of Uganda. The scheme has been in operation since August 1996. It borrowed its initial design from the Chogoria hospital and was set up with technical assistance from the Ministry of Health.

Community Health Fund

The Community Health Fund (CHF) is an initiative of the Ministry of Health, Tanzania. A pre-test of the scheme was started in Igunga District in 1996 and in 1997 expanded to one more district. Now it is at varying stages of implementation in 10 districts.

1.3.3 Assessment Criteria

Assessment of the CBHI schemes was made under seven headings, namely: resource mobilization, efficiency, equity, quality, community participation, solution strategies, and sustainability and replicability. These criteria were chosen because they:

- ▲ Focus attention on areas that are of concern to governments and donors in the Eastern and Southern Africa region; and,
- ▲ Provide the opportunity to compare experiences in Eastern and Southern Africa with West and Central Africa where a similar study was conducted in 1998 (Atim 1998) using similar criteria.

These criteria are important for the following reasons:

Resource mobilization: The health sector in Africa suffers from underfunding coupled with an ever-increasing demand for health care. The inadequacy of public funds and falling standards of health care has led to the emergence of private-sector initiatives that aim to make health care accessible to wider sections of the population. CBHI schemes are examples of such initiatives. The ability of a scheme to mobilize funds from the community towards financing health care is an important criterion in the assessment of the success of a scheme.

Efficiency: The provision of health care in Africa, particularly in the public sector and, in many cases, also in the NGO sector has been inefficient in controlling costs and often allocates available resources to more expensive tertiary care at the expense of primary health care. The issues considered under this criterion include: methods of service delivery, financial efficiency, technical efficiency, and allocative efficiency (i.e., tertiary vs. primary health care).

Equity: Poor rural populations tend to be disadvantaged in their access to health care. This is due partly to the unavailability of health care facilities and the inability of the poor to afford services where user fees are in operation. CBHI schemes could make a positive contribution in addressing this imbalance by adopting policies that provide some protection for the poor and making membership accessible to a wider section of the community. For example, exemption mechanisms may provide poor members of the community with scheme membership, paid for through community funds; orphaned children may be “adopted” by richer families in the purchase of scheme membership.

Quality: Due to the inadequacies in funding and in efficiency, the quality of health care in many health care facilities is very low. This criterion assesses scheme impact on the quality of health care provided to its members and hence to the public. CBHI schemes could make a significant impact on the quality of health care through their contractual relations with health care providers. For example, there is scope to negotiate for cost and quality, particularly where the insurance scheme has a number of providers from which to choose.

Community Participation: Reforms currently underway in most African countries encourage the participation of the public in the management of the public health care system. Decentralization of health care services has given communities a greater say in the provision of health care through public health institutions. In many cases now in East Africa, the formation of district-level health boards, whose membership is drawn from the community, has given the public more direct involvement in the decision-making process. CBHI schemes can also contribute to this process of democratization of health services by involving communities in various aspects of their management. This criterion looks at the extent to which communities are involved in the operation of the scheme.

Solution Strategies: The ability and manner in which schemes respond to change or to critical issues as they arise provides important information about the scheme’s management and potential for success. Here such instances are assessed.

Sustainability and Replicability: The ability of a scheme to remain a viable organization is important if the benefits associated with the assessment criteria are to be realized. This criterion examines specific issues relating to how well the scheme is run and what institutional and administrative factors assure its survival.

2. Findings

2.1 Basic Information About Each Scheme

Annexes A to E contain detailed descriptions of each scheme as well as an assessment of performance based on the assessment criteria described above. Each scheme is described under the following headings:

- ▲ General Introduction
 - △ History of the Scheme
 - △ Objectives
 - △ Key Achievements and Challenges
 - △ Legal Framework/Enabling Environment
- ▲ Operating Guidelines
- ▲ Data Management
- ▲ Benefits Package and Premiums
- ▲ Membership
- ▲ Management
- ▲ Community Participation
- ▲ Relations with Service Providers
- ▲ Relations with Government and Other Social Groups
- ▲ Marketing
- ▲ Population Data
- ▲ Financial Data

Table 2 profiles each of the schemes in this study.

Table 2. Basic Information on Study Schemes

	Kisiizi (Uganda)	Chogoria (Kenya)	CHF (Tanzania)	Mburahati (Tanzania)	Atiman (Tanzania)
Year Founded	1996	1991	1996	1992	1995
Membership - Titular 1998 - Beneficiaries	1,400 6,580	311 1,481	5,295 31,770*	23 78	239 239
Legal Framework	Department of the hospital. No separate legal registration	Department of the hospital. No separate legal registration	Established through legal by-laws of the District Councils	Not registered with government	Constitution submitted to government for registration
Operating Guidelines	None	Yes	Yes	Yes	Yes
Data Management	Manual; no regular reports. Records kept in scheme office.	Computerized; regular reports at least monthly. Records kept in scheme office.	Manual at facilities and district headquarters. Computer spreadsheets at headquarters	Manual; records are kept by different official of the scheme.	Manual; incomplete after theft. Records are kept in church office.
Benefits package	Outpatient care. Inpatient care in general ward bed. No annual limit	Outpatient and inpatient care subject to annual limits	Outpatient care only. No limit	Outpatient care in designated dispensary. 10% of costs of hospitalization in public hospital	Outpatient care at local church dispensary. No limit to cost.
Main Exclusions	Eye glasses, ambulance, cosmetic dental care, referral to other hospitals, self-inflicted injuries. Normal deliveries.	HIV/AIDS in excess of annual limit per policy, pregnancy / delivery, eye glasses, dental care, self-inflicted injuries	Inpatient care.	Chronic diseases, HIV/AIDS, TB.	None
Management	Hospital Committee Consultative group with community members	Hospital Committee	District CHF Board Ward Health Committee Facility staff	Scheme management committee elected by members	Scheme Executive Committee. Parish Office
Community Participation	Yes	No	Yes	Yes (members run the scheme)	Yes
Marketing	1. Scheme staff assisted by CBHC nurses 2. Community	Scheme staff	Local authority workers District Health Board and Ward Committees	Members and the scheme committee	Parish Scheme Executive Committee
Target Population	100,000	450,000	Approx. 600,000**	27 members of cooperative society	38,000
% Population Enrolled	6.5%	0.3%	5.3%	85% of cooperative society members	0.6%
Financial Data Revenue - 1998 - 1997 - 1996	US\$ 18,530 5,757 -	26,990 30,115 28,724	90,512*** 72,117 27,962	727	Data n/a 3,366 2,388

* Estimated, assuming six individuals per household

**Total for the two districts participating in this study

*** Total for the two districts participating in this study

2.1.1 Nature of Schemes: Insurance or Prepayment?

The schemes in the study are not all strictly health insurance schemes. Some, for example, the CHF and Atiman schemes are more like prepayment schemes. Two types of risk-sharing scheme can be identified here: those covering high cost, low probability health care events and those covering low cost, high probability events.

An insurance scheme expects to deal with high cost but low probability health care needs, for example, inpatient care for randomly occurring illnesses. High probability events may be uninsurable because the price (premium) that the insurer would charge would probably be equal to or exceed the cost that the consumer would have to pay if he/she did not insure. The schemes that more closely fit into this category tend to be hospital-based/owned.

A prepayment scheme, on the other hand, normally covers high probability (hence, more predictable) low cost events such as outpatient care. The consumer pays an annual or monthly amount to ensure that he/she receives health care for the period covered. Such schemes tend to be based at the village level and the benefits package and premiums are set on the basis of ability to pay. The objective is to raise revenue to supplement existing sources of funding for health care. A complementary objective is to enable persons with seasonal income to pay in advance for health care at the time or times when they have disposable income.

2.2 Assessment of Performance

2.2.1 Resource Mobilization

The impact of CBHI schemes on resource mobilization was assessed by looking at the following issues:

- ▲ Enrollment-percentage of the target population covered by the scheme;
- ▲ Proportion of health facility operating costs covered by scheme receipts;
- ▲ Proportion of health facility income received from scheme;
- ▲ Use of scheme resources; and,
- ▲ Scheme contribution to financing health care in the district.

The schemes in eastern Africa are relatively new. The oldest in the study is the Chogoria Hospital Health Insurance scheme which has been in existence since 1991. The manner in which most of these schemes were designed and implemented was such that they have not achieved wide coverage of the target population and have thus been restricted in the amounts of money they generate. Their target populations are mostly low (and sometimes, irregular)-income earners.

Enrollment

The schemes have been able to create awareness in the community about their existence but have not had much success in converting that awareness into enrollment. It is worth investigating why this happens. The presence of public health facilities that charge nominal fees and can take care of less-serious disease conditions may be a deterrent to scheme membership. People know that they only

need insurance coverage (which they self-insure) for the more serious illnesses that a public hospital may not be able to cure or for which they may choose admission into a mission hospital, whether they can afford it or not.

Table 3 demonstrates the level of penetration of study schemes into their target populations.

Table 3. Scheme Enrollment

	Kisiizi	Chogoria	CHF (study districts)	Mburahati	Atiman
Target population	100,000	450,000	Approx. 600,000*	27 members of cooperative society	38,000
% of population covered 1998	6.5%	0.3%	5.3%	85%	0.6%
% of population covered at peak of membership	6.5%	0.5%	5.3%	85%	4%

* Total for the two districts participating in this study

Membership has tended to peak after about two years of scheme existence and then has fallen. For example, the Chogoria scheme was popular at the beginning when controls were weak and abuse by members was high. When controls were tightened and premiums adjusted upward, membership fell and has not recovered; at the end of 1998 only hospital staff were members. Membership of the Kisiizi scheme has not suffered much though 12 out of the peak membership of 44 Engozi societies have fallen out of the scheme for failing to achieve or maintain the group membership enrollment of 60 percent.

The Atiman schemes have not fared much better: the membership trend has been downward since each scheme was set up. Atiman's Msimbazi scheme was started in May 1995 and has relied quite heavily on gifts; the Yombo scheme was started in March 1997 and has been able to sustain itself without external funds. Membership and revenues in both schemes have been falling each year.

The Mburahati scheme has not required external funds. During its first full year of operation, February 1998 to March 1999, it made a small surplus.

To date their contribution to the financing of health services of the participating health facilities has been minimal. Table 4 demonstrates this:

Table 4. Scheme Contribution to Health Facility Financing

	Kisiizi	Chogoria	CHF (Igunga district)	Mburahati	Atiman
Scheme Income 1998	Ush 21,793,500 US\$ 18,530 (Ush 1,176/US\$)	Ksh 1,587,040 US\$ 26,990 (Ksh 60/US\$)	Tsh 42,405,000* US\$ 72,117 (Tsh 588/US\$)	Tsh 479,550 US\$ 815	Tsh 1,280,000 US\$ 2,178
% of health facility operating costs financed by scheme	6.6%	2.1%	7.2%**	Data not available	Data not available***

* Igunga district only. Data on total district expenditure on health not available.

**Proportion is based on total expenditure for dispensaries and health centers in 1994 (Tsh 561,731,1354), adjusted to 1998 prices on the basis of \$/Tsh exchange rates

*** The dispensaries in the Atiman scheme realized between 3.1 percent and 5.4 percent of their total revenue from insurance claims.

In order to attract members, premiums tend to be kept quite low. The Kisiizi scheme pitches its premiums to a level that will not raise any more money per member than would have been raised through its user fee program, which recovers only about 75 percent of costs. The Chogoria scheme based its premiums on full cost of providing services; the scheme has not been popular with the community. The CHF is quite heavily subsidized; the government provides matching funds for each member enrolled through funds provided under a World Bank project that expires in June 1999 but is anticipated to be extended. The premium paid covers about 65 percent of the cost of the basic package of health services delivered in health centers and dispensaries. The Atiman schemes also rely on gifts and/or subsidies for their survival.

2.2.2 Efficiency

This section considers the contribution of CBHI schemes to the efficient delivery of health care and efficiency in the allocation of resources. The study analyzed efficiency under the following headings:

- ▲ Methods of service delivery: hospital-based care vs. community-based health care;
- ▲ Scheme's impact on the allocation of resources to primary health care versus other services;
- ▲ Technical efficiency, including risk management techniques to avoid moral hazard and adverse selection, and control of costs;
- ▲ Methods to control fraud, abuse by members, providers, and scheme administrators; and,
- ▲ Referral policies and practices.

The box on the following page contains definitions of common terms used in the assessment of risks in an insurance scheme.

Definitions: Risk
<p>1. Moral hazard: This is the tendency of the insured person to behave in a way as to use the services more intensively than if s/he were not insured. Such (often unnecessary) use results in over-consumption and imperils the financial viability of the insurance system. This is different from fraudulent use of the services (see below) because it relates mainly to the fact that the price of using the service to the insured person is often much lower (more so where there are no co-payments or deductibles) than the actual price of the service, so that for instance a minor health condition which s/he would ordinarily overlook if s/he were paying the full price would make them seek medical attention.</p>
<p>2. Adverse selection: This is the tendency of those who are at greater risk of falling ill (high risks), or who are already ill, to subscribe to the insurance scheme in greater numbers than those who are less at risk (low risks). This also imperils viability because the premiums are calculated on the basis of the whole community's or target group's average risk of illness, and if the actual subscribers tend to be those who would use the services more intensively than the average, then the scheme is likely to become insolvent.</p>
<p>3. Cost escalation: This refers to the danger that an insurance scheme will face rapidly rising costs due to a variety of reasons related to the behavior of providers and patients once such a scheme is implemented. Providers, with the collusion of insured patients, may have incentives to use costly treatment techniques, or provide excess services in the knowledge that the scheme will pick up the bill. Patients, as shown in points 1 and 4 here, might tend to behave in ways that drive up the costs of the scheme.</p>
<p>4. Fraud and abuse: An insurance system is open to the dangers of "free-riding" i.e. to individuals who would want to enjoy the benefits of the scheme without bearing the price involved; e.g. some individuals not entitled to services may usurp the identity of those entitled in order to receive the benefits without paying for them. If there is no effective system of checking identities then it is difficult to know whether people demanding the benefits are entitled to them or not. Insurance is particularly open to such risks because in its operation, there is often a perception that somebody else is paying for the services, not the direct user of those services, which arguably gives incentives for abuse.</p>
<p>5. Risk management: This covers the range of tools or techniques which can be deployed by the scheme managers to minimize the impact of the above risks. The two crucial steps involved are the identification and quantification of the risks. Identification depends to a large extent on available data (gathered from existing sources such as providers or from research). Quantification depends either on the use of the tools of actuarial science or sound judgement or a combination of both. An insurance scheme's level of risk is greatly affected by the benefits package it offers and its terms of membership.</p>

Source: Atim 1998.

Cost Control

Few health care providers make deliberate efforts to ensure that health services are delivered in the most efficient manner. The development of standard treatment guidelines requires an investment in time and effort to which many ministries of health and individual service providers have been unwilling or unable to commit themselves. In Kenya, the government Clinical Treatment Guidelines were only developed in 1994. In Tanzania these have been available since 1991 and in Uganda since 1993.

The availability of treatment guidelines does not guarantee their use by clinicians. In Kisiizi, the hospital uses the British Drug Formulary; staff were not aware about the National Treatment Guidelines, nor of the National Essential Drugs List. Chogoria Hospital has made the effort to develop its own Standard Treatment Guidelines, which must be used by all clinicians. These, however, have not been adapted for use by its network of community dispensaries. In Tanzania, staff at the dispensaries and health centers were vaguely aware of treatment guidelines given to them during training workshops, but no one had them readily available. The available Standard Treatment

Guidelines developed locally call for the use of generic drugs (usually selected from the national essential drugs list) where appropriate and for the most cost-effective treatment for the illness.

Risk Management

The ability of a health insurance scheme to control the risks inherent in such a business is one of the key factors affecting its survival. This study found that risk management techniques varied from one scheme to another (see Table 5). The level of success in controlling fraud and over-use of services was low, at best, as most did not appear to have taken an official position on the matter. The Chogoria scheme had to be redesigned and relaunched in 1995 after four years in operation due primarily to poor risk management as well as other design problems. The Atiman scheme does not have much by way of controlling risk; only a photo ID is required.

Table 5. Risk Management Techniques

Risk	Chogoria	CHF	Kisiizi	Mburahati
Moral hazard	<ul style="list-style-type: none"> ▲ Co-payment for out-Patient visits 	<ul style="list-style-type: none"> ▲ None 	<ul style="list-style-type: none"> ▲ Co-payments for out- and in-patients 	<ul style="list-style-type: none"> ▲ Social control – group is small
Adverse selection	<ul style="list-style-type: none"> ▲ Waiting period 2 weeks. ▲ Exclusion of pre-existing conditions ▲ Discount for those who join as a group 	<ul style="list-style-type: none"> ▲ None 	<ul style="list-style-type: none"> ▲ Requirement that only groups will be accepted into membership. At least 60% of the group must enroll 	<ul style="list-style-type: none"> ▲ 3-month probation period. ▲ Whole (nuclear) family must enroll in scheme
Cost escalation	<ul style="list-style-type: none"> ▲ Ceiling of cover ▲ Use of generic drugs ▲ Use of standard treatment guidelines ▲ Use of dispensaries before hospital - referral encouraged by the co-payment structure 	<ul style="list-style-type: none"> ▲ None ▲ Use of Essential Drugs Program drug kit 	<ul style="list-style-type: none"> ▲ None 	<ul style="list-style-type: none"> ▲ Provider must use generic drugs where possible. ▲ Ceiling on cost of hospitalization
Fraud and abuse	<ul style="list-style-type: none"> ▲ Member identification card and photograph. ▲ Monthly reports on utilization ▲ Good internal controls over use of service, plus external audit 	<ul style="list-style-type: none"> ▲ Member ID card 	<ul style="list-style-type: none"> ▲ Member ID card ▲ Good internal controls over use of hospital services plus external audit 	<ul style="list-style-type: none"> ▲ Family photograph in dispensary ▲ Patient must sign for treatment received

Service Delivery

The Chogoria scheme has in place a mechanism to encourage members to use the lowest facilities (dispensaries) before coming to the hospital. The co-payment for those who skip their designated dispensary is KShs.50 instead of the normal KShs.30 per visit.

Mburahati scheme has contracted with one service provider who attends to all outpatient needs of the members.

The CHF in Tanzania is predominantly a dispensary and health center-level scheme with only one public hospital involved. The Kisiizi hospital scheme does not have a wide network of community-based clinics and hence there is no requirement that members be seen at those clinics in the first instance.

2.2.3 Equity

The aspects of equity investigated by the study were the following:

- ▲ Financing—the structure of financial contributions to the scheme;
- ▲ Utilization of services between members and non-members to determine whether scheme membership gave inequitable access to the available health resources;
- ▲ Access—protecting poor and vulnerable groups; and,
- ▲ Impact on service delivery—Are benefits related to financial contributions to the scheme?

Financing

The premium structures investigated by the study tend to favor ease of administration. The Chogoria scheme provides three different levels of benefits and charges premiums based on the number of persons insured under the policy. Under this scheme members buy only the coverage they can afford. The Kisiizi scheme premiums depend on the family size, from family sizes of 1-4; 5-8; and 9-12. Any additional member above 12 pays a flat rate of Ush. 1,200. Benefits are the same for all members. The Community Health Fund has a flat premium per household. Larger households benefit at the expense of smaller ones. The average household size in Igunga and Singida districts is six persons. Each household pays a premium of Tsh. 5,000 per year.

The Atiman and Mburahati schemes' premiums are structured in such a way as to make them easy for the community to afford them. Mburahati scheme premiums may be paid daily, so that the members, whose income is received daily, can afford to pay. The Atiman scheme's premiums are payable monthly.

Utilization

A scheme's ability to control member utilization of services has an important bearing on the equitable distribution of health services in the community. This is particularly so where public health facilities are involved since the supply of services can be limited. For example, in situations where it is normal for drugs to run out, it is important that they are fairly distributed. In the three main schemes in the study, control over utilization was found to be a major problem.

Table 6. Service Utilization by Scheme Members

Scheme	Outpatient department (OPD) Visits by scheme members	Total OPD visits	% of utilization by members	% of population covered by scheme
Kisiizi	3,912	18,353	21%	6.5%
Chogoria	3,242	158,570	2%	0.3%
CHF (Igunga District Hospital)	3,221	4,349	74%	5.0%

In the CHF in 1998, members accounted for 74 percent of all outpatient visits in the Igunga District Hospital. This was low compared to the dispensaries and health centers, where utilization by members was as high as 88 percent and in Singida Rural district, utilization in one dispensary was 92 percent by scheme members. In both districts membership is about 5 percent of the population.

It is quite clear that scheme members use a disproportionate share of health services. This is partly indicative of poor controls by the service providers over utilization.

Access

The study observed that those in the community who are not members of the CHF only presented in the health facilities when they are really ill. No studies have been done to determine whether the poor are being denied necessary health care. The scheme allows for the very poor in the community to be given scheme membership free of charge after receipt of an exemption. However, the process of getting such exemption is quite lengthy and few have benefited from it.

The schemes in Kisiizi and Chogoria make no special provision (e.g., exemption) for the poor. The Kisiizi and Chogoria mission hospitals seek donor funds to provide health care to those who can not meet their hospital bills. This is not normally disclosed to patients and all are billed and encouraged to pay. The bills of those who do not pay eventually get written off as bad debts and the loss is borne by the hospital if donors do not provide funds.

The design of the Atiman scheme allows Small Christian Communities to pay the premiums for the poor among them. This, however, has not been put into practice. The Mburahati scheme is exclusive to members of the cooperative.

2.2.4 Quality

Health insurance schemes can influence the quality of health care service that providers make available to members of the insurance scheme if this is included in the contractual arrangements between the scheme and the service provider. This is particularly so where there are multiple service providers and there is competition between service providers.

The Mburahati scheme in Tanzania was the only scheme in the study that provided for competition between providers. Kisiizi and Chogoria schemes are initiated by a single service provider, while the CHF in Tanzania only includes public health facilities. If scheme management were separate from service delivery, competition would be a healthy way to force providers to give higher quality health care while at the same time controlling costs. Such incentives would be given depending on the provider payment mechanisms in place.

Some quality improvements attributable to the scheme were noted in the CHF. These include:

- ▲ Improvements in the supply of drugs and medical supplies in the health facilities. This has been possible because unnecessary use has been reduced among non-members (but perhaps encouraged among members); therefore the drug kits which used to run out within a week or so of arrival, can now last a whole month;
- ▲ Staff are more motivated because they have the drugs and supplies to treat patients more effectively; and,
- ▲ The community is now more interested in the welfare of the health facilities in their ward and the health committees are playing an important supervisory role.

Scheme members interviewed were generally happy with the services they received through the scheme. For Kisiizi and Chogoria, there was no differentiation between the scheme and the hospital. This separation was more clear cut when talking to members of the CHF.

Areas of dissatisfaction with the schemes included the following:

- ▲ Co-payments were considered too high in Kisiizi;
- ▲ The Chogoria scheme had no mechanism for including the poorer members of society;
- ▲ Most schemes offer no choice of provider;
- ▲ In Chogoria and Kisiizi, waiting time for treatment was considered too high – no preference is given to scheme members to speed up service to them; and,
- ▲ Dispensaries were too far in the Atiman scheme, and they were only open during the day.

2.2.5 Management

The management of health insurance schemes is a critical factor in their sustainability. Poor management has been the bane of most health providers in Africa, particularly in the public sector and not-for-profit organizations. The management of the schemes studied requires strengthening in the following areas:

- ▲ These schemes (at least initially) were designed as insurance schemes with the pooling of risks as the guiding principle. It is important that they are managed by people who have sufficient knowledge of insurance theory and practice.
- ▲ In Chogoria and Kisiizi, there is little separation between the schemes and the management of the hospitals. The same applies to the Atiman scheme where there is no separation between the dispensary, the church, and the scheme. There is little objectivity when the scheme management addresses the needs of the scheme members if the same management runs the health facility. The Mburahati scheme, however, is fully managed by the members.

The involvement of the community in the management of the scheme is important in ensuring that the community has a sense of ownership and identity with the scheme. This problem was more noticeable in the Chogoria scheme, where it has been difficult to penetrate the community for a wider

membership base. In both the CHF and Kisiizi, the community is involved in the management of the scheme, and this has helped to popularize the schemes in the community.

2.2.6 Community Participation

This section discusses the extent to which the community has been involved in the design and management of the schemes.

It appears that the schemes with greater community participation have had more success in mobilizing community support. In Kisiizi, marketing the scheme through the Engozi societies shifted some of the responsibility for marketing to the Engozis. The Mburahati scheme which is fully managed by the members has recruited about 85 percent of the members of the cooperative society. Chogoria has had no community participation in the scheme and has had little success penetrating the community to sell the scheme to existing groups.

In the CHF, the communities were involved in the formulation of fund by-laws; although they were given a draft to work with, they had the final say in the level of premiums and the mode of management of the scheme in the district. In Kisiizi, the community was consulted during the design of the scheme. Community members gave input into the scheme guidelines, premium periods, and collection of premiums. A consultative group made up of representatives from the community groups and the hospital/scheme management still meets from time to time to review the progress of the scheme.

2.2.7 Solution Strategies

All the schemes have relied to a large extent on external technical assistance to resolve difficult issues when they arise. All have had input from the ministries of health through consultants engaged under projects implementing health sector reforms. There is not much internal expertise, nor strategies to handle problems.

In the Kisiizi scheme, monitoring was done by the Ministry of Health from inception until 1997. Since the consultant attached to the MOH left, no further reviews have been done. The scheme's computer program for monitoring crashed in 1997 and scheme has not been able to assess its own performance.

The CHF still relies to a large extent on the direction of the project coordinator in the MOH headquarters. However, districts do learn from each other's experiences. For example the district by-laws in Igunga district were changed to allow the collection of premiums to be the responsibility of the person in charge of the health facility rather than the ward executive officer when there was suspicion of misuse of funds. Singida Rural district has taken the cue from Igunga and is in the process of amending its by-laws.

The Chogoria scheme has been more proactive in recognizing problems and addressing them. They are more up-to-date with their management reports and can identify problems more easily. Major decisions have, however, been taken only with outside help. Such decisions have included: the revision of the scheme in 1995; delinking the scheme from Apollo Insurance Company in February 1998; and relaunching the scheme in 1999, after a market survey.

2.2.8 Sustainability and Replicability

This assessment criterion examined specific issues relating to how well the scheme is run and what institutional and administrative factors assure its survival. The factors included:

- ▲ Financial performance;
- ▲ Viability, i.e., examining the factors that jeopardize the viability of the scheme; and,
- ▲ External factors, e.g., harmonization with national insurance policies or other schemes.

Financial Performance

The three main schemes have not broken even financially; however, this is not always their objective. The Chogoria scheme's performance has only recently shown signs that it may become financially viable. The scheme aims at full cost recovery on the services rendered to scheme members. The Kisiizi and CHF schemes do not aim at full cost recovery. Kisiizi's stated objective is to raise no more revenue from scheme members than it would through its normal user fee program. The CHF aims to bridge the gap in government financing of health care. The inability of community-based health insurance schemes to attain full cost recovery is not peculiar to East Africa; similar experiences have been recorded elsewhere. In one study of 36 schemes from different parts of the world "all schemes relied on funds other than those received from premiums. Bwamanda Scheme [Zaire] stands out, with a cost recovery rate of about 80 percent. Cost recovery ratios are much lower in other schemes" (Creese and Bennett 1997).

Performance at Chogoria over the last three years is shown below in Table 7. This table shows the scheme's performance in terms of meeting its own costs; Table 4 earlier looked at the schemes' contribution to the overall health care financing for the facilities. The deficits incurred by the Chogoria scheme are absorbed by the hospital.

Table 7. Chogoria Hospital Insurance Scheme Financial Performance (in Ksh)

	1995/96	1996/97	1997/98	1998/99
INCOME	1,963,917	1,587,040	1,581,060	1,392,690
Claims	1,831,481	2,022,023	1,916,819	1,126,916
Direct Staff Costs*	174,455	191,900	211,090	232,200
Total expenditure	2,005,936	2,213,923	2,127,909	1,359,116
SURPLUS/(DEFICIT)	(42,019)	(626,883)	(546,849)	33,574
Cost Recovery %	97%	71%	74%	102%

*Figures based on two clerks working full-time in the scheme.

The CHF financial performance is more difficult to assess since there are so many facilities involved—26 dispensaries and health centers in Igunga district and 36 in Singida Rural district. The example in Table 8 uses one of the dispensaries to demonstrate the likely financial performance at the current premium levels. If the dispensary had to pay its way, it would not be sustained by the CHF funds. However, the government is committed to continue supplying all health facilities with drugs and staff. For the time being, therefore, the money generated from the CHF goes towards the purchase of additional drugs and maintenance of facilities and equipment. In assessing the success of the CHF, it is worth noting that any money currently being raised through the fund is "new money," i.e., it would not have been available were it not for the introduction of the fund.

Table 8. Ziba Dispensary Financial Performance, 1998 (in Tsh)

INCOME	
CHF membership fees	275,000
Cost-sharing fees	621,000
Matching funds	275,000
Total income	1,171,000
EXPENDITURE	
Drugs and medical supplies*	2,016,000
Staff costs**	2,040,000
Other costs (estimated)	Negligible
Total cost	4,056,000
Estimated deficit	(2,885,000)
Cost recovery %	29%

*Based on the cost of the Essential Drugs Program (EDP) Kit for dispensaries which costs Tsh 168,000 per month.

** Based on a staff complement of 5: Clinical Officer in charge earning Tsh 50,000 plus 4 nurses earning an average of Tsh 40,000 each per month.

The Kisiizi scheme has not fared much better (see Table 9). The scheme continues to make big deficits and has not been able to break even since inception. The level of claims in 1997/98 was higher than expected due to a malaria epidemic. The government contributed Ush. 10 million to the scheme in “compensation” for the excess claims arising from the epidemic. This is included under “Donations.” The claims shown in Table 9 are what the hospital has billed the scheme; this fee is not a full cost recovery fee.

Table 9. Kisiizi Hospital Health Society Income and Expenditure (in Ush)

	1996/97	1997/98
Income		
Premiums and co-payments	6,045,310	21,793,500
Donations	5,161,310	12,873,550
Total income	11,206,571	34,667,050
Expenditure		
Claims	9,319,910	36,019,661
Operating costs @ 250,000 per month	2,750,000	3,000,000
Total costs	12,069,910	39,019,661
Surplus/(Deficit)	(863,339)	(4,352,611)
Cost recovery %	93%	89%

* Estimated by MOH 1997.

It is important to bear in mind that, for all the schemes, despite their ability to recover up to 93 percent of their internal operating costs, the scheme revenue is still a small fraction of total operating costs of the health institutions (See above 2.2.1)

Viability

Factors that have jeopardized the viability of the schemes include the following:

- ▲ Management is not closely monitoring the use of health services by members and hence moral hazard is a real threat.
- ▲ The level of premiums may not sustain the level of service use by members. In the CHF, a primary assumption is that the government will continue to support the schemes through matching funds and the provision of EDP (Expanded Drug Program) kits to dispensaries and health centers.
- ▲ Internal controls over fraud need to be strengthened. Providers have the scope to misuse member names to obtain drugs for non-member patients.
- ▲ The schemes have not achieved much coverage of the community, hence the risk of adverse selection. Currently Chogoria and Kisiizi mitigate this risk by insisting that at least 60 percent join from any group.
- ▲ There is an absence of qualified staff to handle insurance matters professionally.
- ▲ Market surveys should be conducted to gauge consumer preferences and satisfaction with the scheme. Quality of care issues that are now being addressed, e.g., long waiting times for treatment, could have been dealt with earlier.
- ▲ Problems with data management are a threat to the survival of these schemes because without a sound information base, it will be impossible to make informed decisions.
- ▲ Government services within the catchment that charge nominal user fees can reduce interest in membership in mission facility based schemes, thereby hindering scheme viability.

External Factors

- ▲ Competition
 - △ There are plans to start a national health insurance scheme in Tanzania. It is expected that there will be no overlap between the National Health Insurance Scheme and the CHF because the national scheme will include (at least initially) only civil servants working in central government. Civil servants in the districts, who are employees of the Ministry of Local Government, will continue to be members of the CHF. Currently, the CHF membership comprises about 50 percent local government employees.
 - △ The mission hospital schemes face competition from public hospitals that charge nominal cost sharing fees. Potential scheme members may be discouraged from joining because they can afford to pay the cost sharing fees at government health facilities and if they do not get well, wait until they are too ill to be denied care and present themselves at the mission facilities.

3. Key Lessons Learned

This section summarizes lessons learned from the study of existing CBHI schemes. It first summarizes overall issues and then enumerates successes and shortcomings of the three major schemes looked at by the study.

3.1 General

- ▲ Community participation is important to the success of a community-based health insurance scheme. Such participation needs to be active so that the community has real empowerment in decision making.
- ▲ Failure in risk management is one of the greatest threats to the viability of the CBHI schemes.
- ▲ Provider staff require training to appreciate the need for the scheme so that they may handle the client/patient with the respect they deserve.
- ▲ Marketing to the community is very important. This is very important in the initial design of the scheme and should go on throughout the life of the scheme to ensure that membership levels are kept high.
- ▲ Underwriting of the initial losses by the government or a donor can help the scheme set low rates at the beginning but may also give a false sense of affordability to the community.
- ▲ Scheme design is critical to the successful implementation of a health insurance or prepayment scheme. Learning from existing schemes and improving on their design can assist in this process.

3.2 Scheme Specific

Kisizi Hospital Health Scheme

- ▲ The scheme has yet to prove that it is financially viable. Without the support it has received from the MOH, premiums and co-payments would only have covered about 55 percent of scheme costs. This would have been a serious drain on the hospital's scarce resources.
- ▲ There is a need for greater financial management support for the scheme from the hospital's senior management in terms of monitoring performance on a regular basis. Since the computer program crashed in 1997, no alternative reports have been designed for use while a new program is sought.
- ▲ Marketing of the scheme is the responsibility of the scheme staff. There has been a problem Engozi societies not able to meet the 60 percent membership enrollment. There seems to be no formal strategy for aggressive marketing in the community.

- ▲ The technical efficiency of the scheme is low. There is no evidence that the management have consciously thought through the issues involved in the management of risk, particularly moral hazard and cost escalation.

Chogoria Hospital Insurance Scheme

- ▲ The scheme has encouraged members to use the dispensaries as their first contact for health care unless the hospital is their nearest provider.
- ▲ Setting ceilings of cover has enabled the scheme to control the costs to the scheme. This has been possible because of the availability of a computer system for tracking utilization of services by members.
- ▲ The scheme has succeeded in controlling member fraud by requiring each policy holder to provide a photograph with all the insured persons for that family on it.
- ▲ A good cost analysis is important in setting premiums.
- ▲ The community has not been given the opportunity to participate in the decision-making processes of the scheme; the membership numbers appear to have suffered as a result of this omission.
- ▲ The scheme has not been an effective tool in raising finances for the hospital.
- ▲ The original objectives of the scheme have not been achieved. The incidence of bad debts has not decreased, nor have more people in the community been able to access health care at the hospital.

Community Health Fund

- ▲ The CHF is not functioning fully as an insurance scheme; it is more of a scheme for prepaid health care. Most of its income is derived from cost sharing and matching funds.
- ▲ There is need to be prepared to handle the data that will be generated out of a program like the CHF. Manual systems can only cope with minimal analysis of data.
- ▲ The scheme has not yet had significant impact on the generation of financial resources for health care. Membership in the scheme is too low (at about 5 percent of the community) to make much difference.
- ▲ The CHF can make a useful contribution in the financing of health care if it is only targeting the financing gap in the provision of health services. Currently, the CHF can pay for up to 25 percent to 74 percent of the cost of drugs in dispensaries and health centers.
- ▲ There is not much consideration given to technical efficiency of the scheme. Moral hazard and adverse selection are major problems. Approximately 80 percent of the household who have joined the CHF have six or more members and there is a flat rate per family.
- ▲ The scheme has had a favorable impact on the quality of health care delivered by the health facilities.

4. Conclusions and Recommendations

This section makes overall conclusions and then more specific conclusions in regard to the seven assessment criteria set out in Chapter 7. It makes recommendations according to each major scheme and then others aimed at health care policymakers and international donors in the East Africa region.

4.1 General Observations and Conclusions

4.1.1 General Observations

The CBHI schemes studied were introduced with inadequate management training in the critical aspects of an insurance business such as risk management and marketing. Some of the earlier design problems encountered have been corrected but serious financial management issues still remain to be addressed. External assistance has helped most of them to stay on track but there is need for internal capacity to be built up to deal with issues as they arise.

Key issues to be addressed include financial management training for scheme managers and development of risk management capacity within each scheme.

Community awareness has not led to wide membership as other external economic factors have also had a negative impact, e.g., famine in the region has made it difficult for many to spare the lump sum required to join the schemes.

4.1.2 General Conclusions

The schemes can be sustainable in the long term only if serious attention is paid to their design and management. Their current problems are not, however, a failure of the concept of health insurance and its applicability to low-income communities, but are due to difficulties encountered in the design and implementation of the schemes.

4.2 Specific Conclusions Related to Assessment Criteria

Resource Mobilization

- ▲ The schemes have not been able to make a significant impact in the mobilization of resources for health care financing. Due to the relative youth of most of the schemes, it is not possible to make definite judgments regarding their ability to contribute to the health care financing of the participating facilities.
- ▲ The structure of the contributions to the schemes does not pay sufficient attention to issues of equity; premiums are set as a flat rate for the only benefit package available (CHF, Kisiizi) or variable rates depending on the choice of benefit package (Chogoria).

Equity

- ▲ Membership in the schemes is open to those who can afford the premiums except in the CHF where there is an exemption policy for the poor; the mechanism for exemption is slow and not many poor have benefited from it.
- ▲ The use of health services by members of the schemes has been inequitable. The 5 percent or so who are members of the scheme consume up to 74 percent of the health care services; this was particularly so with the CHF.

Efficiency

- ▲ The impact of the schemes in the efficiency of health care delivery has been varied. On the one hand, they have encouraged the use of lower-level health facilities for first contact (this is particularly so in Chogoria), but, on the other hand, they have not been able to effectively address issues of risk management. The lack of control over use of health facilities by members results in heavy abuse and misuse of resources.
- ▲ The schemes have attempted with different methods to control the risk of adverse selection. The Kisiizi scheme does not accept any individuals; all must join as part of a group. Chogoria discourages individual membership by setting very high premiums but giving big discounts to group membership. The CHF does not pay attention to adverse selection.
- ▲ Cost control through the use of essential drug lists and standard treatment guidelines is not consistently practiced in the schemes visited. There is ongoing education of health providers to follow the guidelines.

Quality

- ▲ The schemes have had some impact on the quality of health care delivered to members. In the Kisiizi scheme, members have an opportunity of expression through their Engozi representatives during scheme consultative group meetings. Issues addressed tend to be more related to member satisfaction with the manner in which they have been served than in the quality of clinical services. In the CHF members are pressing for higher quality health care by asking for diagnostic equipment to be made available in all the facilities. Scheme members are also able to make proposals regarding the staff in the facilities.

Community Participation

- ▲ The level of community participation has been an important factor in the development of the schemes. In Chogoria, where the community is not involved in the design or the management of the scheme, it has been difficult to recruit large numbers. In Kisiizi, on the other hand, membership recruitment was easier due to the involvement of the community right from the beginning.

Solution Strategies

- ▲ The schemes do not have any formalized manner for handling problems. They have mostly depended on outside help (ministry of health consultants) to assist with any of the non-routine problems.
- ▲ There appears to be little capacity in the schemes to deal with management issues, especially those that have to do with the scheme as an insurance business.

Sustainability and Replicability

The financial viability of the schemes is in doubt due to the following factors which jeopardize their survival:

- ▲ Poor financial performance,
- ▲ Inadequate financial management procedures to address key areas such as internal controls over fraud by members and providers; and performance indicators;
- ▲ Lack of risk management techniques to prevent, in particular, moral hazard and adverse selection. Cost escalation due to clinician prescribing practices has been detected but the extent is not known; and,
- ▲ The schemes do not appear to pay much attention to marketing the product to the community.

The schemes have been designed in such a way that they can be replicated without need for much modification. The Chogoria scheme was replicated in Kisiizi and the CHF has now been replicated in nine districts after the initial pre-test district.

4.3 Recommendations

4.3.1 Scheme Specific

Kisiizi

- ▲ The financial viability of the scheme requires urgent attention. It is important that premiums are set on the basis of good cost analysis and sound assumptions regarding use of hospital services by scheme members.
- ▲ The scheme needs to be run under sound business principles to ensure its sustainability. Financial management procedures should be designed to monitor the scheme's performance and to keep management aware, at least on a monthly basis, of the key financial indicators. Such indicators would include: utilization of services per member, if possible, per group/Engozi; scheme bank balances; outstanding claims (number and value).
- ▲ The scheme requires more aggressive marketing to keep existing members and recruit new groups to join. The loss of an Engozi society due to inability to achieve the 60 percent group threshold is a big blow to the scheme.
- ▲ Risk management techniques require strengthening. It is vital that the scheme controls the use of services by members. At the same time the hospital should adopt the most cost-effective treatment methods in order to keep costs down.

Chogoria

- ▲ The scheme requires more aggressive marketing than the staff can probably handle on their own. In the recent market survey, only 12 percent of the people interviewed were aware of the scheme. The use of outsiders (insurance agents) to help in marketing is worth considering.

- ▲ The failure to involve the community may be one of the reasons for the low popularity of the scheme. A way needs to be found to involve the community in the decision-making processes of the scheme. The scheme could borrow an idea from Kisiizi where they have a consultative group made up of scheme/hospital and community members.
- ▲ The scheme has not tried to entice members to join by packaging the benefits in an attractive manner. It would make business sense to try and give scheme members something that they value apart from the health care. For example, members queue with everybody else and are not given any preference for the services they receive. Some have complained about these waiting times, and this is something that could be addressed easily. It is important to start using satisfied members as part of the scheme's sales team in the community.
- ▲ The hospital is in the process of relaunching the scheme under a new name, but with a similar benefit structure as before. The expectation is that this scheme will be more successful than the previous two attempts. The question of staff capacity should be addressed in order for the scheme to be run more professionally, in terms of day-to-day management and marketing.

Community Health Fund

- ▲ Data management is going to become a major problem if not addressed early enough. The volume of data is such that manual processing may not be possible for long. The design of the reports should therefore be such that only critical information is reported. Alternatively, there should be a computer for data analysis at the district headquarters.
- ▲ Marketing should be more aggressive to increase the membership. This will also help to minimize the risk of adverse selection.
- ▲ Risk management requires urgent attention. Currently members are overutilizing the health facilities. The possibilities of facility staff misusing drugs in the name of CHF members exists due to the absence of proper internal controls to prevent this.
- ▲ There are indications that some poor people are being denied necessary health care due to the introduction of user fees and the CHF. Evidence of this is the seriousness of illnesses now presenting at the health facilities. No study has been conducted to examine the state of wellness of people in the community.

4.3.2 Government Policy

- ▲ The governments in the region should provide the policy framework within which schemes can be formed. They should amend existing laws, where necessary, so that CBHI schemes can be formed without fear of conflict with other insurance law.
- ▲ Provide the regulatory framework for schemes to ensure that members' interests are protected.
- ▲ Provide technical support to those wishing to form new schemes.

4.3.3 Donors

Donors should provide targeted technical assistance to develop the managerial capacity within the schemes to be capable of running an insurance or prepayment business.

4.3.4 Areas Which Would Benefit from Technical Assistance and Training

- ▲ Training in the management of an insurance scheme.
- ▲ Training in the use of treatment guidelines/protocols as well as in the assessment of existing guidelines for cost effectiveness.
- ▲ Cost analysis to set premiums based on actual costs so that the value of any subsidies/discounts given is clearly identified.
- ▲ Development of a manual for setting up CBHI schemes, including tools for management information, taking into account existing materials.

4.4 Possible Areas for Further Investigation

- ▲ Impact on the poor: Health care financing reforms have had an impact on the ability of patients to have access to necessary health care. The impact on the poorer members of the community has not been fully investigated.
- ▲ Demand for health insurance package: How does competition with the public-sector delivery of health care impact on the ability of hospital-based schemes to recruit members? It has been speculated that lack of membership in insurance schemes could partly be due to the low prices of public-sector pricing of services. Other reasons include the package of benefits.
- ▲ Impact of CBHI schemes on CBHC/preventive health services.
- ▲ Social dimensions of the scheme, particularly reinforcing community cohesion.

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Annex A. Kisiizi Hospital Health Society

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1. Findings

1.1 Basic Information About the Scheme

1.1.1 General

The Kisiizi Hospital Health Society (KHHS) is a project of the Kisiizi Hospital. The Kisiizi Hospital is a rural, Church of Uganda mission hospital in Rukungiri district of southwestern Uganda, founded in 1958. The hospital has a catchment area with a population of 100,000. The majority of the people living in the area derive their livelihood from agricultural production of food crops and rearing of cattle. The hospital provides a wide range of health services within the hospital itself and through its community-based health care program. In 1998, 58,361 outpatients were treated—43,566 of them at the hospital and the rest in the community clinics—and 11,909 patients admitted for inpatient care. The hospital has 180 beds in six wards.

The causes of morbidity for five-year olds and over are as follows, in order of importance: malaria; pulmonary tuberculosis; pneumonia; immunosuppressive syndrome; trauma; diarrhea; dysentery; congestive cardiac failure.

The Minister of Health launched the KHHS scheme in August 1996. The following factors motivated the formation of the scheme:

- ▲ Reduced patient attendance, partly due to the high hospital fees;
- ▲ Failing economy leading to poor incomes;
- ▲ High patient debts. Many of these are for inpatients who come for lengthy and expensive treatment often after trying other providers; and,
- ▲ Demand for high quality health care.

The objectives of the scheme are to:

- ▲ Improve access to health care for the local communities; and,
- ▲ Provide a stable source of funding for the hospital and reduce its problem of bad debts.

The scheme was built around the existing social structures of the Engozi societies—these are local burial and ambulance societies to which about 96 percent of the community belong. “The “engozi” is a hand-carried stretcher. It can be owned by an organized group/society or by an

individual. Engozi societies cover burials and transport of ill members; many often have a loan scheme or income generating projects.”¹

The reasons for choosing the Engozi societies were that:

- ▲ Most people in the district are members of an Engozi society;
- ▲ The idea of insuring against a future eventuality was not new to them; and,
- ▲ No other suitable groups could join the scheme (e.g., large employers).

The scheme has grown since it was started and as of February 1999 has a membership of 6,580 individuals drawn from 32 Engozi societies. Its growth, however, has been slow since the data management computer program crashed in 1997. (A new program has been developed and will be available in mid-March 1999.)

The scheme’s key achievements to date are:

- ▲ Recruitment very quickly surpassed the original targets, as the scheme proved popular with the community. During the first year of operation, the target was for 3,000 members (in 500 households) but the actual enrollment was about 4,000;
- ▲ Cost recovery has been at the same level as would be achieved using user fees, at about 50 percent; and,
- ▲ Membership renewal has been good as most members express satisfaction with the scheme.

There have, however, also been major problems with the implementation of the scheme. The key ones have been:

- ▲ The scheme computer program crashed as a result of a virus plus other hardware problems in 1997. It took a long time to get the computer operational again and the scheme program was not re-installed, as there was no back-up copy. The hospital is waiting for a new (and better) program to be available in mid-March 1999.
- ▲ The attitude of some hospital staff was negative towards scheme members. Members were misconceived as not paying properly and this led to strained relations between members and staff. This problem is now being resolved and the staff are more positive about the scheme.
- ▲ Some Engozi groups have had to be excluded from the scheme for failing to reach the 60 percent enrollment threshold. Twelve groups have so far dropped out, leaving 32 active groups.

Legal Framework

The scheme is recognized and supported by the Ministry of Health. It is not yet clear how the schemes in Uganda are viewed by the Commissioner of Insurance. The Uganda Community Based Health Financing Association is in the process of clarifying this and other legal issues on behalf of all the member schemes.

¹ Claesson, Rosana, Allen Ashaba-Magezi; J. Arube-Wani and H. Lwanga. *Kisiizi Hospital Baseline Survey Report*. Child Health and Development Center, Makerere University, 1996.

Initial Assumptions and Premium Rates

The following were the initial assumptions:

- i One outpatient visit per member per year
- ii Cost per outpatient visit – Ush. 2,100 (US\$ 1.5)
- iii Members requiring inpatient care – 6 percent per year (including deliveries)
- iv Median cost per inpatient stay – Ush. 22,000 (US\$ 16.3)
- v Membership mix – Children: Adults 1:1; Average family size – 5.9 individuals

Based on the above assumptions, premium rates were set at:

Family size	3-Month Premium	Annual premium
1 – 4 members	3,000	12,000
5 – 8 members	4,500	18,000
9 – 12 members	6,000	24,000
Every additional member	1,200	4,800
Outpatient co-payment	500	
Inpatient co-payment	1,000	

Based on the above assumptions, a family of six individuals would need to pay Ush. 20,520 annually. Instead they paid Ush. 18,000.

1.1.2 Operating Guidelines

The following documents are available:

- i. Baseline survey report.
- ii. Ministry of Health and Kisiizi Hospital agreement.
- iii. Outline of scheme description defining:
 - ▲ Membership criteria for Engozi groups
 - ▲ Waiting period
 - ▲ Exclusion
 - ▲ Identity card system
 - ▲ Premiums
 - ▲ Co-payments
 - ▲ Definition of cover
 - ▲ Accountability
 - ▲ Payment mechanism
- iv. Procedure guide for scheme patients and staff on how to handle scheme patients in hospital.

An operational manual has not yet been compiled from this information. The scheme relies on the knowledge of the staff who have been involved since its inception who know the procedures of processing claims. The manual that exists is that of the Chogoria Hospital Insurance Scheme on which the KHHS was modeled.

Data Management

The scheme is not processing any detailed data on a regular basis. The system presently in operation is manual, awaiting the installation of the newly developed computer program.

1.1.3 Benefits Package and Premiums

Members have only one choice of benefits package. The current benefits package covers the following:

- ▲ Outpatient and inpatient care at Kisiizi Hospital and outreach clinics;
- ▲ Chronic diseases, provided the patient attends regular clinics for their disease; and
- ▲ Delivery, as long as the woman is referred to the hospital for delivery due to high risk of abnormal delivery. The woman must also have attended antenatal care at least three times.

Members pay only the co-payment fee on attending the hospital. The balance of their treatment charges is paid directly to the hospital by the scheme.

Exclusions

The scheme excludes:

- ▲ Eye glasses
- ▲ Cosmetic dental care
- ▲ Cosmetic surgery
- ▲ Ambulance
- ▲ Private rooms in ward
- ▲ Self-inflicted injuries/problems
- ▲ Referral to other providers
- ▲ Transporting bodies for burial

Premiums

The minimum membership period is three months. The premium rates per the three-month period are shown in Table A-1:

Table A-1. KHHS Premiums

Family size	Premium 1996	Premium 1997/98	Premium 1999*
1 – 4 members	3,000	4,500	4,500
5 – 8 members	4,500	6,000	6,000
9 – 12 members	6,000	7,500	7,500
Every additional member	1,200	1,500	1,500
Co-payments			
Outpatient – normal working hours	500	700	1,000
Outpatient – outside normal working hours	1,000	1,500	1,700
Inpatient	1,000	2,500	3,500

*The necessary adjustments to meet the deficits of 1998 were addressed through an increase in co-payments only with no change in premiums. This was done at the members' request.

Joining Procedures

Groups wishing to join the scheme apply for membership. Meetings are held to teach the prospective group the scheme rules and regulations. It is the responsibility of the group to collect premiums and remit them to the scheme. Scheme staff check against the groups records to ensure that only the group's members have been allowed to pay the premiums and that at least 60 percent of the members have paid. The new members must wait for two weeks before cover commences. This is to stop people joining the scheme when they have just fallen sick.

1.1.4 Marketing

The KHHS conducts its marketing activities primarily targeting the officials of the already existing groups in the community, particularly the Engozi societies. Once the Engozi societies join the scheme, they do most of the marketing to their members in terms of encouraging those who have not joined to do so, as well as collecting premiums. The scheme targets the Engozis since it is estimated that over 96 percent of the population belong to an Engozi society. This helps in recruiting large groups of people and hence reduces the risk of adverse selection. The Engozi members do not all join and, therefore, the risk is not totally eliminated. However, there is a requirement that no group will be accepted into membership unless at least 60 percent of the members enroll.

The scheme conducts education meetings to help prospective members gain a basic understanding of health insurance. The hospital has a community-based health care program and this provides the framework in which most outreach for the scheme takes place.

The way the scheme has been sold to the community is such that the scheme should be seen as an extension of the services that the Engozi societies provide to their members. Already some Engozis are involved in some forms of microfinancing, where they advance small soft loans to their members. Helping members with health care was seen as a natural growth for the Engozis. The scheme does not give any incentives to those involved in marketing.

A baseline survey was conducted in 1996 before the launch of the scheme.² The objectives of the survey were to obtain household and hospital data on: expenditure on health care, health service utilization, prescribing patterns, and the hospital's financial position.

Claim Experience Since Inception

The following table shows the development of claims since the scheme started.

Table A-2. Claims Experience 1996 to 1998

Period	Inpatient		Outpatient	
	Actual	Target	Actual	Target
August 1996–January 10, 1997	30	23	211	383
January 10, 1997–April 10, 1997	53	59	393	984
April 10, 1997–December 1997	Data not available			
January 1998–September 1998	794	294	2,952	4,935
October 1998–December 1998	153	99	960	1,645

1.1.5 Membership

Membership is currently only open to those who wish to join as a group. There are now 32 active groups (all of them Engozi societies) enrolled in the scheme. These consist of 1,400 households, representing 6,580 individuals.

The hospital's catchment has a population of about 100,000. These are predominantly rural agricultural people, many of them subsistence farmers. The present membership represents 6.5 percent of the population. The initial target was to enroll 500 families in the first year. This was easily exceeded due to the popularity of the scheme.

1.1.6 Management

The KHHS falls under the Community Based Health Care (CBHC) Department. The staff of the scheme report to the head of this department. The scheme has two full-time staff. A consultative group made up of the chairmen of the enrolled Engozi societies, the scheme staff, and representatives of hospital management meets to review premiums and to address any problems that members may be encountering. The Engozi chairmen are knowledgeable people, most of whom are trained CBHC workers. They have a good working relationship with the hospital. Their involvement is voluntary as they see the scheme representing an extension of the services their Engozis provide to members.

The agreement between the hospital and the Ministry of Health at the inception of the scheme was that the Ministry, through funding from the British Department for International Development (DfID), would underwrite the losses of the scheme for the first year of operation up to a maximum of Ush. 18,000,000 (US\$13,300: \$=Ush 1,350). The Ministry has also implicitly accepted responsibility for losses arising due to epidemics. A malaria epidemic in 1998 cost the scheme Ush 8.5 million; a reimbursement has already been received from the Ministry.

The Kisiizi Hospital is a member of the Uganda Protestant Medical Bureau. The scheme is a member of the newly formed Community Based Health Financing Association. The Ministry of

² Claesson, Ashaba-Magezi, Arube-Wani and Lwanga, p. A-2.

Health is actively involved in supervision of the scheme through its Planning Department. The Ministry was involved in the formation of the scheme.

1.1.7 Community Participation

The community has been involved in the design and implementation of the scheme. During the design of the scheme, meetings were held in the community with officials of the Engozi societies to educate them on the basic principles of insurance and also to involve them in the decision making process. They were given the opportunity to make recommendations about the premiums, how they should be collected and what the minimum membership period should be.

The community is still involved in the management of the scheme through the Engozi leaders. Regular consultative meetings are held between them and the scheme administration. The community has been supportive of the scheme because of the benefits they derive from it. Benefits that were cited by members of the community interviewed included:

- ▲ Assurance of receiving health care throughout the year, even when the head of the household is away.
- ▲ Health education on prevention of disease.
- ▲ Good quality health care.

The following were seen as the major drawbacks of the scheme:

- ▲ High co-payments after working hours.
- ▲ Delays in the processing of members' "claim" so that they can collect drugs from the pharmacy.
- ▲ Exclusion of new members until the beginning of the following scheme quarter.
- ▲ Lack of any payment (not even lunch or travelling allowance) to officials of the Engozi society when they attend meetings of the scheme.
- ▲ Lack of coverage for uncomplicated maternity cases. The community would like to have this benefit included in the package even if they have to pay "a little" more.
- ▲ Lack of sufficient staff. Hence, service to members is sometimes slow when the key staff are away.

The community considers the scheme as an extension of the services they receive from their Engozi societies. They therefore see it as a community initiative and support it.

1.1.8 Relations with Service Providers

The hospital management administers the scheme and hence there is no clear separation between it and the hospital. The hospital and its clinics are the only providers recognized by the scheme and due to the scheme being seen as part of the hospital, there is no contractual arrangement between the hospital and the scheme.

Staff in the hospital are now more receptive towards scheme members after a series of meetings to help them understand why the scheme was necessary. There were problems when staff attitude was very negative towards scheme members.

No other health care providers have been contracted to serve scheme members.

1.1.9 Relations with Government and Other Social Groups

The scheme has been helped and supervised by the Ministry of Health since its design and implementation. The Ministry provide technical assistance under the DfID-funded Community Health Financing Project and also signed a memorandum of understanding with the hospital in which it undertook to underwrite any losses incurred by the scheme in the first two years, up to a maximum of Ush 18,000,000 (US\$ 13,300). The Ministry also provided computer equipment and peripherals for use by the scheme.

The Ministry of Health Planning Unit still maintains an interest in the progress of the scheme. The Ministry plans to conduct an evaluation of the scheme in 1999.

The Kisiizi Hospital is a member of the Uganda Protestant Medical Bureau, which is also interested in the progress of the scheme. The newly formed Uganda Community Health Financing Association is a coordinating body which aims to bring together all the various groups that have been implementing similar schemes. KHHS is a member of this organization.

1.1.10 Financial Data

The scheme's financial performance for the two years it has been in operation is shown in Table A-3.

The scheme does not prepare a separate set of financial statements. All its transactions are recorded in the hospital's books of account. There is a monthly review of its overall financial performance by the hospital management. The only detailed reviews that have been done were by the Ministry of Health.

Table A-3. KHHS Income and Expenditure

	1997/98 (Ush.)	1996/97(Ush.)
Income		
Premiums and co-payments	21,793,500	6,045,310
Donations	12,873,550	5,161,310
Total income	34,667,050	11,206,571
Expenditure		
Claims	36,019,661	9,319,910
Operating costs @ 250,000 per month	3,000,000	2,750,000
Total costs	39,019,661	12,069,910
Surplus/(Deficit)	(4,352,611)	(863,339)

*Estimated by Ministry of Health. "May 1997. Review of Kisiizi Health Society." Health Planning Dept. MOH.

1.2 Assessment of Performance

1.2.1 Resource Mobilization

The KHHS has not yet been very successful in raising resources to finance health services. Compared to the hospital's total revenue from patient fees the scheme income accounts for only about 8 percent in 1997/98.

The scheme aims to raise the same amount of money per patient served as would have been realized through the existing user fee program; i.e., it does not budget for a surplus. It is on this basis that premiums were based on the hospital's fee schedule at the time. The hospital does not charge for full cost recovery for some services, especially inpatient care. As seen in Table A-4, in 1998, patient fees accounted for 98 percent of hospital operating costs, but 73 percent when administration overheads are included.

Table A-4. Scheme Income vs. Hospital Income and Expenditure

	1997/98 (Ush.)	1996/97 (Ush.)
Hospital Income		
Patient fees	324,328,164	216,595,700
Donors	287,090,348	200,652,220
Other	38,123,102	32,048,300
Total	649,541,614	449,296,220
Expenditure		
Operating costs	329,152,472	259,517,637
Administrative costs	117,953,660	62,023,034
Other costs including projects	115,442,243	126,032,754
Total	562,548,375	447,573,425
Surplus	86,993,239	1,722,795
Scheme premiums and co-payments	21,793,500	6,045,310
% of hospital operating costs	6.6%	2.3%
% of hospital patient fees	6.7%	2.8%

1.2.2 Efficiency

The hospital delivers health services primarily through its outpatient and inpatient departments, but also has a community-based outreach program.

The hospital endeavors to keep its health services as affordable as possible for the local community. However, the fees are still prohibitively high for many. Efforts to subsidize fees include fund raising from friends overseas and income-generating projects.

It was not possible to obtain historic data on the volume of primary health care services. We could not, therefore, investigate the impact, if any, of the scheme on the demand for such services.

Technical Efficiency

The scheme has been designed with a view to minimizing the risk of adverse selection. This is achieved by requiring that only whole families may join, that any Engozi group joining the scheme must enroll at least 60 percent of its members, and that the group must have documentary evidence of being in existence for at least three years. This ensures that not just the sick join the scheme. However, this still leaves scope within joining the group for the sickly to be the majority in the 60 percent of those who join. There is no checking of pre-existing conditions before joining. However, those suffering from chronic illnesses must regularly attend the hospital clinics for their illness.

The level of utilization of hospital services by scheme members is not monitored closely. Studies during the first year of the scheme indicated that members were not using services as much as had been assumed at the design stage. An analysis of usage is given below in Section 1.2.3. When members present themselves for services, there is no checking to see how often they have been to the hospital so far in the scheme year.

The hospital's policy on cost control is not clear. It has its own locally developed treatment guidelines but does not use the Uganda National Treatment Guidelines. The hospital purchases most of its drugs from the Joint Medical Store, which operates under the National Essential Drugs List.

Through consultation with the Engozi group chairmen, the scheme has some influence on the hospital's manner of service delivery and on the cost of services to members.

The scheme covers outpatient and inpatient care with no cost ceiling at the hospital and its outlying clinics, leaving open the possibility of cost escalation.

The use of hospital services by members has not been as high as was initially expected. However, inpatient admissions, over which the hospital has greater control, were higher than targeted.

Table A-5. Claims Experience

Period	Inpatient		Outpatient	
	Actual	Target	Actual	Target
August 10, 1996 to January 10, 1997	30	23	211	383
January 10, 1997 to April 10, 1997	53	59	393	984
April 10, 1997 to December 1997	Data not available			
January 1998 to September 1998	794	294	2,952	4,935
October 1998 to December 1998	153	99	960	1,645
Total outpatient visits by scheme members—Adjusted			6,842	12,041

The initial assumptions regarding utilization of services were that each individual member would make one outpatient visit and that 6 percent of members would require inpatient treatment. Based on the 1998 membership, 6,580 per year outpatient visits would have been by members; total curative outpatient visits in 1998 were 18,353. The target utilization by members was therefore close to 36 percent of outpatient curative services. The actual number of outpatient visits by members was 3,912 or 21 percent of all outpatient curative visits. Given that only about 6.6 percent of the population are enrolled in the scheme (6,580 out of a population of 100,000), this level of utilization looks quite high.

1.2.3 Equity

The contributions to the scheme are fixed but the total premium per household depends on the family size. There is no consideration for equitable contributions based on level of income. The scheme is for those who can afford it. Access for the poor has not been considered. The premiums are fixed and no special consideration is given to the poor and those who live far from the hospital.

1.2.4 Quality

Members express satisfaction with the scheme. Those interviewed cited the following as the key benefits:

- ▲ Once a group has paid, people are not worried about paying for their sickness. Members readily accept to be admitted for inpatient care. Formerly people would ask for time to organize finances once a clinician proposed admission.
- ▲ Members are being taught preventive measures against diseases.
- ▲ The hospital gives good reception and treatment to members.

The reasons for dissatisfaction include:

- ▲ Misunderstanding about insurance; some members who experience no illness and make no claims during the quarter expect refund or “no-claims bonus” against the following year’s premiums;

- ▲ Bad treatment by some staff members;
- ▲ The poor's lack of access because they cannot raise the money to join;
- ▲ High co-payments after working hours;
- ▲ Delays in collecting drugs after the prescription is given; and,
- ▲ Delay of coverage eligibility for new members in the community once the Engozi society has made the quarterly payment.

Meetings are held with the officials of the member Engozi societies to review the scheme's progress. Quality of care problems are discussed during these meetings. Some issues, for example staff attitude, have been dealt with and resolved.

1.2.5 Management

The management of the scheme is not separate from the management of the hospital. The scheme has not had employees with an insurance background, and the clerks who are involved in the day-to-day running of the scheme have learned the rules to the scheme without a good understanding of the insurance principles that are important for its viability. There are plans to train the scheme staff on a new computer program that will replace the one that was lost when the computer crashed.

The hospital has a computerized financial accounting system. The KHHS is treated as a cost center in the chart of accounts, although all relevant costs of running the scheme are not captured; for example, the staff costs and other overheads are not allocated to the scheme. The hospital's system of internal controls and all other financial management procedures also apply to the scheme. The scheme receipts and payments are audited during the hospital's annual external audit.

The scheme falls under the Community Based Health Care program of the hospital but also receives input from the administrator/finance manager of the hospital. Given the absence of detailed data analysis it would appear that the scheme would benefit from more attention from senior management of the hospital.

1.2.6 Community Participation

The KHHS has involved the community right from the beginning. The idea of the scheme was introduced to the community as an extension of the services of the Engozi societies. The officials of the Engozi societies were involved in the decision-making process and were trained in the concepts of health insurance. They were asked for their input regarding the premium periods and manner of collecting premiums from members and were also involved in reviewing the scheme rules. Many of the leaders of the Engozi societies are community health workers by profession; they received the idea very well because it was introduced by the hospital's community-based health care program officers, people with whom they had worked before.

The involvement of the community at an early stage made it possible for the scheme to find acceptance with the community; aspects of the scheme which would otherwise have been more difficult to accept, e.g., co-payments, were also accepted.

The Engozi societies are responsible to collect membership fees from their members. They ensure that members renew in time and that the group reaches the 60 percent requirement for eligibility.

A consultative group composed of members of the hospital/scheme administration and officials of the Engozi societies who are members of the scheme meets from time to time to review the operations of the scheme. The community thus can voice any problems they have experienced and the scheme can communicate any new decisions which may affect member satisfaction, e.g., change in premiums.

1.2.7 Solution Strategies

The scheme responds to changes as they occur through the hospital management team, and, if appropriate, in consultation with the Consultative Group of the hospital and the Engozi societies.

1.2.8 Sustainability and Replicability

The scheme has been pre-tested for just under three years. Considering it was the first such scheme in the country, its financial performance has been adequate, despite the fact that it has not yet managed to break even.

The factors that have jeopardized the viability of the scheme have included:

- ▲ A malaria epidemic that resulted in higher than usual inpatient utilization.
- ▲ The crash of the computer system, which made it difficult for management to keep track of membership details and utilization of services.
- ▲ Negative staff attitude towards the members of the scheme, considering them a nuisance because they did not follow the traditional routines of the hospital and were seen as not “paying their way.” It was necessary to hold seminars for staff to educate them on the procedures to be followed by scheme members and the benefits of the scheme to the hospital.
- ▲ Difficulty for some Engozi societies to achieve the 60 percent threshold required for membership. This has necessitated four such groups to be denied renewal of their membership.
- ▲ Unnecessarily high costs to the scheme due to overprescribing by some doctors to members. This has meant that any benefit that would have been realized due to members presenting early in the hospital for treatment (therefore receiving first line, less costly treatment) is masked by the higher costs of the drugs prescribed.
- ▲ Lack of detail in the scheme’s financial accounting, obscuring the true picture of its financial performance. The hospital is hoping to introduce a new computer program which will process all patient bills so that scheme members are billed promptly (through the scheme) and such costs reflected in the scheme accounts. There will still remain a problem with regard to capturing all the costs of running the scheme; currently the hospital administrative costs are estimated at Ush. 250,000 per month.

2. Key Lessons Learned

The KHHS has been in operation now for just under three years. During this time it has learned some valuable lessons:

- ▲ Community participation in the design and implementation of a CBHI is vital; this participation enables the community to view the scheme as part of their initiatives in managing their own health care. Community education in the basic principles of insurance will enable them to participate knowledgeably. Many in the community are unable to differentiate the premiums from savings—they believe that the money they have paid will be available as long as they have not used it up.
- ▲ The computer program that the scheme borrowed from another hospital was good but not easy to fix in the event of a problem. It is important that any program is in computer language that is widely used. Data management is critical to ensure the safety and integrity of data. When the computer crashed, data that had not been backed up was lost. Alternative data processing methods should be available should the need arise, so that management information flow can be maintained.
- ▲ Provider staff should be made fully aware of the scheme operations and its benefits to the hospital and community. Without their support, the scheme may not attract and keep sufficiently large numbers of members to be viable.
- ▲ Underwriting the initial losses by the government was useful to get the scheme set up. The support of the Ministry of Health in dealing with the malaria epidemic of 1998 also demonstrated the need to involve the Ministry in the design and implementation of the scheme.
- ▲ There is a need for skills in management of community health insurance before inception of the schemes.

3. Conclusions and Recommendations

3.1 Conclusions

The following conclusions can be drawn from the analysis of the KHHS.

- ▲ The scheme has yet to prove that it is a financially viable proposition but the trend is encouraging with the possibility of breaking even in 1999. However, without the support it has received from the Ministry of Health, premiums and co-payments would only have covered about 55 percent of scheme costs and it would have become a serious drain on the hospital's scarce resources. This shows the importance of taking a long-term (five-year) view when setting up the schemes.
- ▲ There is inadequate financial management support for the scheme for the hospital's senior management in terms of monitoring of performance on a regular basis. Since the computer program crashed, no alternative reports have been designed for use while a new program is sought.
- ▲ Marketing of the scheme is the responsibility of the scheme staff assisted by the Engozi officials. There has been a problem with some Engozi societies not able to meet the 60 percent membership enrollment.

3.2 Recommendations

3.2.1 Scheme Specific

- ▲ The financial viability of the scheme is not yet proven. It is important that premiums are set on the basis of good cost analysis and sound assumptions regarding use of hospital services by scheme members.
- ▲ The scheme needs to be run under sound business principles to ensure its sustainability. Financial management procedures should be designed to monitor the scheme's performance and to keep management aware, at least on a monthly basis, of the key financial indicators. Such indicators would include utilization of services per member, if possible; per group/Engozi; scheme bank balances; and outstanding claims— number and value.
- ▲ The scheme requires more aggressive marketing to keep existing members and recruit new groups to join. The loss of an Engozi society due to inability to achieve the 60 percent group threshold is a big blow to the scheme.
- ▲ Risk management techniques require strengthening. It is vital that the scheme controls the use of services by members. At the same time the hospital should adopt the most cost effective treatment methods in order to keep costs down.

3.2.2 Government Policy

Assist with defining legal framework within which the CBHI schemes can operate without conflicting with other insurance laws.

3.2.3 Donors

- ▲ Provide targeted technical assistance to provide the managerial capacity required within the scheme.
- ▲ Management tools for monitoring the performance of the scheme.

3.2.4 Areas Which Would Benefit from Technical Assistance

- ▲ The capacity for the hospital to set premiums and conduct the necessary level of market research and marketing may be limited. Assistance in marketing and in the review of premiums would assist the scheme.
- ▲ Financial management procedures to ensure that the scheme is run in a business-like manner are necessary and they are not within the hospital's expertise to develop them.

Annex B. Chogoria Hospital Insurance Scheme

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1. Findings

1.1 Basic Information About the Scheme

1.1.1 General

The Chogoria Hospital Insurance Scheme (CHIS) was initiated by the Chogoria Hospital in 1991. This mission hospital, under the Presbyterian Church of East Africa, offers a comprehensive range of health care services at the hospital and in 31 community dispensaries. It is situated in Meru district in central Kenya and serves a population of 450,000, mainly subsistence farmers with some coffee and tea also. Some statistics for 1998 are listed here:

Beds	312
Admissions	8,703
Bed occupancy	78%
Outpatient attendance	44,914
Major operations	1,139
Minor operations	3,018

The community dispensaries attended to 183,317 curative and preventive patient visits and gave 35,590 immunizations. The top 10 causes of death in the hospital patients have been as follows in order of importance: malaria; pulmonary tuberculosis; anemia; heart failure; hypertension; pneumonia; hepatitis; carcinoma of stomach; septicemia; bronchopneumonia.

The CHIS was started with an arrangement between the hospital and an insurance company. The insurance company agreed to offer health insurance cover to patients attending the hospital. The hospital would act as an agent in the collection of premiums and in marketing the scheme, but would also help in controlling costs by using cost effective health care delivery methods and controlling utilization.

The original objectives of the scheme were:

- ▲ To reduce the number of patients leaving the hospital with unpaid hospital bills, only 10 percent of which ever get recovered; and
- ▲ To allow those with low (and irregular) incomes in the community to receive services at the hospital.

No information is available regarding the scheme's original assumptions. It appears that the burden of assessing the adequacy of the premiums was left to the insurance company.

Membership growth was slow in the first two years, but in 1993 the scheme gained wide popularity, enrolling many hospital employees and also members of the community. Membership climbed to 1,682 members, representing 7,746 individuals. However, the scheme showed a net financial loss for its first four years, a loss that was shared between the hospital and the insurance company; and,

In 1994, there was evidence of excessive utilization by members. Changes were made to the scheme to make it more viable: scheme rules, premiums, and benefits were adjusted. Nevertheless, several problems continued:

- ▲ Adverse selection: the scheme was not adequately marketed, so it failed to attract groups. Instead it enrolled individuals and families, without making a serious attempt to screen joining members for pre-existing conditions;
- ▲ Moral hazard: overutilization of services forced the scheme into serious liquidity problems;
- ▲ High treatment costs: clinicians were prescribing too many drugs.
- ▲ Fraudulent claims by members: this was particularly a failure of the hospital to identify members' dependents; and,
- ▲ Relaunching of the scheme early in 1995: numerous changes attempted to make it more viable. Scheme rules were adjusted and premiums raised considerably.

Premiums were set in 1995 with the following assumptions:

- ▲ Outpatient utilization four times per member per year;
- ▲ Average charge per outpatient visit of Ksh.109;
- ▲ Inpatient utilization of 0.025 admissions per member per year;
- ▲ Average charge per inpatient of Ksh.422 per day; and,
- ▲ Administration costs 8 percent of total direct costs.

For the 1995/96 year, the scheme broke even financially, but membership fell drastically, to 424 members representing 2,340 individuals. In 1996/97 and 1997/98, the scheme lost money. For the 1998/99 year, membership fell to 307 members—all of the employees of the hospital—representing 1,494 individuals. The scheme again broke even, excluding administrative costs.

After eight years of operation (1991 to 1998), the CHIS had not met its original objectives. There was little impact, if any, on the incidence of bad debts on patient bills owed to the hospital. Although the scheme has been able to assist most of the hospital's employees by allowing them to enroll their families, poor members of the community (unemployed or with irregular income) have not joined the scheme. In other words, those people who would have found it difficult to pay their hospital bills still did not join the insurance scheme.

1.1.2 Operating Guidelines

As of the end of 1998, the scheme has a set of operating guidelines for staff, developed with assistance from the Ministry of Health through the Kenya Health Care Financing Project. Brochures are available to members, setting out the benefits and related premiums. Training of service providers and scheme staff has been ongoing, especially since 1995 when the new scheme was relaunched.

1.1.3 Data Management

The scheme has a computer program that analyzes member information and utilization of services, and also prepares claims for the hospital. It can generate various reports for management use. The scheme data is frequently backed up. There is adequate support from the hospital's own Management Information System department in case of any problems.

1.1.4 Marketing

The hospital did not carry out any formal market research before launching the scheme in 1991. Marketing efforts after the relaunch in 1995 did not bear much fruit as the target groups did not respond with the enthusiasm anticipated. In 1998, marketing was undertaken by the hospital staff, none of whom was specially trained in insurance matters or in marketing. Later in 1998, Research International (EA) Ltd. carried out a major research in the community covering all services of the hospital including the CHIS. The results of this research will be used in the 1999 relaunch of the scheme and are further described later in this report.

1.1.5 Benefits Package and Premiums

A member of the scheme is defined as the policy holder. A member may enroll as "dependents" his/her spouse and his/her children under the age of 18. The 1998 scheme offered benefit packages at three levels depending on the member's ability to pay. The following table shows the different packages and their costs. The costs differed with the type of package and whether a person joined as an individual or as part of a group. All members were required to be members also of the Kenya National Hospital Insurance Fund (NHIF), which covers some inpatient costs.

Table B-1. Premiums and Benefits, 1998/99 (in Ksh.)

	Standard Package	Silver Package	Gold package
Annual premium (Joining with a group)			
1 person	1,080	1,320	2,880
Couple	1,980	2,400	5,160
Each child	660	780	1,680
Annual premium (Joining alone)			
1 person	3,960	4,800	10,080
Couple	5,280	6,360	13,680
Each child	1,200	1,440	4,320
Benefits per year per policy	Outpatient cover up to Ksh.8,000 per year Inpatient cover up to Ksh.20,000 per year in a general ward in Chogoria Hospital AIDS patients – ceiling of Ksh.2,000 per year	Outpatient cover up to Ksh.8,000 per year Inpatient cover up to Ksh.20,000 per year in a shared room in the private wing of Chogoria Hospital AIDS patients – ceiling of Ksh.2,000 per year	Outpatient cover up to Ksh.12,000 per year Inpatient cover up to Ksh.26,000 per year in a private room in the private wing of Chogoria Hospital AIDS patients – ceiling of Ksh.2,000 per year
Co-payment for outpatient care	Ksh.30 at dispensary Ksh.50 at hospital	Ksh.30 at dispensary Ksh.50 at hospital	Ksh.30 at dispensary Ksh.50 at hospital

The following conditions are excluded:

- ▲ AIDS treatment costs in excess of Ksh. 2,000 per policy per year;
- ▲ Expenses associated with pregnancy and delivery (operation fee for a first caesarian section is covered);
- ▲ Self-inflicted injuries;
- ▲ Reading glasses, eye or ear tests, and hearing aids;
- ▲ Birth defects and cosmetic surgery;
- ▲ Dental procedures; and,
- ▲ Pre-existing illnesses.

The scheme pays the member's medical expenses up to the limit of the member's entitlement. Members may inquire about the balance of their entitlement at any time.

The benefits and premiums are structured in such a way as to attract a wide cross-section of the target population. The local cooperative societies are encouraged to register their members as a group, and the rates for group membership are much more attractive than for individual membership.

Premiums are paid in full at the hospital. A new member must also submit:

- ▲ Two photographs showing the member and all dependants to be covered under the scheme;
- ▲ Copy of the member's national identity card;
- ▲ Birth certificate for those under 18 or over 45; and,
- ▲ National Hospital Insurance Fund (NHIF) membership card.

On joining the scheme, a new member must wait for two weeks before making any claims.

The costs per day/per visit were based on cost analysis studies conducted in the hospital. The current premiums are based on the same assumptions and compare favorably with the 1998 hospital cost analysis, which gave a cost per outpatient department (OPD) visit as Ksh.158 and cost per day, Ksh.433.¹ Using these rates a family of six would pay a premium of Ksh.4,160 under the Standard Scheme. The new scheme (for 1999) charges Ksh.4,620.

Development of Claims

Table B-2 shows the claims experience since inception of the scheme.

Table B-2. CHIS Claims Experience, 1995 to 1998

Year	No. of policies	No. of persons insured	No. outpatient visits	No. inpatient admissions	Average no. of admissions per person	Average no. of OPD visits per person
1991 – 1994	Data not available.					
1995/96	424	2,340	5,381	248	0.11	2.3
1996/97	390	1,636	6,109	261	0.16	3.7
1997/98	368	1,400	5,259	185	0.13	3.8
1998/99	311	1,481	3,242	144	0.10	2.2

From 1995 through 1998, there have been unsuccessful efforts to recruit cooperative societies as groups in order to reduce the risk of adverse selection. The scheme was marketed by hospital staff to the community. Because no insurance professionals were involved in selling the scheme to potential clients. No incentives were offered to staff who sell the scheme, there was not much motivation to do aggressive marketing.

1.1.6 Membership

The scheme has always been open to anyone who wished to join, but the structure of premiums favored group membership. The target groups in the community were coffee and tea cooperative societies and schools.

¹ Musau, Stephen N. and Kimani, S. 1998. *PCEA Chogoria Hospital Cost Analysis* MSH/APHIA Financing and Sustainability Project.

The scheme was not able to attract people to join as groups and those who joined as individuals soon found the premiums too high for the benefits received and so they dropped out. Other reasons cited for withdrawal from the scheme are covered below (Section 1.1.8 “Community Participation”). The membership in 1998/99 consisted of the group of hospital employees only.

1.1.7 Management

From 1991 through 1997, the CHIS was linked to an insurance company. The hospital collected premiums from members and remitted the money to the insurance company. The hospital was also responsible for keeping all records of service utilization by members and making periodic claims for reimbursement to the insurance company. This system proved very cumbersome as the claiming process required too much clerical work, particularly prior to the installation of the computer system. The hospital de-linked from the insurance company in February 1998. Since then, the hospital bears any losses and benefits from any surpluses made by the scheme.

During 1998, the scheme employed two full-time clerks. The clerks were responsible for entering data in the computer and receiving patients, as well as dealing with all routine administrative matters regarding the scheme, e.g., maintaining membership data, processing claims, reporting to hospital administration, and performing data maintenance.

The hospital administration was still involved in the administration of the scheme and provided oversight over all operations of the scheme. The scheme has an office of its own within the finance department.

In effect, the scheme was managed by the hospital and did not involve the community or scheme members at all.

1.1.8 Community Participation

The community outside the hospital did not participate in any way in the design or management of the scheme. A market survey² conducted at the end of 1998 among 1,000 residents of the hospital catchment area found 236 (24 percent) aware of the Chogoria scheme. Only 14 had ever been members. The following advantages and drawbacks were mentioned by respondents:

Advantages

- ▲ The CHIS covers all hospital bills.
- ▲ The hospital health services are of good quality.

Drawbacks

- ▲ The CHIS did not cover all costs.
- ▲ Services were slow.
- ▲ Premiums were too high.

² Research International (EA) Limited. 1999. *Chogoria Hospital RI/2454 Final Report on Main Findings*, pp. 64-69.

1.1.9 Relations with Service Providers

The scheme and the service provider are effectively one and the same: Chogoria Hospital. Furthermore, current members are all employees of the hospital. There has been need to train the hospital staff to control costs of scheme members, as it became clear that clinicians were overprescribing for scheme members.

1.1.10 Relations with Government and Other Social Groups

The CHIS has in the past received technical assistance from the Ministry of Health through the USAID-funded Kenya Health Care Financing Project. The government has been trying, through donor assistance, to strengthen the private sector health care providers.

Now that the scheme is run entirely from the hospital, it is not clear whether there are insurance issues that need to be addressed with regard to compliance with the Insurance Act in Kenya. Other organizations that operate health maintenance organization-type businesses have come under some scrutiny and there is still uncertainty about their legal standing vis-à-vis the Insurance Act.

The Chogoria Hospital is a member of the Christian Health Association of Kenya (CHAK). CHAK is an umbrella organization for Protestant mission hospitals in Kenya. It provides a forum for discussion of health care issues and assists member hospitals with various aspects of their management. Health care financing is one of the issues about which CHAK is concerned.

1.1.11 Financial Data

The scheme performance since 1991 is shown in Table B-3. The CHIS has not prepared balance sheets as it has always been viewed as a department of the hospital and prepares only ad hoc income and expenditure statements. The scheme year runs from March 1 to February 28.

Table B-3. Financial Performance

	1991 to 2/1995	1995/96	1996/97	1997/98	1998/99
INCOME					
Premiums	N/A	1,346,287	996,450	995,540	1,019,430
Co-payments	N/A	150,030	167,090	142,480	111,360
Insurance claims – NHIF		467,600	423,500	443,040	261,900
Insurance reimbursements Apollo Insurance Co.	6,474,450				
TOTAL Income	6,474,450	1,963,917	1,587,040	1,581,060	1,392,690
EXPENDITURE					
Claims made to ins. co.	8,276,210				
Outpatient costs		1,103,291	1,410,881	1,352,555	706,396
Inpatient costs		728,190	611,142	564,264	420,520
TOTAL Expenditure	8,276,210	1,831,481	2,022,023	1,916,819	1,126,916
SURPLUS/(DEFICIT)	(1,801,760)	132,436	(434,983)	(335,759)	265,774

During the period from 1991 to February 1995, the scheme experienced very heavy use by members, and the hospital could not cope with the volume of claims which had to be submitted to the insurance company within 60 days of treatment. This situation led to many claims being time-barred, hence the big loss.

1.2 Assessment of Performance

1.2.1 Resource Mobilization

The Chogoria Hospital derives most of its income from patient fees, which account for about 80 percent of total income. The receipts from the scheme have not made a significant impact in the financing of health services at the hospital, since only about 2 percent of total income is received from the scheme.

Table B-4. Hospital Sources of Income

Year	Patient fees	%	Donations	%	Other (incl. net project income)	%	Total income	CHIS receipts	% of total income
1997/98	70,167,000	83	6,605,000	8	7,642,000	9	84,414,000	1,581,060	1.9%
1996/97	68,613,284	79	11,181,936	13	6,732,639	8	86,527,859	1,587,040	1.8%
1995/96	65,012,294	84	6,130,612	8	5,837,393	8	76,980,299	1,581,060	2.0%
1994/95	58,077,575	80	10,490,114	15	3,974,635	5	72,542,324	1,963,917	2.7%
1993/94	42,828,891	73	8,956,122	15	7,140,107	12	58,925,120	<i>Data not available</i>	
1992/93	31,259,204	65	10,231,688	21	6,451,397	14	47,942,289	<i>Data not available</i>	

The hospital's operating expenditure for 1996/97 and 1995/96 was Ksh.72,645,230 and Ksh.64,012,205 respectively. Scheme receipts in those years, therefore, covered 2.1 percent and 2.5 percent of the operational costs.

As noted earlier, the scheme year runs from March through February. The dates were chosen because the new scheme was launched in March 1995. This schedule does not coincide with the income earning periods of the target community. Some community members overcome this obstacle because they have access to credit. For example, members of the coffee cooperative societies can receive credit from the society, on the strength of the quantity of coffee they have delivered to the society. This makes it possible for members of the cooperative societies to join even if they have not yet been paid for their produce.

1.2.2 Efficiency

The CHIS encourages efficiency in the modes of service delivery and reinforces the hospital's commitment to providing the most suitable health care at least cost. The scheme encourages members to receive treatment first at the Chogoria dispensary nearest their home, where the co-payment is Ksh. 30 per visit. If a member skips the dispensary and goes directly to the hospital, the co-payment rises to Ksh.50. This encourages members to use the lowest-level facilities first and strengthens the referral mechanism. To date, the number of CHIS members who use dispensaries has not been high enough to

make any impact on the total numbers of curative or preventive visits in the dispensaries (see Table B-5).

Table B-5. Curative and Preventive Visits to Dispensaries

Year	1998	1997	1996	1995	1994	1993	1992	1991	1990	1989	1988
All Visits	183,317	109,076	237,012	248,969	261,029	260,290	225,173	200,990	198,376	175,870	175,209
CHIS Visits	1,424	1,529	1,210	1,336	Data not available						

Technical Efficiency

The scheme has introduced mechanisms for risk management in order to prevent recurrence of the problems of uncontrolled use that plagued it in the early years of implementation. These procedures include:

- ▲ A co-payment charged for every outpatient visit.
- ▲ A waiting period of two weeks for new members.
- ▲ A premium structure that favors those who join as a group in order to reduce adverse selection.
- ▲ A computer program that can track service utilization by member. Many in the community do not quite understand the concepts of insurance and consider the premium to be a prepayment that has to be fully utilized in the year of membership. To prevent excessive utilization, a ceiling is set for each benefits package. The computer tracking system shows the balances available for each policy when a patient comes for services. No member is allowed to exceed their benefits limit.
- ▲ Review by the scheme/hospital administration of monthly reports that show the utilization of services under the different categories of membership. Ad hoc reports are also prepared showing number of outpatient visits per person, number of bed days or admissions per person, and average cost of outpatient claims.
- ▲ Control of cost escalation through the use of generic drugs whenever appropriate, together with adherence to the hospital's treatment guidelines. Problems have been encountered with clinicians at the hospital either overprescribing or prescribing more expensive drugs to scheme members simply because they have the insurance cover. The treatment guidelines were designed for the hospital and the nurses in charge of the dispensaries have said that they do not find them appropriate; the hospital is considering issuing dispensary-specific treatment guidelines.
- ▲ Fraud reduction. When the scheme was introduced in 1991, there were many cases of fraud as members brought in their relatives to be treated free of charge because there was no good method of identifying members. In 1995, the scheme introduced a requirement for each member to submit a recent group photograph showing the member and dependents covered under the scheme. One copy of the photograph is filed for reference whenever a member or dependant comes for services at their nearest dispensary. The other copy is filed in the hospital.

1.2.3 Equity

Premiums are fixed, based on the benefits package the member chooses. Benefits are therefore related to the premium one can afford or chooses to pay. There is no consideration of the prospective member's ability to pay. The scheme is voluntary and open only to those who can afford it.

The current levels of utilization of services are no higher than would be expected by other insurers in Kenya; many of them base their premium computations on the assumptions that each insured person will make four outpatient visits per year. The highest annual utilization rate at the hospital was 3.8 visits per person insured in 1997. This would seem to indicate that the level of assumptions and related premiums might be reduced, giving the scheme more flexibility to address the situation of the poor.

The scheme does not incorporate any mechanisms for protecting the poor. The hospital has its own charity funds which it uses to assist poor patients. Other non-specific donations and endowment fund income also help to cover bad debts occasioned by patients' inability to pay. Poor patients are encouraged to use the government facilities; these facilities have procedures for waiving the fees due from the indigent.

1.2.4 Quality

The quality of services received by members of the scheme is considered to be good by some of the members who were interviewed by Research International. They were happy with the scheme because the quality of health care received at the hospital was good. Members expressed dissatisfaction with the scheme for the following reasons:

- ▲ It did not cover all costs;
- ▲ Services were slow; and,
- ▲ Premiums were too high.

Because there is no separation of scheme and hospital management, there is also no separation of the quality assurance mechanisms employed by the hospital and those that would be applicable if the scheme were independent. Although the hospital does not have a Quality Assurance Department, weekly meetings of doctors and management do review the quality of health care provided by the hospital. Some of the quality assurance mechanisms are use of treatment protocols; continuous professional education for providers; and committees to discuss quality of health care.

1.2.5 Management

The scheme management is not separate from the hospital management. The scheme employs only two clerks, who do data entry and analysis and receive members who come for treatment in the hospital. They also handle all member services including membership renewals, membership database, etc.

A computer program developed for this scheme tracks member utilization of the scheme including tracking members accounts to prevent exceeding their benefit limits; and holding member

information on renewals, beneficiaries, designated dispensary, addresses, etc. The system can produce a variety of monthly reports for monitoring the financial performance of the scheme. This program is now being rewritten for use by the Uganda Community Health Financing Association-member schemes. The program was developed under technical assistance provided by the Ministry of Health through a USAID-funded project, the Kenya Health Care Financing Project.

The scheme's financial management procedures fall under the hospital's own procedures and are governed by the same internal controls to ensure transparency and accountability. The hospital has a comprehensive internal control system over all financial procedures. The scheme activities are accounted for in the hospital's accounting system as a department with its own accounts codes.

The scheme has not invested in employing staff with insurance qualifications. The major changes that have taken place in the design and implementation of the scheme have primarily been as a result of consultant advice. This weakness in the management of the scheme has not been addressed yet. One constraint that keeps the hospital from investing much in the scheme is the desire to keep costs as low as possible in order to keep premiums affordable to a wider cross-section of the community.

1.2.6 Community Participation

The community was not involved in the design of the scheme and has no say in its management. This has created some distance between the community and the scheme and may be partly responsible for the low response to the existing scheme. There are thoughts to create a forum for community participation in the 1999 scheme.

The market research recently completed showed that, of the people in the catchment area interviewed, only 24 percent were aware of the existence of the scheme. This indicates the failure to penetrate the community which further reinforces the need for the scheme management to re-think their strategy of making the scheme known to their target population.

1.2.7 Solution Strategies

The scheme management addresses problems in the scheme as they arise. There is no structured system for reviewing the scheme's progress. This is due, to some extent, to the fact that the scheme has shrunk to the point where only hospital staff are members.

1.2.8 Sustainability and Replicability

The review of the scheme's financial performance in section 1.1.11 indicates that the scheme may be on the way to becoming financially viable (see Table B-6). Heavy losses were incurred in the first four years due to poor controls over utilization, fraud, and inefficient procedures for processing claims. The improved performance does not include the time costs of the hospital management; only direct staff costs have been taken into account.

Table B-6. Scheme Financial Performance

	1995/96	1996/97	1997/98	1998/99
Total Income	1,963,917	1,587,040	1,581,060	1,392,690
EXPENDITURE				
Claims	1,831,481	2,022,023	1,916,819	1,126,916
Direct staff costs*	174,455	191,900	211,090	232,200
Total expenditure	2,005,936	2,213,923	2,127,909	1,359,116
SURPLUS/(DEFICIT)	(42,019)	(626,883)	(546,849)	33,574

*Figures based on two clerks working full time in the scheme.

The financial success of the scheme—and therefore its sustainability—has been jeopardized in the past by the following factors:

- ▲ Failure to attract a large number of members, preferably in groups; the lack of community participation in the scheme may have contributed to this failure;
- ▲ Poor control over utilization;
- ▲ Costly prescribing habits by clinicians for members;
- ▲ Absence of qualified staff to handle insurance matters professionally; and,
- ▲ Failure to conduct market surveys to design and gauge consumer satisfaction with the scheme. Quality of care issues that are now being addressed (for example, long waiting times for treatment) could have been dealt with earlier.

For inpatient care, the CHIS pays benefits for costs remaining after payments by the National Hospital Insurance Fund. The NHIF pays for members' hospitalization on a per diem rate of Ksh.450. Through 1998, the CHIS required all its members to be members of the NHIF too. Membership in the NHIF is compulsory for all employees earning in excess of Ksh.1,000 (US\$17) per month. The contributions vary from Ksh.30 to 320 per month (US\$ 0.50 to 5.3).

Replicability

The financial information and member tracking system developed for the scheme was successfully replicated in Uganda in the Kisiizi Hospital and was operational until a computer problem caused it to crash. The computer program is easy to understand and use.

Competition

The competition from government hospitals and health centers may contribute to the scheme's inability to recruit many members. Due to the low prices in government health facilities, people decide that these institutions will effectively be their insurance as they can always go there if the worst happens.

2. Key Lessons Learned

2.1 Scheme Specific

- ▲ The scheme offers different premiums for individual and group membership and this has proved useful in reducing the number of high-risk members on the scheme. However, this has also excluded low-risk families who would otherwise have joined but are deterred by the high premiums.
- ▲ The use of co-payments has minimized the incidence of member patients coming to the hospital for minor ailments that they could have dealt with by self-medication.
- ▲ It is important to engage in aggressive marketing to promote the scheme in the community.

3. Conclusions and Recommendations

3.1 General Observations and Conclusions

3.1.1 General Observations

The hospital management has made great efforts at controlling costs and trying to ensure that the scheme is sustainable in the long term. There is still a problem with the scheme in terms of recruiting large enough numbers of members to make it viable and sustainable for the long term.

3.1.2 Conclusions

- ▲ The scheme has encouraged members to use the dispensaries as their first contact for health care unless the hospital is their nearest provider.
- ▲ Setting ceilings of cover has enabled the scheme to control the costs to the scheme. This has been possible because of the availability of a computer system for tracking utilization of services by members.
- ▲ The scheme has also succeeded in controlling member fraud by requiring each policy holder to provide a photograph with all the insured persons on it.
- ▲ A good cost analysis is important in setting premiums.
- ▲ The community has not been given the opportunity to participate in the decision-making processes of the scheme; the scheme appears to have suffered as a result of this omission.
- ▲ The scheme has not been an effective tool in raising finances for the hospital.
- ▲ The original objectives of the scheme have not been achieved. The incidence of bad debts has not decreased, nor have more people in the community been able to access health care at the hospital. In view of the revised objectives for the redesigned scheme in 1999, those initial objectives were probably unrealistic and inappropriate

3.2 Recommendations

3.2.1 Scheme Specific

- ▲ The scheme requires more aggressive marketing than the staff can probably handle on their own. In the recent market survey, only 24 percent of the people interviewed were aware of the scheme. The use of outsiders (insurance agents) to help in marketing is worth considering.

- ▲ The failure to involve the community may be one of the reasons for the low popularity of the scheme. A way needs to be found to involve the community in the decision-making processes of the scheme. The scheme could borrow an idea from Kisiizi where they have a consultative group made up of scheme/hospital and community members.
- ▲ The scheme has not tried to entice members to join by packaging the benefits in an attractive manner. Members queue with everybody else and are not given any preference the services they receive. It would make business sense to try and give scheme members something that they value apart from the health care. Some have complained about waiting times, and this is something that could be addressed easily. It is important to start using satisfied members as the scheme's sales team in the community.
- ▲ The hospital is in the process of relaunching the scheme under a new name, but with similar benefit structure as before. The expectation is that this scheme will be more successful than the previous two attempts. The question of staff capacity should be addressed in order for the scheme to be run more professionally, in terms of day-to-day management and marketing.

3.2.2 Government Policy

There is no government policy that can be relied on to help the scheme deal with an epidemic and other outbreaks of disease. The Ministry of Health responds to epidemics by sending drugs and personnel but this may happen too late to protect the scheme from over-utilization from members.

3.2.3 Donors

Donors have been involved in the Chogoria scheme since 1995 by providing short term technical assistance and training. Assistance should be targeted at the core issues that remain unresolved, such as marketing.

3.2.4 Areas Which Would Benefit from Technical Assistance and Training

- ▲ Targeted technical assistance to provide the managerial capacity required within the scheme;
- ▲ Effective marketing to the target population; and,
- ▲ Development of treatment protocols for use by dispensaries.

3.3 Possible Areas for Further Investigation

- ▲ Investigate the cost effectiveness of the existing treatment protocols.

Annex C. Community Health Fund

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1. Findings

1.1 Basic Information About the Scheme

1.1.1 General

The Community Health Fund (CHF) was introduced in Tanzania as part of the government's health sector reform measures. It was intended to contribute to the generation of revenues in the health sector as well as strengthening the government's commitment to decentralize health care planning and financing, not only to the districts but also to the community level.

A pre-test of the CHF was started in 1996 in one district (Igunga district in Tabora Region), followed by Singida Rural district in Singida Region in 1998. Currently, the CHF is operational in 10 districts countrywide.

The CHF is a voluntary, community-based health financing scheme. It is designed in such a way as to ensure participation of the community both in the management of the fund and in the running of public health facilities that serve its members.

The objectives of the fund were to:¹

- ▲ Establish a financial resource base for basic curative and preventive health care, primarily to fill the financing gap in government funding; and,
- ▲ Ensure security of access and equity to health services to the community members.

The strategies for the achievement of these objectives were to:

- ▲ Ensure adequate medical supplies at all facilities;
- ▲ Strengthen the capacity of health facilities to deliver health care;
- ▲ Enhance the skills of health workers and other key workers in the health delivery system; and,
- ▲ Increase the involvement and participation of communities in the management of health requirements and services.

The CHF covers outpatient care at the health centers and dispensaries. There are no set limits to the level of utilization per member per year.

¹ TFNC. 1997. *Indicators for Monitoring and Evaluation of Community Health Fund*. Consultancy Report. Dar Es Salaam.

The following are the key achievements:

- ▲ The supply of drugs in health centers and dispensaries is now assured;
- ▲ Staff are more motivated as they can now serve the community better;
- ▲ The community has a higher sense of ownership of the health facilities in their ward (an administrative area covering a few villages) and takes more interest in facility performance;
- ▲ The communities participating in the scheme have been given more skills in planning and managing their health care as they are involved in all decisions pertaining to the spending of money collected from membership fees; and,
- ▲ Some poor patients who would otherwise not have afforded the cost sharing fees charged at health facilities are given membership into the fund free of charge.

The key issues in the implementation of the CHF are:

- ▲ Training of all staff involved in the implementation of the fund and local authority officials in each ward has been a big challenge. There are still some problems with the ward executive officers (WEOs), who are the collectors of fund contributions; among these are failure to remit money on time (some fraud may also be involved) and submission of reports. Financial management training is required for members of the district health management teams (DHMT) and district community health boards (DHB) also referred to as district CHF boards.
- ▲ Patients are demanding improvement of diagnostic services, now that the problem of drug availability has been solved.
- ▲ There is need for training of staff at the dispensary level so that they may be able to do basic diagnostic services, e.g., use of microscope for examination of blood slides.
- ▲ Capacity to spend the money collected is limited due to inexperience in planning.

1.1.2 Operating Guidelines

The CHF has written guidelines for staff and others involved in its management. There are also by-laws enacted by the district councils to govern the operations of the fund. Training and close supervision have been going on since the inception of the fund. There appears to be quite good understanding of the fund's operations among ward staff and staff in the facilities.

1.1.3 Data Management

There is a considerable amount of data generated every month by the fund. The systems in use at the district and facility level are manual. Registers kept in each facility are the main source of information on utilization of services and of the membership status of those enrolled. Monthly reports are prepared manually and submitted to the project coordinator in Dar Es Salaam for entry into computer spreadsheets.

The volume of data is such that manual processing makes it difficult for anything more than the most critical financial information to be reported. Utilization figures, for example, are not reported. There is therefore no monitoring of utilization outside the facility itself; such monitoring only happens at the initiative of the individual in charge of the health facility, not on a routine, formalized basis.

If the CHF is to be managed professionally, there is urgent need to devise appropriate data collection and analysis tools, and suitable reports that provide useful information for management decisions.

1.1.4 Benefits Package and Premiums

The CHF members enjoy unlimited access to outpatient care at the participating health centers and dispensaries. There are no exclusions as long as one is a fully paid up member.

Currently the premiums in both districts stand at Tsh. 5,000 per household. Other districts have introduced the CHF at up to Tsh. 10,000 per household. The premiums were set with affordability by a wide section of the community as one of the guiding principles. A study conducted during the design of the CHF² concluded that, based on 1994 expenditures and patient numbers, it cost on average, Tsh. 1,286 (US\$ 2.0) per visit in a dispensary or health center, to provide a basic health package in Igunga district. However, data gathered from the communities in Igunga district in 1996 indicated that they were only prepared to pay on average Tsh. 5,000 (US\$ 9) per household per year. The initial premium was therefore set at Tsh. 5,000. With the matching funds provided under the World Bank-funded Health and Nutrition Project, the CHF receives a total of Tsh 10,000 per member household per year. Assuming that each household has six individuals, the cost of their care per household per year would be US\$12 (\$2 x 6) if each individual receives treatment only once a year. The Tsh. 10,000 received (US\$15 at 1998 exchange rate of 660) would be sufficient to cover the cost. If consumption is two visits per member per year, then the fund would be “out of pocket” by US\$ 9 per household.

Membership

Membership is open to anyone living anywhere in the country. The by-laws establishing the CHF do not restrict membership to residents of the district in which the fund operates. Membership is through payment of the annual premium of Tsh 5,000 per household. Under the by-laws, a household consists of father, mother, and dependent children below the age of 18. Under a polygamous situation, each wife constitutes a separate household.

Membership is voluntary except for civil servants employed by the Ministry of Local Government. Their membership is compulsory; the annual premium is deducted from their salaries. For this reason, civil servants account for up to 50 percent of CHF members.

² E.M. Mkusa, 1996. *Costing a Basic Health Services Package for Igunga District*. Ministry of Health.

1.1.6 Management

CHF management at the district level is in the hands of the district CHF board. The secretary to this board is the district medical officer (DMO) of health. Other members of the board are selected by the District Council, to which the board reports.

The district CHF board is responsible for all matters pertaining to the implementation of the CHF, including authorizing expenditure of fund monies.

At the ward level, the fund is managed by a ward health committee. Members of this board include the chairman of the ward council, a representative of any private organizations involved in health activities in the ward, the nurse in charge of the health center or dispensary and the ward executive officer. The district board supervises the ward committees, and approves all expenditure plans submitted by the ward.

1.1.7 Community Participation

The community is involved in the decision-making process and is represented in the management through elected leaders at the ward and district levels. Premiums are collected by the revenue collectors who are employees of the council.

Interviews with community members indicated a high level of satisfaction with the fund. Consistently, all those interviewed cited the availability of drugs as the single most important benefit of the CHF. Before the CHF was introduced, health centers, and dispensaries relied entirely on the drug kits supplied by the government. These drugs kits used to run out within seven days of being received at the health facility as most people came to collect drugs to keep at home. With the introduction of the CHF and cost sharing, the number of people coming to the facility only to stock up on drugs was drastically reduced.

1.1.8 Relations with Service Providers

At the district office of the CHF, records are kept of scheme membership, revenues, and expenditures for each of the health facilities in the ward. Each health facility has an “account” which shows how much money is available at the end of each month.

The CHF collects funds on behalf of the health facilities in each ward. Each facility is at liberty to use the money available to purchase drugs and any other goods and services approved by the district health board. How much money they get has no relation to the volume of services they have given to CHF members. The CHF only acts as a banker for the participating health facilities. There are no contracts between the service providers and the CHF. Health care provider staff are very enthusiastic about the CHF because it has helped to remove one of their biggest problems and demotivators, i.e., the shortage of drugs and medical supplies.

Only the public hospitals and health centers and dispensaries participate in the CHF. Private providers have not joined due to the low premiums that would not be adequate to reimburse them at full cost since the CHF is not based on full cost recovery, even for public facilities.

1.1.9 Relations with Government and Other Social Groups

The CHF was initiated by the Ministry of Health. It is therefore a government initiative and receives full recognition. Technical assistance has been provided by a consultant engaged under the Health and Nutrition Project, who initially was involved in pre-testing the scheme in two districts and who now is helping seven more districts to start similar schemes. Cost analysis was conducted at the beginning by other consultants, who helped to estimate the level of premiums.

1.1.10 Marketing

The CHF is targeted primarily at rural communities. Community mobilization is carried out by the local administration together with the district health management team. The initiative for the introduction of the CHF in new districts comes from the community as word spreads about the benefits enjoyed by members in those districts that have introduced the scheme.

Those involved in selling membership of the scheme receive 5 percent of the premium collected. Most of this now goes to the nurses in charge of the health facilities as most people purchase their membership when they go to receive treatment.

1.1.11 Population Data

The population of the Igunga district is about 250,000 (1996 estimate), while that of Singida Rural district is estimated at 383,000.

The disease pattern in the district is as follows in order of importance: malaria; acute respiratory tract infections; pneumonia; diarrhea; helminthiasis; skin diseases; eye diseases; anemia; accidents; and nutritional disorders.

1.2 Assessment of Performance

1.2.1 Resource Mobilization

The health facilities in Igunga and Singida Rural districts are mainly health centers and dispensaries. The only hospital included in the study was Igunga District Hospital, which was previously a health center. In Tanzania patients pay user fees at public hospitals. Services at health centers and dispensaries are free of charge. In order to encourage membership in the CHF, the government agreed for user fees to be introduced at dispensaries and health centers in those districts where the CHF was implemented. The Ministry of Health matches all funds raised through CHF membership.

The revenues raised by the CHF through user fees and membership contributions are detailed in Tables C-1 and C-2.

Table C-1. CHF Contributions and User Fees, 1996-1998, Igunga District (in Tsh.)

	Total Households	CHF Member Households	% of Households Enrolled	CHF Contributions	User Fee Revenue	Total CHF and User Fees
1996	50,142	2,448	4.8%	12,240,000	3,223,200	15,463,200
1997	50,142	2,948	5.9%	14,740,000	24,573,510	39,313,510
1998	50,142	3,085	6.1%	15,425,000	15,074,000	30,499,000
Total				42,405,000	42,870,710	85,275,710

Table C-2. CHF Contributions and User Fees, 1998, Singida Rural District (in Tsh.)

	Total Households	CHF Member Households	% of Households Enrolled	CHF Contributions	User Fee Revenue	Total
1998	57,204	2,210	3.9%	11,050,000	11,672,000	22,722,000

The funds generated by cost sharing and the CHF have been used primarily to purchase additional drugs and to assist in financing maintenance of facilities. In Igunga district, the purchase of drugs accounted for 73 percent of all expenditure while facility maintenance accounted for 16 percent, and fuel, vehicle maintenance, and office expenses took 11 percent. In Singida Rural all expenditure was on drugs. The expenditure on drugs is shown in Table C-3.

Table C-3. CHF and User Fee Contribution to Drug Costs, 1998 (in Tsh.)

	CHF Contributions	Cost Sharing Receipts	Total	Expenditure On Drugs	% of Drug Costs Covered By User Fees and CHF	% of Drug Costs Covered by CHF Contributions Alone
Igunga District						
Nanga Health Center	735,000	813,000	1,548,000	3,834,000	40%	19%
Choma Health Center	1,110,000	1,737,000	2,847,000	3,834,000	74%	29%
Ziba Dispensary	275,000	621,000	896,000	2,016,000	44%	14%
Igunga Hospital	3,645,000	2,092,500	5,737,500	15,727,590	36%	23%
Singida Rural District						
Puma Dispensary	470,000	259,000	729,000	2,016,000	36%	13%
Ihanja Health Center	530,000	556,000	1,086,000	3,834,000	28%	14%
Dung'unyi Dispensary	355,000	168,000	523,000	2,016,000	26%	18%
Ilongero Health Center	875,000	700,000	1,575,000	3,834,000	41%	23%
Ikhanoda Dispensary	310,000	200,000	510,000	2,016,000	25%	15%
Mdilu Dispensary	375,000	513,000	888,000	2,016,000	44%	19%

*This represents the annual allocation of Tsh 12,000,000 plus direct purchases from the CHF of Tsh 3,727,590. The expenditure for health centers and dispensaries is the cost of the drug kits supplied monthly. Health center kits cost Tsh 319,500 (US\$ 455) while dispensary kits cost Tsh 168,000 (US\$ 240).

The Ministry of Health is committed to continue to supply the EDP drug kits to the dispensaries and health centers. Any additional drugs will be purchased with CHF and cost sharing funds. Currently, the proportion of drug costs covered by the CHF is still low because of the low contribution of Tsh. 5,000 per household. The proportion of drug costs covered by CHF contributions doubles when the matching funds are included. There is uncertainty about the future ability of the

Ministry of Health to continue matching the CHF contributions. The districts which are now introducing the CHF are setting much higher membership contributions, some as high as Tsh. 10,000.

The collection of premiums is open throughout the year so that those who wish to join can do so whenever they have the money. The membership period is 12 months from the date of joining.

Most facilities had cash available in their accounts at the end of 1998. The expenditure on drugs has been low because the drug kits supplied have been quite adequate for the low volume of patients. Other categories of expenditure depend on the ability of the local ward health boards to make and execute expenditure plans. Ongoing training is designed to make these committees more effective. It is expected that expenditures will be higher in future since health facilities are looking to the CHF and cost sharing funds to pay for all their operating costs except staff and drugs.

1.2.2 Efficiency

The CHF was primarily designed for health care services at the lowest levels of the health care delivery system; i.e., at the dispensaries and health centers. The pricing of the benefits package was based on outpatient department (OPD) health services at this level.

The membership of the CHF consists mainly of the employed. These are the people who would normally have been able to afford to pay for their health care if the CHF did not exist; they are also the most likely to make use of primary health care services (maternal and child health and family planning). The scheme's impact on the use of these services has been minimal. Proper records to assess this are not available but anecdotal evidence from service providers indicates that there was no noticeable difference in the volume of patients/clients.

Technical Efficiency

Membership to the CHF is open to all who can afford the annual fee. There is no attempt to restrict membership on the basis of pre-existing conditions nor to track usage of services by members. Service utilization between members and non-members was investigated, taking a sample of at least five months from each facility. Full records were not always available. Tables C-4 and C-5 show the pattern of utilization between members and non-members.

Table C-4. Service Utilization, Igunga District

Igunga District	1997			1998		
	OPD Sample Total	CHF	% CHF	OPD Sample Total	CHF	% CHF
Igunga Hospital	2,622	1,834	70%	4,349	3,221	74%
Nanga Health Center				925	815	88%
Ziba Dispensary	4,608	3,938	85%	2,787	2,175	78%
Choma Health Center	6,707	3,904	58%	8,467	7,358	87%

Table C-5. Service Utilization, Singida Rural District

Singida Rural District	1998			1999		
	OPD Sample Total	CHF	% CHF	OPD Sample Total	CHF	% CHF
Puma Dispensary	2,198	1,924	88%	514	473	92%
Dung'unyi Dispensary	1,534	1,359	89%	Data not available		
Ilongero Health Center	6,124	5,222	85%	Data not available		
Ikhanoda Dispensary	No data available			346	271	78%
Ihanja Health Center	No details of CHF members in the treatment registers					

The high rate of service utilization by members is attributable to:

- ▲ Non-member patients are discouraged by the introduction of user fees for non-members.
- ▲ Only the very ill non-CHF members seek treatment at the health facilities. Before the introduction of the CHF and user fees, people used to come to the health facilities as soon as they knew that drugs were available, whether they were ill or not, simply to stock up on the common drugs for use when the facility ran out of drugs. This artificially raised the volume of patients. Now, only the CHF members can afford to present at the health centers with minor ailments.
- ▲ There is adverse selection: the sick are most likely to join the scheme since there are no prohibitions in place to bar them from joining.
- ▲ An evaluation of the CHF observed that 52.3 percent of the sampled member households reported that they suffered from a chronic ailment.³ This clearly suggested that the risk of adverse selection is very high.
- ▲ The same study also found that larger households tend to become members of the CHF; smaller households prefer to pay user fees for their health care. Out of 532 households interviewed, 273 were members of the CHF; 78 percent of these had six or more individuals in the household. Table C-6 details household size and CHF membership.

³ TFNC. 1997. *Indicators for Monitoring and Evaluation of Community Health Fund*. Dar Es Salaam.

Table C-6. Household Size and CHF Membership

Household size	Number of households	Membership		Number of CHF Households	Number of Non-CHF Households
		CHF	Non-CHF		
Less than 3	39	23.0%	87.0%	9	30
3	26	36.6%	63.4%	10	16
4	43	46.5%	53.5%	20	23
5	51	41.2%	58.8%	21	30
6	75	46.7%	53.3%	35	40
7	72	45.8%	54.2%	33	39
8	61	60.7%	39.3%	37	24
9	55	70.9%	29.1%	39	16
10	41	80.5%	19.5%	33	8
11 and above	69	52.2%	47.8%	36	33
Total	532	273	259	273	259

Source: Indicators for Monitoring and Evaluation of Community Health Fund in Igunga District report.

There was no evidence of fraudulent use of the CHF cards. Service providers did mention that some members have tried to obtain drugs for non-members, perhaps for financial gain; the few who have been suspected claim symptoms of an illness they did not appear to have. In some such cases providers have either requested laboratory tests (particularly the more painful ones involving a prick for blood sample) or prescribed an injection; the “patients” refuse the treatment and go away. Other clinicians simply advise the patient on lifestyle/eating habits and refuse to give any drugs.

There is scope for the providers themselves to engage in fraud by stealing drugs and recording visits by fictitious CHF members. No audit is performed to check that the patients who did not pay the cost sharing fees were valid CHF members.

1.2.3 Equity

Financing

Since the scheme is rural, there was need to make it as administratively simple as possible. Therefore, the contributions to the scheme were fixed at Tsh. 5,000 per household. It does not matter how many people are in the household as long as none of the children is over 18. This favors larger families. In addition, the fixed premium does not recognize the relative ability of community to pay; the poorer pay a larger proportion of their income than the rich, for the same benefits. However, as the communities gain more confidence in it and there is greater awareness, it is hoped that different benefits packages will be offered for different levels of contribution.

Members utilize more than 75 percent of all outpatient services in the dispensaries and health centers. This proportion is very skewed toward member households, as the percentage of households that have joined the CHF is, on average, only 6 percent for Igunga and 4 percent for Singida Rural districts (see Tables C-7 and C-8).

Table C-7. CHF Member Households, Igunga

Ward	Total Number of Households	Number of CHF Households	CHF Percentage
Nanga	2,326	248	11%
Choma	2,486	222	9%
Ziba	2,301	140	6%
District Total	50,142	3,085	6%

Table C-8. CHF Member Households, Singida Rural

Ward	Total Number of Households	Number of CHF Households	CHF Percentage
Puma	2,249	94	4%
Dung'unyi	2,227	71	3%
Ilongero	2,225	175	8%
Ikhanoda	2,156	135	6%
Ihanja	2,409	106	4%
District Total	57,204	2,210	4%

No study has investigated the health of the majority of community residents who are not now receiving health services from the public facilities. However, the clinicians in the facilities visited admitted that the non-CHF patients seek treatment only when they are very ill.

Vulnerable Groups

There is a mechanism for exempting the very poor (generally defined as those who have no means of income and are old, physically or mentally handicapped or chronically ill) from payment of cost sharing or CHF fees. However, the number of people who have benefited from this is very few because the procedure is so cumbersome: Names of the poor have to be presented to the ward health board for consideration. After that, approval must be sought from the district CHF board. In addition, many wards have not been able to identify the poor. Health workers suspect that some wards are too strict in their definition.

Those who cannot afford to pay the Tsh. 5,000 at once are allowed to pay in installments; they only receive their membership card once they pay the final installment.

Children below the age of 5 are exempted from payment for all health services. Pregnant mothers are exempted from payment for services related to their pregnancy.

1.2.4 Quality

The quality of health care as perceived by both patients and service providers has improved with the introduction of the CHF and cost sharing. Patients interviewed mentioned the following as the quality improvements:

- ▲ Drugs were now available throughout the year; and,

- ▲ Staff in the facilities are doing their work better and are more friendly.

None of the patients interviewed was unhappy about the scheme. Some however, would like to be able to have laboratory tests performed at the dispensaries. Currently such diagnostic services are only available at health centers and hospitals.

The staff also cited the availability of drugs as the most important quality improvement. Other improvements mentioned included:

- ▲ They feel more motivated because they have all the drugs and other clinical supplies to be able to attend to their patients.
- ▲ The buildings are better maintained, therefore they have a better working environment.

Some of these improvements might have been achieved even without the CHF since they emanate from the reduction in the number of patients, which would also have been achieved through the reintroduction of user fees. However, since the introduction of user fees was directly related to the introduction of the CHF, the reduction in the number of patients cannot be considered as happening independently of the CHF.

The communities are now more closely involved in the management of the health facilities through the ward health boards. They are able to monitor the quality of health care delivered and have been known to influence the removal of the head of a dispensary who was not treating patients well. There is no formal mechanism yet for assessing the quality of health care delivered at each health facility.

The staff at the health centers and dispensaries did not seem to be aware of the existence of treatment guidelines/protocols.

1.2.5 Management

As described in section 1.1.6, management of the CHF is primarily district-based with the district CHF board doing routine management and supervising the work of the ward CHF committee.

Collection of premiums is officially the responsibility of the ward executive officer, who has a team of revenue collectors working under him/her. Due to delays in the banking of CHF fees collected by the WEO, most payments for membership now happen only at the health facility. Weak internal controls, including a lack of regular audit of CHF funds, has resulted in some cases of fraud.

The reports submitted to the DMO and to the Ministry of Health focus more on enrollment and cash collections (CHF and cost sharing) than on other aspects of the fund, e.g., utilization of services and the value of services consumed by members. The scheme is now run as if it was just a prepayment of cost sharing fees. Facilities do not receive any reimbursement for services rendered to CHF members, but the full amount of membership fee is credited to the ward to be shared among the facilities in the ward (usually one or two dispensaries or a dispensary and a health center). They use the money from CHF membership, matching funds and cost sharing to purchase any additional drugs and medical supplies, facility maintenance, or for any other purpose approved by the CHF board.

Problems in the implementation of the CHF are handled by the ward committees and board. The DMO is the primary person in terms of technical issues. Matters pertaining to community satisfaction with services, exemptions and the use of funds are dealt with by the committees and the board.

1.2.6 Community Participation

The CHF involves the community in the management of the scheme. The ward CHF committee consists of community-elected members who do the following:

- ▲ Recruit households into the CHF and issuance of membership cards;
- ▲ Ensure that a register of members is maintained, usually only at the health facility;
- ▲ Ensure that money is banked;
- ▲ Prepare expenditure plans;
- ▲ Recommend cases for exemption to the district CHF board; and,
- ▲ Submit quarterly implementation reports to the district CHF board.

The design of the CHF is proposed to the communities and they have the liberty to make modifications. For example:

- ▲ The by-laws establishing the CHF in any district are district-specific although they are based on those developed by Igunga, the pre-test district. The district council can change them to suit the community needs best; and,
- ▲ The fee per household can be changed depending on the economic wellbeing of the community.

1.2.7 Solution Strategies

The CHF is still in the process of implementation, the oldest district having been in operation it for just over two and one-half years. There have been few mechanisms to deal with issues at a national level. The Ministry of Health has relied so far on a World Bank consultant to resolve problems. The project under which the consultant works will end in June 1999 and there are no clear indications as to who in the Ministry will take over this role. At the districts, however, the system of responding to changes and problems is much clearer, with the DMO serving as the “chief executive officer” of the scheme. The devolution of authority from the Ministry headquarters to the districts ensures that each scheme can run with minimal administrative support from outside the district.

1.2.8 Sustainability and Replicability

The sustainability of the CHF is difficult to measure because the facilities serving members are also supported by the government; all staff costs as well as the majority of drugs are paid through the annual budgetary allocations.

The Tanzania Food and Nutrition Project study indicated that on average, each person in Igunga district attends a health facility twice a year. At the current level of utilization of health services at health centers and dispensaries, Table C-9 illustrates the financial performance for a typical ward that has one dispensary.

Table C-9. Income and Expenditure Statement, Ziba Dispensary, Igunga District (In Tsh.)

Income	
CHF membership fees	275,000
Cost sharing fees	621,000
Matching funds	275,000
Total income	1,171,000
Expenditure	
Drugs and medical supplies*	2,016,000
Staff costs**	2,040,000
Other costs (estimated)	Negligible
Total cost	4,056,000
Estimated deficit	(2,885,000)

* Based on the cost of the EDP Kit for dispensaries which costs Tsh 168,000 per month.

** Based on a staff complement of five: Clinical Officer in charge earning Tsh 50,000 plus four nurses earning an average of Tsh. 40,000 each per month.

If the CHF were to pay each health facility on the basis of the consumption of services by members, it appears that the fund would not be sustainable at current levels of utilization and premiums. Table C-10 below shows the performance if health services are charged to the Fund at the cost sharing fee levels, i.e. Tsh. 1,000 per visit to a dispensary.

Table C-10. CHF Financial Performance, Ziba Dispensary, 1998 (in Tsh.)

Income	275,000
CHF membership fees	275,000
Matching funds	
Total income from CHF	550,000
Expenditure	
Value of services consumed	
1,884 OP visits @ Tsh. 1,000 each	1,884,000
Deficit	(1,334,000)

The factors that jeopardize the viability of the CHF include:

- ▲ Management does not closely monitor the use of health services by members and hence design a coordinated approach to risk management and service utilization issues. Each facility does whatever it thinks fit to control misuse of services by members.
- ▲ The level of premiums may not sustain the level of service use by members. The low premiums are based on the assumption that the government will continue to support the

schemes through matching funds and the provision of EDP kits to dispensaries and health centers.

- ▲ Internal controls over fraud are weak. Providers can misuse member names to obtain drugs for non-member patients.
- ▲ Currently the scheme covers only about 6 percent of the population. A much higher coverage is necessary in order to limit the risks of adverse selection.

Competition

There are plans to start a national health insurance scheme in Tanzania. It is expected that there will be no overlap between the National Health Insurance Scheme and the CHF because the national scheme will only include (at least initially) civil servants working in central government. Civil servants in the districts, who are employees of the Ministry of Local Government, will continue in the CHF. Currently, the CHF membership comprises about 50 percent of local government employees. However, a senior MOH official has said, “When the national health insurance scheme increases its coverage to all formal sector employees, then the CHF will be considered as any other voluntary health insurance scheme.”⁴

⁴ Comments by Mr. Maximillian Mapunda, Ministry of Health Tanzania, Health Sector Programme Support, May 1999.

2. Key Lessons Learned

2.1 General

- ▲ The communities are willing to participate in a health insurance plan as long as they understand the concept and have the resources to pay for membership.
- ▲ The introduction of a mandatory user fee program together with the CHF has eliminated inappropriate use of services, such that the EDP drugs kits which would not have lasted for a fortnight previously can now last for a month. This situation requires careful monitoring and investigation to determine whether the poor are being denied essential health care due to their inability to pay either the CHF premiums or user fees.
- ▲ The empowerment of the community in the provision of health care requires concerted efforts in training. Some wards are still not using the CHF money due to their inexperience in planning.
- ▲ The subsidies received from the government (matching funds) have been useful in pitching the premiums at a level that more people in the community can afford in order for the scheme to gain popularity.

3. Conclusions and Recommendations

3.1 Scheme Specific Conclusions

- ▲ There is need for preparation in the means of handling the data that will be generated out of a program like the CHF. Manual systems can only handle minimal analysis of data.
- ▲ The scheme has not yet had significant impact in the generation of financial resources for health care. Membership in the scheme is too low (at about 5 percent of the community) to make much difference and a fixed membership fee per household is adequate (78 percent of the households who have joined the CHF have six or more members).
- ▲ The CHF can make a useful contribution in the financing of health care if it is only targeting the financing gap in the provision of health services. Currently, the CHF can pay for up to 25 percent to 74 percent of the cost of drugs in dispensaries and health centers.
- ▲ There is not much consideration given to technical efficiency of the scheme. Moral hazard and adverse selection are major problems.
- ▲ The scheme has had a favorable impact on the quality of health care delivered by the health facilities based on the key criteria of availability of drugs and supplies.

3.2 Recommendations

3.2.1 Scheme Specific

- ▲ Data management is going to become a major problem if not addressed. The volume of data is such that manual processing may not be possible for long. The design of the reports should therefore be such that only critical information is reported. Alternatively, there should be a computer for data analysis at the district headquarters.
- ▲ Marketing should be more aggressive to increase membership. This will also help to minimize the risk of adverse selection.
- ▲ Risk management of the scheme requires urgent attention. Currently members are overutilizing the health facilities. The possibilities of facility staff misusing drugs in the name of CHF members exists due to the absence of proper internal controls to prevent this.
- ▲ There are indications that some poor people are being denied necessary health care due to the introduction of user fees and CHF membership fees. Evidence of this is the seriousness of illnesses now presenting at the health facilities. No study has been conducted to examine the state of wellness of people in the community.

3.2.2 Government Policy

The CHF exists legally in the districts because they have passed by-laws to facilitate this. Nationally, the scheme is known but has no legal standing as it is not governed by any act of parliament. It is important that this situation is rectified.

3.2.3 Donors

- ▲ Provide targeted technical assistance to develop the managerial capacity required within the scheme.
- ▲ Management tools for designing and monitoring the performance of the scheme.

3.2.4 Areas Which Would Benefit from Technical Assistance and Training

- ▲ Training in management techniques for an insurance scheme.
- ▲ Development and introduction of tools for monitoring the performance of the scheme.

3.3 Possible Areas for Further Investigation

- ▲ The introduction of the CHF and user fees appears to have caused poor people in the community to be denied health care because they can no longer afford it. There is need to examine whether this is true and if so, to suggest actions that might address it.

Annex D. Atiman Health Insurance Scheme

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1. Findings

1.1 Basic Information About the Scheme

1.1.1 General

Background

The Bima ya Afya ya Atiman is a community-based health insurance initiative of the Catholic Church. Presently, the scheme has two units in Dar Es Salaam, one in Msimbazi Parish (started in May 1995), and the other one in Yombo Parish (started in March 1997). The general aims of the two schemes are the same but there are differences in the structures and the implementation of the scheme in each unit.

The initiators of the scheme are the secretary of the Peace and Justice Commission, the Medical Department of the Tanzanian Episcopal Church (TEC) and the parish priest of Msimbazi Parish. The scheme is using the structures of the parish, that is, with the participation of the Parish Office personnel and the Small Christian Communities. Small Christian Communities are a group of 6-10 families in the same neighborhood, who meet on a regular base for social activities and prayer.

Early 1995, the initiators prepared a first draft framework and guidelines of the scheme and made a small study on the utilization pattern and costs of services at three local health care providers. The draft was further discussed with the Medical Board of the Dar Es Salaam Diocese, priests of Msimbazi Parish, and parish leaders. The initiators also consulted the management of the National Insurance Company (NIC) and the Parastatal Pension Fund (PPF). All indicated that they saw the scheme as a worthwhile experiment. The PPF management indicated that “The project is technically feasible. However its success will depend on the willingness of members to contribute and adhere to the laid down procedures. Members must therefore be psychologically well prepared before the project takes off. This may involve a deliberate educational campaign. A pilot project to get experience is recommended.”

After finalizing the draft framework and guidelines of the scheme, the initiators discussed with the leaders of the 80 Small Christian Communities in Msimbazi Parish, who approved the concept and decided to go ahead with implementation. Several consultative meetings with the leaders of the Small Christian Communities followed to discuss rules and regulations.

The Msimbazi scheme started officially on March 1, 1995. From this date members were registered. Services were rendered at the selected dispensary starting May 1, 1995. A constitution was prepared and signed in June 1995.

Based on the experiences of the Msimbazi scheme, in 1997, the Parish Council (leaders of all Small Christian Communities) and the parish priest decided to start a similar initiative in Yombo Parish. After a sensitization campaign within the Small Christian Communities, the scheme started its operations in March 1997.

Table D-1 shows population data for the Atiman scheme, broken down by parish.

Population Data

Table D-1. Population Data

	Msimbazi Parish	Yombo Parish
Total Parish members	26,000	12,000
Females	48 %	55 %
Males	52 %	45 %
Women of child-bearing age	25 %	20 %
Children < 5 years	15 %	20 %
Children < 1 year	n.a.	4 %

Epidemiological Data

Top diagnoses in Msimbazi Dispensary in 1998 (for >5 yrs) were, in order of importance: malaria, skin diseases, rheumatic joint pain, upper respiratory tract infection, intestinal worm, urinary tract infection, pneumonia, diarrhea, cardiovascular diseases, schistosoma haematobium, minor surgeries, fungal infection, and anemia.

Main causes of death in Dar Es Salaam are: HIV, pulmonary TB, maternal death, cancer, acute febrile illness and acute diarrhea disease, stroke, injuries.

Scheme Objectives

The basic reason for starting a health insurance scheme was the Christian concern for the needs of the ordinary people. Many people experience great difficulties when they become sick. How to help people without making them dependent and how to help one another were the two main issues. The answer to these questions was expressed in this project.

During the sensitization meetings, the concept of the scheme was described as follows: The aim of the scheme is to help every family cope with the experience of regular sickness and the need for medical service. As often happens, such events can cause anxiety, as the necessary finances may not be available at such moments, especially among the poorer section of the population. Health insurance foresees such needs. People who join the scheme put together their small contributions into a fund that pays the expenses of the members when they need medical services. Many small contributions put together regularly constitute a fund that is big enough to pay for members' expenses. In this way, people learn to carry together this burden. They administer the fund together, as it is their money. These contributions can be called pre-payments for services that will be needed in the future. When the need arises people do not have to look for money elsewhere; it is already there." The motto of the scheme is "Tusaidiane," meaning "let's help each other," expressing the solidarity within the Small Christian Communities.

According to the guidelines, the scheme rests on two basic pillars:

- ▲ A Christian conviction that Christianity must be expressed in concrete solidarity with all brothers and sisters; and,
- ▲ A technical structure of solidarity via an insurance scheme based on regular contributions by the members.

The objectives of the scheme have not changed over time.

Development of the Scheme to Date

The Msimbazi scheme started in April 1995 with 970 members. It initially experienced an increase in membership (peak 1570 members in August 1995), followed by a drop in membership. Presently there are only 20 active members. This scheme has always operated with outside subsidies.

The Yombo scheme started in March 1997 with 349 members. Membership peaked in June 1997 with 460 members, and thereafter gradually decreased to 219 members in December 1998.

Achievements

A functioning scheme was established in 1995, proving that the members of the Small Christian Communities managed to put their solidarity in practice. The scheme has encountered a number of problems. The lessons from the scheme provide a good insight for future schemes.

The scheme has improved the members' access to health care. The members are ensured of treatment when they fall sick, even if they don't have cash at hand.

Two other parishes in Dar Es Salaam have expressed interest in the scheme.

Through their experiences with the Atiman schemes and their collaboration with other mutual health insurance schemes (promoted by ILO SSMECA), the TEC Medical Department responded to the need to revise the treatment guidelines. It has agreed to assist existing schemes in checking the quality of the medical care.

Constraints

Major problems in the functioning of the Msimbazi scheme were a drop in membership, quality of the dispensary, abuse of the scheme, absence of control mechanisms, weak scheme management, and negative financial results.

According to the Church's technical support team, the major cause of problems is the weak management of the related dispensary. This dispensary is part of the Church structure and reports to the Diocese medical director and the Diocese Medical Board. The weak management has resulted in the following problems:

- ▲ Irregularities in leadership and accountability of the dispensary;
- ▲ Over-prescription of drugs;
- ▲ Incomplete records which made it difficult to assess causes of problems; and,
- ▲ Poor quality of health care.

During the first two years of its operation, the scheme did not have control systems to avoid abuse by both the provider staff and members. According to the Church's technical support team, detection of abuse could have been avoided if financial and statistical records of the dispensary were properly kept and analyzed.

In response, the Church's technical support team consulted with the Christian Mutual Association in Belgium, who proposed some control measures, such as introduction of treatment guidelines and a price list and official agreement between the scheme and the dispensary. These tools would mainly be used to check the dispensary's invoices and to control the quality of the services

provided. In the meantime, the Diocese Medical Director and the Diocese Medical Board have acknowledged the problems with the dispensary and are in the process of addressing them through changes of staff and policies. They advised to wait with implementation of the control measures until they have been able to solve the main problems of the dispensary.

The other two problems relate to the management of the scheme: change of staff members and heavy dependency on gifts and subsidies.

There have been several changes in the key parish staff who are involved in the scheme's administration such as the parish priest and the scheme's administrative officer. Although the new parish priest showed interest in the scheme, he did not see it as a priority.

Legal Framework/Enabling Environment

For the time being, there is no legal framework in Tanzania governing the operations of community health insurance schemes.

After the scheme's constitution was signed in June 1995, it was presented to the Ministry of Home Affairs through a lawyer. The Ministry has given no official reply yet. The Ministry of Health is informed of the initiative.

The Atiman Health Scheme has the blessing of the Tanzanian bishops and the Church's technical support group and individual parishes can continue to start similar initiatives. The TEC Medical Department is committed to improve the quality of the Church's health services.

1.1.2 Operating Guidelines

Documentation

The following documentation is available for the scheme:

- ▲ The scheme is described in a booklet which is published by the TEC Medical Department: "*Community Based Health Insurance, Bima ya Afya ya Atiman*" which was revised in January 1999. The contents in this booklet include:
 - △ Aim of the Scheme
 - △ How it was Started
 - △ Membership
 - △ Administrative Aspects
 - △ Services Rendered
 - △ Help to the Poor
 - △ Structures of Administration
- ▲ A document called *Treatment Guidelines with Price List* was prepared in collaboration with the Diocesan Health Coordinator (1st ed. January 1999).

Training

The schemes' leaders, staff, and health care provider have received no training on management of health insurance. Most of the skills needed for the management of the scheme, such as sensitization of potential members and keeping of records of members and contributions, have been acquired on the job. The Yombo executive committee had the advantage to be able to learn through exchange with the Msimbazi executive committee.

One member of the Church's technical support team participated in a workshop on community-based health insurance in Uganda in November 1998.

1.1.3 Data Management

For the Msimbazi scheme all records are kept by an administrative officer, who is affiliated with the scheme through the parish. The administrative officer accepts and registers contributions and prepares financial and other reports for the scheme's Executive Committee. The administrative officer also registers the costs related to treatment and administration.

All records are kept manually. A member of the Church's technical support team is in the process of computerizing certain data. This is done for preparation of reports and for data analysis. Data are not kept in a systematic and clear manner.

In early April 1999, several files were stolen from the scheme's office, including the members' register with details of membership, contributions, and use of services per member for the years 1997 and 1998.

As a back-up, there are some summaries of information available with the members of the Church's technical support team. Therefore, some of the records could be reconstituted. However, detailed information on the members' register is no longer available and the 1997 records are incomplete.

All records of the Yombo scheme are kept by the sister at the dispensary, who is the scheme's administrative officer. Information on members' payment of contributions and monthly treatment costs per Small Christian Community is computerized. A simple spreadsheet format is being used. More information could be recorded and retrieved with the development of an appropriate program. Administrative expenses are not recorded.

Yombo also does not have an official back-up system. However, as the members of the Church's technical support team receive regular reports (also on diskette), there is some back-up information available.

1.1.4 Marketing

The target group of the schemes is described as all the members of the parish. The wealthier ones help to subsidize the poorer ones by joining the scheme.

The strategy that was used to market the scheme is as follows:

- ▲ The initiators held meetings with the leaders of the Small Christian Communities of the parish to explain the basic spirit and reason for such a scheme.

- ▲ The local leaders, in turn, explain to their communities and other interested people how the scheme works, after which they invite people to join. The local leaders register the names of those who desire to become members and they direct them to the administrative officer.

The scheme information booklets highlight the importance of the wholehearted support of the leaders of the parish (priests and lay leaders). After the scheme started its operations, the leaders of the Small Christian Communities were expected to encourage the people to become members of this scheme and make their contributions regularly. In practice, most of the marketing activities took place only during the starting phase of the schemes.

In the Yombo scheme, membership of the health insurance scheme was also promoted at the dispensary. No specific incentives were given to those involved in marketing activities.

1.1.5 Benefits Package and Premiums

Benefit Package

The scheme covers primary health care available at the St. Camillus Dispensary. Services are related to treatment of the ordinary sicknesses and other services that a normal dispensary provides in Tanzania, like malaria, diarrhea, wounds, colds, sores, worms, and infections. Excluded are sicknesses like AIDS, TB, cancer, or cases for hospitalization. The guidelines indicate that this might change in the future. The dispensary does not offer mother and child health care, hence these services are not covered by the scheme.

Members do not have a choice of several benefit packages. The initiators of the scheme proposed the benefit package. The underlying idea was that starting with first line care would permit the scheme to grow on a sound basis. During the conceptual phase, leaders of the Small Christian Communities were consulted and agreed to the proposed level of care. As both schemes are so far only using the parish dispensaries, the packages were limited to the services that are available at these dispensaries.

From a survey done in April 1999 among members, ex-members, and non-members of the Yombo scheme, there is an indication that extension of the package would be appreciated. Many interviewees indicated the need for the following services to be included:

- ▲ Observation (room);
- ▲ Antenatal clinic; and,
- ▲ Minor surgeries.

The provider is paid directly by the scheme on a monthly basis.

Premiums

In the Msimbazi scheme, premiums are payable monthly. The scheme's administrative officer is available at the Parish Office three times a week during fixed hours. In the early days of the scheme, the leaders of the Small Christian Communities were responsible for collection of the premiums (during their regular meetings) and had to bring the contributions to the administrative officer. However, in practice the leaders of the Small Christian Communities delayed turning over the money,

because of the varying distances of their communities from the Parish Office. Therefore, it was decided that members should come directly to the Parish Office to pay their contributions.

In the Yombo scheme, the premiums are payable monthly at the dispensary, where one of the sisters is also the scheme's administrative officer. In Yombo Parish they started with the same arrangement as described above, some members pay through the leaders of the Small Christian Communities, and some pay directly at the dispensary.

When the head of family fails to make the financial contributions at the end of the month, he/she and dependants are no longer entitled to benefit from the agreed service at the dispensary. In Msimbazi, the administrative officer should notify the dispensary of this fact. In Yombo, the information is available at the dispensary. The services are resumed as soon as the member has made the contribution. A member who did not pay for six consecutive months will be considered as not being interested in continuing his membership. He/she will be notified of this fact and the membership card will be returned to the administrative officer by the dispensary. Delays in payment for less than six months do not jeopardize the membership but they cause the member to be withdrawn from the pre-paid service at the dispensary. In order to profit again, a member has to pay the arrears in respect of the months he/she did not pay before benefits can be reinstated.

The premiums for the Msimbazi scheme were set after one of the initiators had made a brief study on average prices for medicines and services per patient visit. This study was done at the Amana Government Hospital, Msimbazi Parish Dispensary, and St. Camillus Dispensary. Based on these prices, the initiators made some scenarios (2, 6 and 12 cases per member per annum and adding 15-25 percent for administrative costs and 10-15 percent for contingency fund). Later, discussions were held with the leaders of the Small Christian Communities and benefit package and premiums were fixed accordingly. The premium is based on approximately three patient visits per member per year.

The Msimbazi scheme started with a registration fee of Tsh. 300 (US\$ 0.43) per family, and monthly contributions of Tsh. 100 (US\$ 0.14) per beneficiary. Based on the financial results of the scheme, and in an effort to cover the costs, the monthly contribution rate was reviewed twice: in January 1996 it was increased to Tsh. 300 (US\$ 0.43) and in 1998 it was increased to Tsh. 500 (US\$ 0.71).

In the Yombo scheme the contribution has remained fixed since the beginning at Tsh. 300 (US\$ 0.43) per beneficiary per month. The registration fee is Tsh. 300 per family. The contribution rate of Tsh. 300 was at that time set according to the Msimbazi scheme.

Theoretically, both schemes practice a short probation or waiting period. As soon as a member registers and pays the registration fee and the first month's contribution, he/she has access to services in the next calendar month. In practice, people are allowed to pay the registration fee and one-month contribution, and use services immediately.

Utilization

The development of claims in the Msimbazi scheme has been as follows:

Table D-2. Msimbazi Scheme Claims

Year	No. of claims per member/year*	Average costs per claim**	
		Tsh	US\$
1995	3.1	737	1.05
1996	2.5	958	1.37
1997	n.a.	1,406	2.01
1998	3.1	1,938	2.77

* Information on membership and claims is not complete for 1996, 1997 and 1998. Numbers are based on estimates.

** Information on number of claims is not complete for 1996 and 1997. Amounts are based on estimates, with exchange rate of 700.

The development of claims in the Yombo scheme has been as follows:

Table D-3. Yombo Scheme Claims

Year	No. of claims per member/year	Average costs per claim	
		Tsh	US\$
1997	4.5	689	0.98
1998	5.6	816	1.17

1.1.6 Membership

Coverage

Initially the target group consisted only of members of the Small Christian Communities in the parish. From July 1998, the decision was made that non-Christians should also be welcomed to join. This has not yet been put into practice.

The head of the family joins the scheme and registers with the administrative officer, including the names of the dependants for whom a contribution will be made. According to the scheme's guidelines, "The head of the family must be encouraged to include only those dependants for whom he/she is able and willing to pay on a regular basis. Their commitment must be a realistic one." It is further stated: "Too many dependents is not realistic in the long run. The head of an ordinary family cannot afford to pay for too many people."

When one of the dependants starts a family of his/her own, they normally become a new unit, a new head of family. Single persons can also register.

From the April 1999 survey of 59 Yombo members, ex-members, and non-members, it was found that the average household size is 6.5 persons. From the 1997 and 1998 figures on membership, it was found that on average three persons per family are registered (varying from one to 10). From the survey it was found that only 33 percent of the members and ex-members had registered all household members for the insurance scheme.

The main reasons for non-coverage of certain household members were:

- ▲ Some household members are covered by other arrangements, e.g., by their employer (53.8 percent); and,
- ▲ Some can not afford to pay the contributions for all household members (38.5 percent).

For the Msimbazi scheme, no detailed information is available.

Profile

The information collected during the survey of 39 members and ex-members of the Yombo shows the following profile of the membership base:

- ▲ In 27 percent of the households, the head of the family and/or the spouse was engaged in formal employment, while 58 percent were self-employed. Only 15 percent of member households had an unemployed head of the family;
- ▲ The average monthly household income is Tsh. 112,439 (US\$ 161), varying from Tsh. 34,980 (US\$ 50) to Tsh. 459,990 (US\$ 657) per month; and,
- ▲ 96 percent of the members live within walking distance of the dispensary.

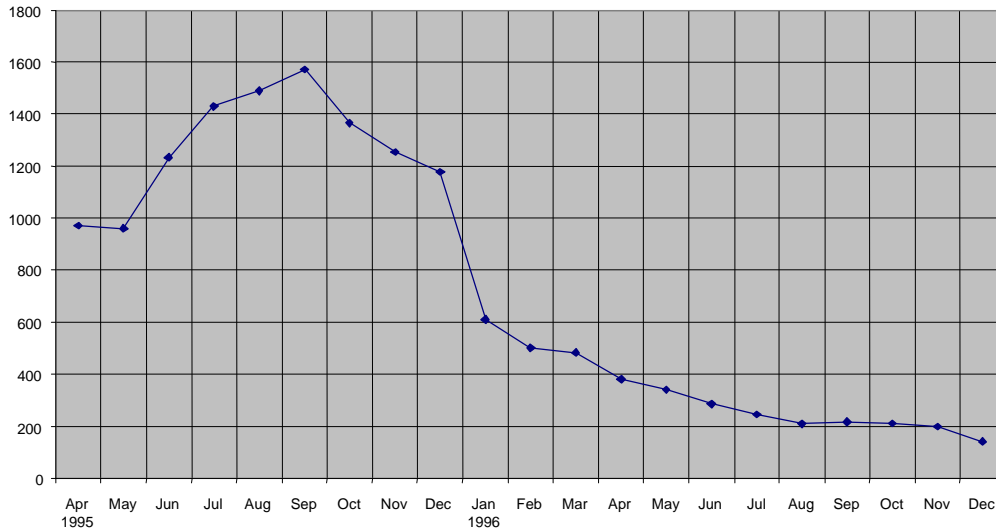
The total population of the Yombo Parish is estimated to be 48,500. The parish has 80 Small Christian Communities, with an estimated number of 12,000 members. Although the scheme is open to all parish members, in reality it will attract those who live close to the dispensary. During 1998, members came from 34 Small Christian Communities within the parish. Given the relatively large number of (mainly private) health care providers in or near the parish, it is difficult to define a catchment area and its population. At the peak of the scheme (June 1997), 3.8 percent of the parish members participated in the scheme.

The profile of the membership base of the Msimbazi scheme could not be established. Msimbazi Parish has 80 Small Christian Communities with 12,000 members. It is a widely scattered area. At the peak of the scheme (September 1995), the scheme reached 13 percent of the parish population.

Trends

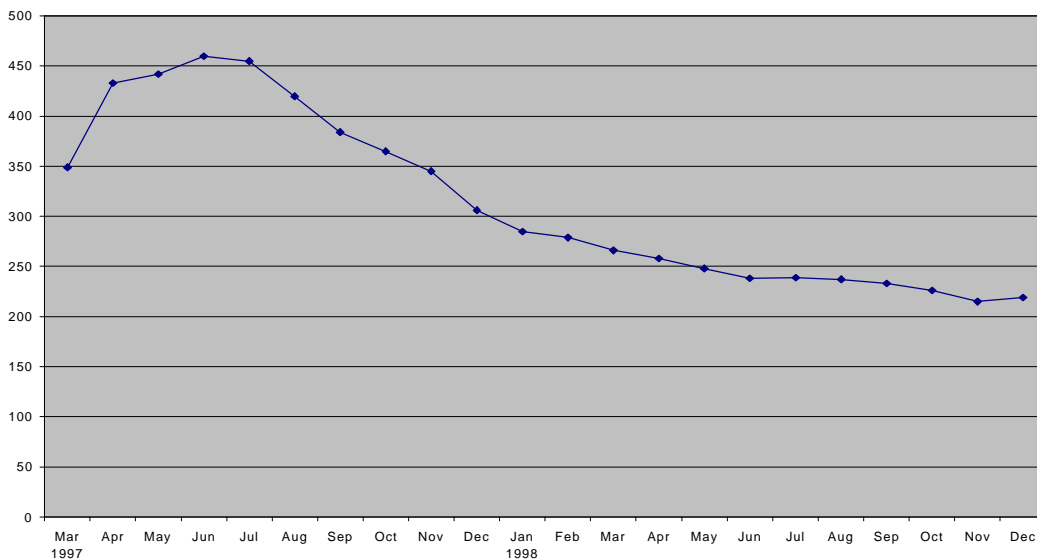
Membership in the two schemes has developed as follows:

Figure D-1. Membership Trend Msimbazi



Figures of 1997-1999 are not available. In progress reports it was mentioned that the number of members was 144 at December 1997 and 60-65 members in November 1998. Membership in April 1999 is 20 persons.

Figure D-2. Yombo Scheme Membership



1.1.7 Management

Responsibilities

According to the guidelines, the parish serves as the basic structure for the scheme composed of:

- ▲ The Small Christian Communities; and,
- ▲ The central parish with the Parish Office and the Parish Dispensary.

The Msimbazi scheme has an elected Executive Committee with seven members: Four of the members are elected (the chairperson, secretary, and two representatives of the Small Christian Communities). Three members are ex-officio (the spiritual director, who is one of the initiators of the scheme, the in-charge of the dispensary, and the administrative officer). The Executive Committee meets when needed, but at least every three months. They take the practical decisions needed and apply the general policy laid down by the general meeting.

Duties of the Executive Committee are mentioned in the constitution. The responsibilities of the administrative officer are clearly defined in the guidelines. This person is responsible for the collection of contributions, administers the fund, and prepares financial reports. According to the guidelines, the spiritual director is responsible to animate the people to express their solidarity through this specific form of a health insurance scheme. "This person takes care that the scheme remains with the right spirit of service, never aiming at making profit and trying to give the best service for the lowest costs."

The leaders of the Small Christian Communities play an essential role in the sensitization of all people living in an area and encourage them to be concerned with one another's problems and to put contributions together into a common fund. They are responsible for organizing regular meetings and collecting the contributions and passing them to the scheme's administrative officer.

In daily practice the administrative officer plays an important role in the functioning of the scheme.

Yombo Parish has a Health and Bima (insurance) Committee which consists of 11 members who were elected by the Parish Council. In addition to management of the scheme, the committee members are responsible for awareness creation on the health insurance within their Small Christian Communities. They also visit the sick and provide counseling (twice a month).

The key positions in the Health and Bima Committee are occupied by dispensary staff. For example the chairperson is a nurse, the secretary is a clinical officer and the treasurer is a sister who works at the dispensary. The treasurer is in fact at the same time fulfilling the role of the Administrative Officer, as she is collecting the contributions and keeps the accounts of the scheme. The Health and Bima Committee's assistant chairperson and the assistant secretary are leaders of Small Christian Communities. Two of the members are health counselors (volunteers).

Linkages with Other Organizations

Contacts with other organizations are mainly kept by the Church's technical support team. For example:

- ▲ There have been consultations with various experts in the government (Ministry of Health) and in parastatal organizations (Parastatal Pension Fund and National Insurance Corporation);
- ▲ There is a close collaboration with the International Labour Organization's SSMECA-STEP Project: sharing of information, workshops, negotiations with providers, etc; and,
- ▲ One representative participated in the Community Based Health Insurance Regional Conference in Kampala (November 9-13, 1998).

Underwriting

Both schemes rely on some level of subsidy. The Msimbazi scheme has used external funds (gifts from individuals) to cover the losses of the scheme. During the 1995-1998 period, these funds were used to pay for 56 percent of the total expenses. In Yombo, the dispensary is covering any deficits. For the years 1997-1998, the dispensary's donation has been equal to 12 percent of the expenses.

Members Involvement in Decisionmaking

According to the guidelines, members are involved in decision making according to the following structures of administration:

- ▲ All members are invited to a general meeting at least once a year. This meeting is the forum for members to make general policy decisions and gives guidelines for the operation of the insurance scheme.
- ▲ Members elect their representatives in the Executive Committee. The Executive Committee meets when needed, but at least every three months. They take the practical decisions needed.

In practice, Msimbazi had four general meetings (the most recent took place in May 1998). Meetings of the Executive Committee were held at irregular intervals. The most recent took place in January 1999.

Yombo scheme held no general meetings. The Health and Bima Committee have regular activities. However, these activities were not focussed on the health insurance scheme only, the members also visit the sick and provide counseling.

In practice it seems that the initiators and members of the Church's technical support team are making several decisions with regard to the scheme. In Yombo, the fact that the dispensary staff is strongly represented in the Health and Bima Committee results in a lower level of participation in decision making by the members.

Volunteerism

Members of the Executive Committee are all involved on a voluntary basis and do not receive any remuneration for the work that they do for the scheme.

The scheme is seen as a service and non-profit making arrangement, therefore the parish is rendering their service free of charge. In Msimbazi the administrative officer works on a voluntary basis, while being paid for some other work for the parish. In Yombo the sister who is the scheme's administrative officer does it as part of her work at the dispensary and volunteers her free time to make reports and take part in meetings.

Epidemics

The scheme has no provision for epidemics. It would probably rely on government or donor assistance to address losses or deficits from an epidemic. Epidemics are not part of "normal services rendered in a dispensary."

1.1.8 Community Participation

After designing a draft proposal, several consultative meetings took place with the leaders of the Small Christian Communities. However it is not clear to what extent these leaders could have made informed decisions on the scheme. As health insurance is quite a new concept in Tanzania, they were probably not aware of the different options with regard to membership, benefit package, organizational structure and procedures.

According to the April 1999 survey of 27 members of the scheme, 63 percent of the interviewees mentioned that the Health and Bima Committee is responsible for funds management and decision making, while 11 percent thought the dispensary is responsible and 26 percent did not know who is responsible. Seventy-four percent of the members never attended any of the scheme's meetings and 89 percent indicated that they never received any information on the fund's finances (e.g., financial reports).

The leaders of the Small Christian Communities are strongly involved in the marketing of the scheme. They are the 'Bima animators' within their communities. According to the design of the scheme, the leaders of the Small Christian Communities would play an important role in funds collection. This, however, did not work well in practice, as the handing over of the funds to the administrative officer was sometimes delayed.

Community Perceptions

From a survey done among 59 people in Yombo Parish, it was found that in general the community perception of the scheme is positive. Members indicate that it gives them a feeling of security because they are sure of getting treatment, even without having money. Some members also think that with the scheme, their expenses for health care are lower than they would be without the scheme. Several people, however, indicated that the scheme should extend its benefit package. Generally, the limited opening times of the dispensary are not appreciated. For non-members and ex-members, these were among the reasons for non-adherence, together with the distance from the dispensary.

From some discussions with the Msimbazi residents it was found that they feel there is a need to sensitize the people on the scheme. Some other suggestions were to increase the opening hours for collection of contributions and to use a dispensary with 24-hour service. Some members indicated that the distance from their houses to the dispensary is a major hindrance.

Information Flow

In both schemes, the Executive Committee members meet regularly. However, it seems that members and potential members are not well informed about the scheme's development. In addition, sensitization of the community took place mainly at the beginning of the schemes, while there is a need for continuous sensitization (IEC). Recently, the Yombo Health and Bima Committee started to be more active in this area.

1.1.9 Relations with Service Providers

The schemes are closely linked to the health care providers as the parishes serve as basic structures, including the parish dispensaries.

In the Yombo scheme, the dispensary staff are the key players in the management and administration of the scheme. With this arrangement, the scheme is not an independent partner of the health care provider. The dispensary staff are very committed to the development of the scheme.

In Msimbazi, the dispensary staff are not participating in the management of the scheme, and in theory they should be equal and independent partners. There have been quite a number of problems in the relationship between the scheme and the dispensary in the past, which were related to the weak management of the dispensary. With regard to the scheme, this resulted in:

- ▲ Problems with regard to accountability of the dispensary (incorrect invoices);
- ▲ Over-prescription practices;
- ▲ Unclear record keeping within the dispensary, which made it difficult to assess causes of problems; and,
- ▲ Problems related to quality of services and staff attitude.

The dispensary management failed to address these problems properly, referring the Executive Committee to the Diocese. The Diocese Medical Board is trying to address the management and quality problems in this dispensary.

The Church's technical support team has suggested some measures to improve and clarify the relations between the schemes and the dispensaries, and to make it possible to check quality and prices of care. They propose to sign a contract between the health insurance scheme and the dispensary. This contract specifies the terms of service and the cost of service rendered. This contract consists of the basic agreement and of the detailed description of the services rendered (including treatment guidelines) and the costs. These arrangements can be revised regularly following changes in costs and medicines available. A sample contract has been prepared but not signed yet.

1.1.10 Relations with Government and Other Social Groups

The members of the Church's technical support team consult with individuals in the Ministry of Health for information and guidance.

Most of the social groups to which the scheme is linked are related to the Church and part of the Church structure. For example, the scheme is closely linked to the Small Christian Communities. The Msimbazi scheme has received financial support from the Association of Christian Professionals.

The Church's technical support team provides technical assistance to other mutual health insurance schemes in Dar Es Salaam in areas such as assessment of health care providers, negotiation with health care providers, development and introduction of treatment guidelines, and checking on quality of care.

1.1.11 Financial Data

Income and Expenditure

The schemes' financial performance has been as follows:

Table D-4. Msimbazi Income and Expenditure (in Tsh.)

	1995	1996	1997	1998
Income				
Contributions	1,795,000	1,321,000	576,100	389,000
Gifts	1,442,300	2,311,000	658,730	1,000,000
Total income	3237,300	2,418,221	1,234,830	1,389,000
Expenditure				
Claims	3,110,945	2,388,121	1,264,025	725,880
Administrative costs	785,780	26,100	242,370	5,370
Total costs	3,896,725	2,414,221	1,506,395	731,250
Surplus(deficit)	(659,425)	1,213,779	(271,565)	657,750

The administrative costs above include marketing costs. The scheme still relies heavily on donations for its survival, as shown above under "Gifts."

Table D-5. Yombo Income and Expenditure (in Tsh.)

	1997	1998
Income		
Gifts	See note below	
Contributions	1,191,300	891,600
Total income	1,191,300	891,600
Expenditure		
Claims	1,253,700	1,121,699
Administrative costs	See note below	
Total costs	1,253,700	1,121,699
Surplus (deficit)	(64,400)	(230,099)

Note: The Yombo scheme's administrative costs were paid by the Parish and hence were the Parish's contribution in kind. Ideally these should be valued and included in "Gifts" and "Administrative costs" in order to give a fuller picture of the scheme costs and income.

2. Assessment of Performance

2.1 Resource Mobilization

The Atiman scheme has not yet made a significant contribution to the financing of the participating dispensaries. The table below shows that in 1998 the highest impact was in the Msimbazi parish dispensary where 5.4 percent of the dispensary's income was from insurance claims.

Table D-6. Scheme Contribution to Service Provider Income

Scheme	No. of visits	Claims	Dispensary total income (Tsh.)	% of Dispensary income from scheme
Yombo	1,375	1,121,699	35,560,900	3.1%
Msimbazi	321	622,180	11,319,310	5.4%

2.2 Efficiency

Methods of Service Delivery

In both schemes, primary health care services that are available at the parish dispensary are provided to members of the schemes. There has not been any expansion of or greater emphasis on the use of preventive health care as a result of the introduction of the schemes.

Technical Efficiency

The design of the schemes has incorporated several risk management techniques and omitted others:

- ▲ In its design, the scheme has not made much use of techniques to minimize the *risk of adverse selection*. Membership in the scheme is voluntary and based on individuals. In the guidelines, scheme members are cautioned not to register dependents for whom they are not able/willing to pay monthly contributions. This design feature may result in members only registering the dependents who have a higher risk to be in need of the services. A technique, which is used in the scheme design to prevent people registering only when they are actually sick, is the use of a probation or waiting period. Members have access to services in the calendar month following the month of registration. Hence, the probation period can vary from one to 31 days. In practice however, this system is not applied and members can access services immediately.
- ▲ According to the guidelines, *risk of moral hazard* is minimized by social control as the leaders of the Small Christian Communities are supposed to report abuse of the scheme to the Executive Committee. However, it is questionable whether the social control system is effective and to what extent the leaders have access to information on the members' visits to the dispensary.

- ▲ Measures to control the *risk of cost escalation* included an understanding that only essential/generic drugs are used. However, there is no written agreement. In Yombo, the dispensary seems to adhere to this policy, but in Msimbazi it is not easy to say so. In an effort to improve cost control, the Church's technical support team proposes the introduction of detailed treatment guidelines for most common diseases, and the registration of the essential/generic drugs policy in an official contract between the scheme and the dispensary. This, together with the regular control of the treatment reports, could contribute to minimizing costs while guaranteeing quality treatment. The decision to exclude costs related to treatment of diseases such as AIDS, TB, and cancer is another measure to avoid cost escalation and the risk that one or few members might drain the fund's resources. The mode of payment used by the scheme is based on fee-for-service. In principle, this fee system is not providing any incentive for the provider to avoid unnecessary treatment and prescriptions.

- ▲ To limit the *risk of fraud and abuse*, several control mechanisms have been put in place. The identity of a member is checked by the dispensary staff, based on the individual member card. The membership card contains a photograph and is covered and sealed with a plastic cover. The dispensary staff also verify whether the member is entitled to services, i. e., is up-to-date with contributions. The scheme has also managed to improve the control system and therefore to limit the risk of fraud and abuse by health care providers by introducing the following procedure: Every day the dispensary brings the invoice (which includes diagnoses, treatment, and prices) for members served that day to the administrative officer, who checks if members were entitled to be treated under the scheme. The Church's technical support team is planning to start regular control of these invoices (i.e., diagnosis, treatment, cost of medicine) by trained people.

2.3 Equity

The Yombo scheme collects a flat fee of Tsh. 300 per person per month, and the Msimbazi scheme collects a flat fee of Tsh. 500 per person per month. Therefore a titular member with a large family pays more than a titular member with a small family (i.e., if all family members are covered). The contribution is irrespective of the members' individual incomes. In interviews held in April 1999 with 59 members, ex-members, and non-members of the Yombo scheme, 43.6 percent thought the level of the contribution was just right while 53.8 percent found the contribution too low. However, it was also found that 13 percent of the members could not afford to pay the premium for all household members.

The difference in use patterns between members and non-members could not be established

One of the ideas behind the fund is that the members of the Small Christian Communities would prove their solidarity and that by having a large membership base, the rich could help the poor and the healthy could help the sick. The idea was that wealthier members were not likely to use the services so much so they are indirectly strengthening the fund. The guidelines state that as a Christian service, the scheme wants to help the poor. However, so far, there is no established means to help the poor to access health care through the schemes.

2.4 Quality

From the survey done among the scheme members and ex-members in April 1999, it was concluded that most members were satisfied with the services provided by the Yombo scheme through the St. Camillus Dispensary.

Table D-7. Yombo Scheme Member Satisfaction

Quality Indicator	Number	Percent
Quality of medical treatment		
Good	33	84.6
Average	3	12.1
Low	1	2.5
Don't know	1	2.5
Attitude of staff		
Good	31	79.5
Average	5	12.8
Negative	2	5.1
Don't know	1	2.5
Waiting times		
Short	5	12.8
Average	23	59.0
Long	4	28.2
Availability of medicines		
Always available	37	94.9
Not always available	1	2.5
Don't know	1	2.5
Prices		
High	2	5.1
Average	30	76.9
Low	12	30.8
Don't know	1	2.5
Cleanliness		
Clean	36	92.3
Average	2	5.1
Don't know	1	2.5

When asked, 88.9 percent of the membership prefers that the scheme continue to use the St. Camillus Dispensary. The others suggested to use a dispensary with 24-hour services, and to use more than one dispensary because of the distance of St. Camillus from the members' homes. Some ex-members indicated that they would renew membership if the scheme would implement some changes with regard to the dispensary. For example: provide a choice of dispensaries; provided 24-hour services at the dispensary; give scheme members first priority in receiving treatment (shorter waiting times); create an observation room in the dispensary. For non-members, the limited opening hours was one important reason for not joining the scheme.

Both dispensaries are under supervision of the Diocesan medical director, who is responsible to oversee quality of services. The Diocesan Medical Board arranges visits of experts to the dispensaries

to check appropriateness of medical care. Until now, the scheme does not have an independent control mechanism in place to monitor quality. However, with the planned introduction of a contract between the scheme and the dispensary, it will be possible to improve quality control.

All clinicians have treatment guidelines and are required to use them. St. Camillus Dispensary in Yombo is using the following guidelines:

- ▲ *Drug Information on Essential Drugs*. Dar Es Salaam Urban Health Project & City Medical Office of Health, 1998.
- ▲ *Standard Treatment Guidelines for Main Diseases in Dar Es Salaam Based on Essential Drugs*. Dar Es Salaam Urban Health Project & City Medical Office of Health, 1996.
- ▲ *Directions for the Management of Diseases*. Ndala Hospital, 1991.
- ▲ *Bima ya Afya ya Atiman Prescription & Prices Guidelines*. Introduced by the Diocesan medical director in all the Church-run dispensaries of Dar Es Salaam early 1999 in a seminar for health personnel.

In Msimbazi there was a history of over-prescription, which is now being addressed by the Diocesan Medical Board. Its staff also participated in the seminar in which the *Bima ya Afya ya Atiman Prescription & Prices Guidelines* were introduced.

2.5 Management

Within the Atiman schemes, management responsibilities, especially with regard to decision making, are not always clear. While the scheme is meant to be managed by the members, in practice the dispensary staff and the Church's technical support team play an important role in the functioning of the scheme.

In Yombo, the close ties of the scheme with the health care providers are demonstrated by the fact that the dispensary staff have key positions in the scheme management. They are probably the ones who take the day-to-day decisions with regard to the scheme. Within this organizational set-up, there is not much room for control of fund management. It might also be difficult for the other members of the Health and Bima Committee, and for common members, to criticize any aspect related to the functioning of dispensary. For example, while members indicate that they would prefer a change in opening hours of the dispensary, it would normally be the responsibility of the scheme management to negotiate with the health care provider on behalf of the members. In the present Yombo scheme set-up, they would not be in a position to have such negotiations.

The Yombo health insurance scheme seems to be running without too many difficulties. The dispensary management is committed to development of the scheme, and members of the Health and Bima Committee sacrifice some of their free time to volunteer for the scheme and meet on regular basis.

The Msimbazi schemes' management does not have clear strategies with regard to the scheme, nor do they have effective solution strategies. This could be related to the fact that none of the Executive Committee members or administrative officers has had any training on insurance issues. The Executive Committee has not succeeded in finding effective solutions for the decline in

membership and the problems with the dispensary. Over the last year, the meetings of the Executive Committee became less frequent.

The schemes are put in place as a 'learning-by-doing' exercise. Collection and analysis of information and identification of problems and solutions is mostly the responsibility of the Church's technical support team.

Financial systems were designed and put in place by the administrative officers of the schemes. The provision of simple, clear, and comparable reports on the scheme's progress and financial situation is lacking. Again, this is probably also related to the fact that no specific training has been provided to the administrative assistants. Another weakness in financial management is that the scheme does not have its own bank account. The scheme's funds are combined with other funds, which are managed by the Parish Office. This makes it more difficult to check the correctness of the accounts. It also allows for transfer of funds that are not authorized by the Executive Committee.

2.6 Community Participation

The initiators of the schemes made an effort to involve the community from the beginning by briefing them on their proposal. The leaders of the Small Christian Communities approved the scheme proposal without suggesting any significant alterations. However, they did not have an opportunity to select from different options with regard to membership, premium base, benefit package, choice of health care provider, and organizational structure and procedures.

The community was involved in the enrollment of the scheme, as initial promotion and registration was done through the leaders of the Small Christian Communities. Leaders were also involved in collection of the monthly contributions. However, this did not function very well in practice, as funds were sometimes not passed on in time to the administrative officer.

As described above, the community is not taking a very active part in the decision making with regard to the scheme. During interviews done in Yombo Parish in April 1999, 74 percent of the members indicated that they had never attended any meeting with regard to the scheme, while 88.9 percent have never received information with regard to the scheme's finances. This is confirmed by the fact that so far the scheme has not had a general meeting.

From the above, it can be concluded that the community is not taking active part in the management of the scheme and that there is no real sense of ownership of the scheme by the community.

2.7 Solution Strategies

It is mainly the Church's technical support team that has tried to address problems as they arise. For example, they have proposed premium increases to address the issue of losses, and they proposed introduction of certain control mechanisms to deal with the accountability and quality problems from the side of the Msimbazi Parish dispensary. However, the process of implementation of changes appears to be too slow.

None of the stakeholders has adequately addressed the problem of declining membership.

2.8 Sustainability and Replicability

Financial Performance

Table D-8. Msimbazi Income and Expenditure (in Tsh.)

	1995	1996	1997	1998
Income				
Contributions	1,795,000	1,321,000	576,100	389,000
Gifts	1,442,300	2,311,000	658,730	1,000,000
Total income	3237,300	2,418,221	1,234,830	1,389,000
Expenditure				
Claims	3,110,945	2,388,121	1,264,025	725,880
Administrative costs	785,780	26,100	242,370	5,370
Total costs	3,896,725	2,414,221	1,506,395	731,250
Surplus(deficit)	(659,425)	1,213,779	(271,565)	657,750

The administrative costs above include marketing costs. The scheme still relies heavily on donations for its survival.

Table D-9. Yombo Income and Expenditure

	1997	1998
Income	Tsh	Tsh
Gifts	<i>See note below</i>	
Contributions	1,191,300	891,600
Total income	1,191,300	891,600
Expenditure		
Claims	1,253,700	1,121,699
Administrative costs	<i>See note below</i>	
Total costs	1,253,700	1,121,699
Surplus (deficit)	(64,400)	(230,099)

Note: The Yombo scheme receives in-kind gifts through donated services of the Parish staff who run the scheme. These have not been quantified for inclusion in "Gifts" and "Administrative costs".

Liquidity

The schemes have no fixed assets. Funds are kept in the parish accounts. In Yombo, as expenses are not fully covered by premiums, the scheme is indebted to the dispensary. In Msimbazi the liquidity might sometimes be high (for example at the end of 1998 it was Tsh. 657,750). This is, however, related to the large donations regularly received by the scheme).

The financial performance over the past years has not been impressive, (particularly not for the Msimbazi scheme). In both schemes, contributions were not sufficient to cover treatment costs. As it is now, the schemes are not financially sustainable. For the scheme to become financially sustainable, the management has to look into measures to control costs and possibly adjust premiums.

Viability

The main factors that jeopardize the viability of the schemes are:

- ▲ Quality health care: To be able to increase the membership base, issues that have to be taken into consideration are opening hours, distance from (potential) members' houses, availability of choice of different providers, etc.
- ▲ Management: To increase the potential sustainability and replicability of the schemes, issues that must be resolved are independence from the health care provider, management's knowledge and competence on health insurance issues, decision-making practices, accountability, and community participation and ownership.
- ▲ Membership base: To create a stable membership base, there is a need for continuous sensitization process in members' involvement.

Institutional Issues

Schemes will have a bigger chance of success if mechanisms are put in place to regulate the relationship between the scheme and the health care provider, such as a contract and tariff agreements. Other important issues are the need for production of periodic financial reports and provision of training.

External Factors

In April 1999, an act was passed on introduction of (compulsory) health insurance for civil servants, which could later be extended to other workers in the formal sector. This insurance will target different groups and is therefore not creating a threat to the Atiman schemes. It might even contribute to the better understanding on the concept of insurance.

3. Key Lessons Learned

The study of the schemes has revealed that there are two levels of lessons learned: cross-cutting and individual scheme specific.

3.1 General

- ▲ All schemes are experiencing a decline in membership. The problem is more acute in the Msimbazi scheme.
- ▲ Contributions are generally low. As such, there is a dependence on gifts and subsidies.
- ▲ Neither scheme has had training that is specific to the establishment of mutual health insurance schemes. The schemes learn by doing.
- ▲ The level of community participation is not the same in the two schemes. In the Yombo case, the community and the health care provider are strongly tied together. Some technical personnel of the health care provider are at the same time executive members of the scheme. This creates a problem on the question of ownership. In Msimbazi, the scheme and the health care provider are more separate.
- ▲ Leaders of the Small Christian Communities are *de facto* the community promoters of the schemes. They carry the task of disseminating information regarding the progress of the scheme regularly.
- ▲ Data management is a critical issue in the two schemes. There are no clear reporting formats for information on membership, finance, utilization, etc.

3.2 Scheme Specific Lessons

- ▲ Msimbazi has a weak management team. There is abuse of the scheme and no control on the use of medicines.
- ▲ Data is processed manually. In April 1999 several files were stolen from the scheme's offices and this has created a problem because there were no duplicate copies and the scheme has been unable to reconstruct the information.
- ▲ The dispensary is not centrally located. Some members live far off and find it difficult to go there when sick.
- ▲ Contributions can only be paid at set hours three days a week

4. Recommendations

- ▲ There is urgent need to further examine and address the reasons for the falling membership in both schemes.
- ▲ The scheme management has not had training in managing such a venture. It is important that they are trained in the fundamental concepts of insurance as well as in financial management.
- ▲ Data management is an area that requires attention in order to provide meaningful information to the scheme management.

Annex E. Mburahati Health Trust Fund

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1. Findings

1.1 Basic Information

1.1.1 General

The Mburahati Metal Works and Carpentry Cooperative Society is a cooperative society engaged in the manufacturing of goods (metals and carpentry) for the local market. The group is located at Mburahati Ward, Kinondoni District, Dar Es Salaam, Tanzania. It was founded in 1984 and registered in 1992. At that time, the group had 20 members. Today, ten of the original members have left the group and another 17 have joined. All members are men. The newcomers are in one way or another linked to the original members. They are either their children, close relatives or were once apprentices working in the same cooperative society. This forms the basis of their solidarity.

Twenty-three members out of the 27 have presently established a mutual health insurance scheme: the Mburahati Health Trust Fund. The total number of beneficiaries (titular members and dependants) is 78. The scheme was established after a sensitization meeting of all cooperative members, which took place in March 1997. The sensitization meeting was organized and conducted by the staff members of the Strengthening Small and Micro Enterprise and their Cooperatives/Associations (SSMECA) Project, which is a joint project of the International Labor Organization (ILO) and the Small Industries Development Organization (SIDO).

After the sensitization meeting, the members unanimously agreed to establish their own mutual health insurance scheme. As a first step, the group nominated three people to attend a training workshop on the establishment and management of mutual health insurance schemes, organized by SSMECA project in August 1997.

Having acquired the basic knowledge on the establishment of mutual health insurance schemes, the three members conducted further sensitization meetings in their workplace. This culminated in the election of a Health Committee team composed of a chairperson, secretary and treasurer.

The Health Committee collected socio-economic information on the members who were able and willing to join the mutual health insurance scheme, including their family sizes. They also drafted the rules and regulations (constitution) to guide the operations of the scheme. In order to achieve this, the SSMECA Project provided guidelines in the form of discussion points—who should be a member, which health care services should be provided, under which conditions, etc.

By September 1997 the Health Committee had already produced a draft constitution. In early October 1997 the SSMECA Project team was invited to a group members' meeting where the constitution was discussed and (finally) approved.

The constitution provides guidelines on the management of the scheme, but the Mburahati Health Trust Fund is not registered as such. What is legally registered is the cooperative society. Although this is the case, the scheme has its own leaders as well as a separate bank account. In this respect it is autonomous from the cooperative society.

Members started making payments in February 1998. In June 1998, the Health Committee signed a contract with a dispensary that is located close to where they are working and started using its services.

Objectives

The development objective of the scheme is to improve access to quality health care for its titular members and their dependants.

The immediate objectives of the scheme as stipulated in its constitution are:

- ▲ Pay full costs of medical care (at dispensary level) to its members;
- ▲ Contribute 10 percent of the costs of hospitalization (government hospital); and,
- ▲ Pay transport costs in referral cases.

The immediate objectives are, in a real sense, the benefit packages that the members have prioritized.

Achievements

As key achievements up to date, the Mburahati Health Trust Fund has empowered its members and increased their access to quality health care:

Empowerment

The Mburahati Metal Works and Carpentry Cooperative Society has managed to establish its own mutual health insurance scheme—the Mburahati Health Trust Fund. With technical assistance from the SSMECA Project, the members of the scheme have actively participated in the design and implementation of their mutual health insurance scheme. In the process of establishing the scheme, the members have discovered the hidden potentials in social protection. As an organized group, they have also learned that they can sit and negotiate with a health care provider. Before the scheme was established, most of the members thought that the provider dictated the relationship between a sick person and a health care provider. In other words, the health care provider had power over the sick person.

The experience in Mburahati shows that this equilibrium is now changing towards a kind of partnership between the health care provider and the scheme. This has necessitated a change in attitude and behavior from both parties.

Improved Access to Health Care

The most direct achievement of the group is, however, improved access to health care. The group members do not have to look for money in the case of medical emergency and they do not have to delay treatment because of lack of cash. Before establishing the scheme, members had to go out to look for money and were delaying treatment as long as possible. Now, the scheme handles. This has not only a positive impact on their health situation, but also on their productivity (in their business).

When asked to comment on the reason why Mburahati established a mutual health insurance scheme, the chairperson of the group replied, “Before the scheme, I could not come to work when one of my children fell sick. I had to go around to look for money to take the child to the dispensary. Things have now changed. I come to work because the scheme takes care of that.”

Constraints

The two major constraints that the scheme has faced so far are arrears in payment of contributions and the adaptation of the dispensary to new reporting requirements.

Arrears

In the February–November 1998 period, most members were up-to-date with payments. Arrears started accumulating in December 1998 and January 1999. There are three reasons for this. One is that the Cooperative suddenly had a change to gain the title deed of the plot on which they work, and were required to pay for the costs involved within one month. Therefore, all members were required to contribute Tsh. 400 daily for this purpose. This went together with the usual expenditures related to the end-of-the-year-festivities.

The second reason is that the holy month of Ramadhan fell in January, where expenses are usually high (most scheme members are Moslems). Third, for those who have children attending schools, the month of January is the time when they are required to pay school fees.

Another reason could be that members felt that the scheme had enough reserves in its bank account because up to that time, only a few people (12 out of 78) went for medical treatment and the bank balance was quite high.

Adaptation to New Reporting Requirements

The mutual health insurance scheme and the health care provider had agreed to use separate treatment reports with basic information per consultation. After using the forms for several months, it was discovered that these were not always filled correctly and that there is a need to improve the format and some of the wording used in the original forms. Examples include the removal of a column on consultation fees which had in fact been waived, inadequate space for writing all the treatment details including unit, rather than total, prices, confusion over the name of the titular member against the patient, etc. In short, there is a need to conduct regular close follow-up of the health care provider.

1.1.2 Operating Guidelines

Documentation

The group has its written constitution with clearly defined rules and regulations. Furthermore the group has established clear procedures for accessing medical care and uses several administrative documents, records and reports.

Constitution

The constitution includes details on objective (including description of benefit package), membership, contributions, management, meetings, probation period, change of regulations, records, members' responsibilities and what will happen in case of disintegration.

Administrative Records

Membership card: The card has a photograph of titular member, family code, individual code, name, sex, age of registered dependants.

Family Registration files: This form is for the dispensary, with photographs and details (individual code, name, sex, age) of titular member and all registered dependants. These forms are used for identification of members at the dispensary. Whenever a member is not entitled to services (e.g., because of unacceptable delay in payment of contributions), the treasurer will make sure that the family file is removed from the dispensary to prevent access to services for this specific family. In the family file, the dispensary also mentions the codes of the related patient files; in other words, there is a link with the dispensary's regular administration. A copy of the family registration file is with the scheme's treasurer.

Treatment reports: These are filled in threefold whenever a member makes use of the services. Information includes date of visit, patient code and name, diagnosis, specification of treatment given (detailed: e.g., number and type of medication(s)) and related costs. The consulting practitioner signs this form. The dispensary keeps two copies for invoicing purposes. The patient receives one copy, which he/she has to sign as being a correct statement of treatment. The titular member also has to sign this form to confirm that his/her registered dependant has been treated. The treatment forms are submitted to the treasurer who should check if the prices of medicines are according to the contract with the dispensary. Also, the information on the forms can be used for basic review (e.g., most common diagnosis, use of (generic) drugs according to the essential drug list of the Ministry of Health and World Health Organization, financial analysis (average cost of treatment), and other analysis (e.g., use of scheme by members and dependants, average number of visits per patient per period, etc.). The treasurer uses the treatment forms to also keep track of total benefits received by each titular member.

Invoice: It is agreed that each invoice from the dispensary should contain the following information: details of each visit made during that month: treatment form number, date of visit, patient code and total amount for the treatment. A copy of the related treatment forms should be attached. The treasurer should control the invoices by comparing the information with the treatment reports he received from members.

Monthly Financial Registers

The treasurer also keeps detailed records of contributions per member, and records of daily income and expenditure. Report of income and expenditure are being produced on a regular basis.

Design of the administrative documents and records was done jointly by SSMECA project staff and scheme management, in consultation with the health care provider. Over time, some documents had to be modified.

Training

Sensitization of all cooperative members was the first training of group received from the SSMECA project. This created awareness of the need for social protection, and of the main characteristics of mutual health insurance schemes.

After the sensitization, three members of the Health Committee attended a three-day workshop on the establishment and management of mutual health insurance schemes.

The Health Committee members received on-the-job training related to administration and management issues during the regular follow-up meetings.

Another aspect of the training has been exchange visits between the Health Committee and other groups wishing to establish their own mutual health insurance schemes.

Training for the health care provider was mainly consultative and focused on improvement of information sheets and administrative documents, form and content of the contract, adherence to established procedures prior to medical treatment, etc.

1.1.3 Data Management

The secretary of the Health Committee is responsible to maintain all documents related to the scheme. This includes membership list, contract with dispensary, constitution, minutes of meetings, correspondence, and others. The treasurer of the scheme is responsible to keep the records of members' contributions, invoices, payments, and financial statements. Family registration files are kept at the Cooperative's office as well as at the health care provider's office.

The originals of the treatment forms remain at the group's offices while the health care provider keeps their copies. Before making payments, the Health Committee verifies the invoices against the corresponding treatment forms (with the assistance of SSMECA and TEC).

The information sheets use simple language and are considered appropriate. Storage and retrieval is equally easy. Due to the size and nature of the group, the data is not computerized. The scheme would have to grow enormously before using computerized data would be justified, as this would require large capital investment and training in modern information technologies.

1.1.4 Marketing

The SSMECA Project first sensitized the Mburahati Cooperative Society on mutual health insurance schemes. After the sensitization, three cooperative members attended a training workshop on the establishment and management of micro insurance schemes. Further awareness and internal marketing was done by the group members who attended the workshop. Their active participation in sensitizing their colleagues resulted in the establishment of Mburahati Health Trust Fund.

The media has equally made a close follow-up of the scheme. Through the press coverage, mutual health insurance schemes for informal sector associations have been promoted.

During frequent meetings of the scheme members, Information Education and Communication (IEC) on mutual health insurance has been provided to scheme members, both by the Health Committee and by SSMECA Project. During the launching ceremony, the community, local government and other interested parties received information on the features of the scheme.

1.1.5 Benefit Package and Premiums

Benefits Package

In the current phase, the scheme focuses on primary health care available in the nearby Harlem Agape Dispensary. The package includes consultation, laboratory tests, medicines (essential/generic drugs), small surgeries, dressing of wounds and dental extraction.

As outlined under the objectives of the scheme, other benefits include payment of 10 percent of the cost of hospitalization. This coverage is restricted to referral cases and use of government hospitals. Ten percent of the value of official receipts are refunded in such cases. In referral cases, transport of the sick person is fully refunded by the scheme.

The benefit packages were decided by the group members after a thorough analysis of their priorities (in medical care), their available resources and the services available at the nearby dispensary.

Chronic diseases, such as diabetes, high blood pressure, AIDS, and tuberculosis are not covered by the scheme due to the long-term high costs involved in the treatment of such diseases. As such, there would be a risk that one or a few chronically ill members could deplete the whole scheme. Moreover, the group members considered in their decision that the central government and other institutions have special programs for these kinds of diseases.

The package does not include mother and child health (MCH) services because they are not available at the selected dispensary. The dispensary is planning to provide these services in the near future. The members of the scheme will then have to decide whether they wish to include MCH services in the benefit package, and the related need to change premium levels for this purpose.

Premiums

There are two types of payments: registration fees and regular contributions. The registration fee of Tsh. 2,000 (US\$ 2.85) is meant to cover costs of preparing the necessary documents and other operational costs related to the start up of the scheme. It does not include the costs of preparing photographs of the members. The titular members pay the registration fee only.

The daily contribution is set at Tsh. 25 per person. This means that the titular member and the dependants pay an equal amount of Tsh. 25 per day or Tsh. 750 (US\$ 1.07) per month. A family of four people will pay Tsh. 100 per day or Tsh. 3,000 per month. Payment is in cash but recently one member paid in kind (for products that have to be sold the profit margin was accepted as premium).

Because of the absence of reliable statistics, the amount for the daily contribution was derived in a participatory training workshop. Workshop participants were requested to mention the average amounts they pay for registration, consultation, laboratory tests, treatment of malaria and other common diseases. They were also requested to estimate the average number of occurrences per year per person. The final decision on the daily contribution was reached in the general meeting of the members and is contained in the constitution.

The contributions are set on a daily basis for the following reasons:

- ▲ The members have a daily income. It is therefore a common practice in the group to make daily contribution for specific purposes such as a savings and credit scheme and co-operative membership.
- ▲ The amounts involved are affordable on a daily basis. If they accumulate for a number of days, they can become unaffordable. The most important aspect here is that all members should be up-to-date with payments at the end of the month.

Probation Period

According to the constitution of Mburahati Health Trust Fund, members will have to contribute for a period of three consecutive months before they can have access to medical care. The purpose of the probation period is to allow the scheme to have adequate reserves. This will also demonstrate that the members are really committed before signing a contract with a health care provider. Should a person fall sick during the probation period, then she/he will have to pay directly from his/her own pocket.

The constitution of the scheme allows for a lump-sum payment (all three months). While this is the case, discussions with the Health Committee show that lump-sum payment will be accepted on a case-by-case basis. It is not a blanket approval to every one. This is meant to avoid a situation where one joins the scheme when he/she falls sick.

Procedures for Accessing Medical Care

The constitution stipulates that members who are not up to date with contributions at the end of the month will not have access to medical care.

An elaborate procedure for accessing medical care has also been established. It involves nine steps and explains what one does when sick. The first step is to obtain an identity card (ID) from the titular member. After presenting the ID to the health care provider, his/her identity (name, photograph, code number etc.) will be searched from the family file of the titular member. Treatment is carried out after the verification of the patient's identity. If the titular member is in arrears, no treatment will be provided because his family file will have already been removed from the appropriate box.

After the treatment, the consulting practitioner and the patient sign the treatment form. A copy of the signed treatment form is hand carried by the patient for the titular member's signature. Then the titular member sends the signed treatment form to the treasurer of the Mburahati Trust Fund.

A flyer explaining the nine steps has been issued to each titular member so that he can inform/educate his family members.

1.1.6 Membership

As outlined earlier, members of the mutual health insurance scheme are also members of the Mburahati Metal Works and Carpentry Cooperative Society. They are all self-employed and engaged in the manufacturing of metal and carpentry products for the local market. Their workplace is located in Mburahati ward, Kinondoni District. Nearly all of them (82 percent) live at a walking distance from their work place. According to a survey done by SSMECA project in April 1999, the average monthly household income is Tsh. 90,000 (US\$ 128.50), varying from Tsh. 45,000 (US\$ 64.29) to Tsh. 210,000 (US\$ 300) per month. Analysis of the household composition shows that the average household size is 4.7 persons, with an average nuclear family size of 3.9 persons. Members' age varies between 25 and 60 years, with the majority (77 percent) between 25 and 40 years of age. In 71.4 percent of the households, the man is the only income earner.

Twenty-three out of 27 cooperative members have joined the mutual health insurance scheme. The total number of beneficiaries is 78 (titular and dependants).

For a person to qualify for membership, the constitution specifies that he should be:

- ▲ Above 18 years;
- ▲ Willing to pay registration fee and daily contributions; and,
- ▲ Honest and adheres to the rules and regulations.

Currently, membership is only open to workers of the cooperative society and their nuclear families. This means that a member has to enroll his spouse and all children. It also means that other

dependants are excluded (according to the constitution). Later on, the scheme might open up to neighbors and to business people who work close by. At the time this report was written, all the 23 original initiators of the scheme who form 85 percent of all the cooperative members, are active members. The original number of beneficiaries was 83. Some time after the launching of the scheme, one of the members who lives at a distance from the dispensary, decided to withdraw the coverage of his dependants.

1.1.7 Management

Leadership

The elected Health Committee is composed of a chairperson, secretary and treasurer. These are elected by all members at the annual general meeting every three years.

According to the constitution, the roles of the Health Committee are to:

- ▲ Receive and keep accurate records of all its members and their contributions;
- ▲ Negotiate with a health care provider on the best prices and quality medicines and to enter into a formal agreement on behalf of the scheme;
- ▲ Open a separate bank account;
- ▲ Call regular meetings to inform members of progress and constraints; and,
- ▲ Link the members to national and international organizations.

The Health Committee members work on a voluntary basis and are not paid any allowances.

In order to improve information flow between the leaders and the members, the group has established two types of meetings – monthly meetings and the annual general meeting (AGM).

Matters which are discussed in the monthly meetings include progress of the scheme (contributions, payments made, use of services, bank balance etc.) and suspension/expulsion of members.

The AGM can discuss the performance of the Health Committee and can call for the general election (secret balloting).

Although the AGM is scheduled to take place after every three years, it can be called at any time provided that three-quarters of all the members request to do so.

The flow of information between members is made easy by the fact that they work in the same place and meet almost every day.

Minutes of the meetings are usually recorded and kept.

1.1.8 Community Participation

The establishment of the scheme has been described in the introduction. It can be said that the initiative to start and develop the scheme came from the members of the Mburahati Metal Works and Carpentry Cooperative Society. Protection against illness was already identified as a major problem among the cooperative members. In the past the group used to have a rudimentary social protection system whereby one day's work was dedicated to meet treatment costs of its members. The system was, however, temporary and not systematic. This explains why after the sensitization meeting, 85 percent of its members worked hard to establish their own scheme.

The members designed the scheme: they elected a Health Committee among themselves, defined their constitution, made payments (registration fee and daily contributions) opened a bank account and signed a contract with a health care provider.

The sensitization meeting was the basis for the scheme and its activities. In all these activities, the SSMECA project provided technical assistance while the group took all the necessary initiatives. It can therefore be said that the scheme is fully designed, managed, and owned by the group.

In general the community's perception of the scheme is positive. In a survey done in April 1999 members were asked to indicate how the membership of the scheme has helped them. Among their replies were:

- ▲ Members felt more secure because they can get treatment even if they don't have cash.
- ▲ Some members mentioned that health care is cheaper and that it is easier for them to get medical services than before.
- ▲ Some members mentioned that membership in the scheme helped them to solve the problem of unnecessary debts.

Members' perceptions about the problems that the scheme is facing are mostly related to the fact that payments of contributions are not always up-to-date.

1.1.9 Relations with Service Providers

Before signing a contract with the Harlem Agape Dispensary, the Health Committee contacted three nearby dispensaries and conducted an assessment of each facility using a questionnaire that was aimed at establishing the quality of the health care providers in terms of:

- ▲ Qualification of medical personnel;
- ▲ Hours of service;
- ▲ Available services, their quality and costs; and,
- ▲ Willingness to establish partnership with the group and accepting monthly payments after service provision.

After the preliminary information was collected, and the Health Committee, accompanied by the SSMECA Project team and a qualified medical consultant, visited the three dispensaries and held initial discussions. The discussions were centered on issues such as period of establishment, average daily number of patients, record keeping, use of essential / generic drugs, the physical condition of the building, prior experience in working with informal sector groups and treatment procedures.

Based on the outcome of the visits and the discussions, the Harlem Agape dispensary was selected. It was nearby, it had qualified staff, fair prices and short waiting times, and the doctor in charge showed a lot of understanding.

Additional contacts with the dispensary were made which culminated in the formal signing of the contract between the Health Committee and the Harlem Agape Dispensary. The contract specifies:

- ▲ Whom should be treated;
- ▲ Which services should be provided and which types of drugs should be prescribed;
- ▲ Which procedures should be followed in accessing medical services; and,
- ▲ When to receive invoice (end of the month) and when to make payments (within 14 days after delivery of invoice).

The Mburahati Health Trust Fund has signed a contract with a private health care provider. Prices for services are comparable to those of other nearby private for-profit dispensaries. Public dispensaries are generally able to deliver services at a lower fee, but for the moment do not provide the same quality in terms of availability of medicines and equipment, waiting times and staff attitude. The Harlem Agape Dispensary agreed to waive consultation fees and to use essential/generic drugs only, to cut down on the costs of treatment. The Dispensary is now in the process of reviewing the treatment guidelines that were proposed by the TEC medical adviser. The use of such guidelines would be another measure to enhance quality of care, while avoiding unnecessary treatment and prescriptions.

There are many private health care providers in Dar Es Salaam. As such, there is strong competition. The fact that the Harlem Agape Dispensary has signed a contract that guarantees the health care provider to have a stable clientele of 78 is a major incentive for the dispensary.

1.1.10 Relations with Government and Other Social Groups

Government

The Cooperative Society whose members have established the mutual health insurance scheme has formal links with the local government. The Kinondoni district cooperative officer provides training on aspects related to cooperative management and is auditing the Cooperative's accounts. To the scheme this link is indirect.

The most direct link which the scheme has had with the local government was during the official inauguration of the scheme (May 25, 1998), where the representative of the Kinondoni district commissioner was the guest of honor. Other local government officials attended the ceremony. This resulted in awareness by the local government of the initiative.

Ministry of Health officials are aware of the activities of the ILO in the promotion of mutual health insurance, and have indicated that they want to learn from the ongoing initiatives, with the intention of setting up guidelines for such schemes in the future.

Other Social Groups

The group leaders of Mburahati have always acted as resource persons in training workshops. Moreover, because of the achievements made by the scheme, other groups have approached the Project for technical assistance in establishing their own micro-insurance schemes. VIBINDO, the umbrella organization for 256 associations of micro-entrepreneurs and petty traders in Dar Es Salaam specifically asked for a sensitization meeting of its members. This was held with the SSMECA Project on January 16, 1999, and was attended by 135 people.

Besides these links, the Medical Department of the Catholic Secretariat of the Tanzania Episcopal Church (TEC), has agreed to assist the group in checking the treatment forms on a regular basis, to check whether treatment guidelines are followed and there are no unnecessary prescriptions.

1.1.11 Financial Data

Income and Expenditure

Income and expenditure figures during the period February 1, 1998 to March 31, 1999 is shown in Table E-1.

Table E-1. Income and Expenditure

Income		Expenditure	
Registration fees	46,000	Administrative expenses	59,300
Contributions	433,550	Treatment	56,900
		Surplus	363,350
Total	479,550	Total	479,550

1.2 Assessment of Performance

1.2.1 Resource Mobilization and Proportion of Health Facility Income Received from Scheme

Members of the Mburahati Health Trust Fund have had access to the services under the scheme since July 1998. In the first nine months of its operation, 18 members used the services, for a total amount of Tsh. 56,900 (US\$81.29) and an average amount of Tsh. 3,161 (US\$ 4.52) per visit. Financial information of the dispensary over the same period was not available. As such, there are no comparable data for non-members.

Resource mobilization seems not to be without problems. In the period January-March 1999, only 23 percent of the contributions were received.

1.2.2 Efficiency

Methods of Service Delivery

The Agape Harlem Dispensary, which provides medical services to the members of the Mburahati Health Trust Fund, is, as the name implies, a dispensary. It offers primary health care services—preventive and curative. In the case of major diseases, the dispensary refers the patients to nearby government hospitals. While the majority of the costs of primary health care are covered by the scheme, costs for care at secondary and tertiary level still have to be borne by the members themselves. As a sign of their solidarity, members decided on inclusion of 10 percent of hospitalization costs in the benefit package and coverage of transport of the patient to the hospital. Full coverage of hospitalization costs would be unaffordable for this low-income group, especially as the membership base is too small for adequate risk sharing of low-risk high-cost events.

The selection of the dispensary was based on more criteria than cost-effectiveness alone. Where a public health care provider in theory could deliver cheaper services, in practice members expected problems related to quality (availability of qualified staff, equipment and medicines) and service level (waiting times, staff attitude, corruption). Other criteria were distance from working place and willingness to co-operate with the scheme.

Technical Efficiency

The design of the scheme has incorporated several risk management techniques:

- ▲ To minimize the risk of adverse selection, membership of the scheme is based on the whole nuclear family, i.e., spouse and all children who reside in the titular member's household. However, the April 1999 survey found that four titular members (18 percent) had not covered their whole nuclear family. One spouse and seven children were excluded. Reasons stated varied from distance between the member's home and the dispensary, to inability to pay contribution for all dependants. One member mentioned the latter reason combined with the fact that this dependent "was never sick." The outcome of the survey indicates the importance of verifying the registration of dependents to control adverse selection.
- ▲ A probation or waiting period of three months also is used to avoid adverse selection. The waiting period avoids the possibility to enter the scheme at the moment that one is in direct need of treatment. Such a long probation period is not really necessary for primary care. Other factors played a role in the decision on the duration of the probation period, such as testing the members commitment to contribute over a longer time and the possibility to build up sufficient reserve funds.

The risk of moral hazard is minimized by social control. The social control system is effective because the group is small and all titular members know each other and meet on a daily basis. Another measure to minimize the risk of moral hazard is that the 10 percent of hospitalization costs and transport to hospitals are only paid in case of appropriate referrals.

Measures to control the *risk of cost escalation* included the agreement to use essential/generic drugs only. The dispensary is obliged to use prices according to the price list that is attached to the contract. These prices are based on the use of generic drugs. Even if brand name drugs are provided, the dispensary can only bill the price of the generic drugs.

The payment of 10 percent of costs of hospitalization has the following restrictions:

- ▲ Hospitalization must be based on referral by the Harlem Agape Dispensary and applies to Government hospitals only; and,
- ▲ Members should produce official receipts (in case of purchase of drugs, the receipts should be accompanied by a prescription from the hospital).

Through the assistance of the TEC Medical Department, the scheme and the health care provider are in the process of introducing more treatment guidelines for most common diseases. This, together with the TEC assistance in the regular control of the treatment reports, could contribute to controlling costs while reinforcing quality treatment.

The decision to exclude costs related to treatment of chronic diseases is another measure to avoid cost escalation and the risk that one or a few members could drain the fund.

The mode of payment used by the scheme is based on fee-for-service. In principle, this fee system is not providing any incentive for the provider to avoid unnecessary treatment and prescriptions. During the training, the health committee members have been informed about the different payment systems and their advantages and disadvantages. The option of fee-for-service has probably been chosen because they are most familiar with it, and because they fear that the health care provider reduce on quality if another payment mechanism such as capitation were used. The scheme has found a way of keeping the costs down by negotiating reduced tariffs (e.g., waiving consultation fees). The scheme has no ceiling on cover of health care to be provided per member per period, which would be another way to contain costs.

To limit the risk of fraud and abuse several control mechanisms have been put in place. The identity of the members is checked by the dispensary staff, based on the family file at the dispensary, which contains photographs of all beneficiaries. Secondly, the scheme's treasurer keeps records of the benefits received per titular member. In case of any abnormal or questionable patterns of use, a check of the treatment reports could be done with the assistance of the TEC Medical Department. A third control measure is that the titular member has to submit a copy of the treatment report (certified by the patient and the titular member) to the treasurer of the scheme. Here the social control aspect also plays an important role.

1.2.3 Equity

Membership to the scheme is based on a nuclear family. The scheme collects a flat fee contribution of Tsh. 25 per day per person; therefore a titular member with a large family pays more than a titular member with a small family. The contribution is irrespective of the members' individual incomes.

According to the constitution, coverage of dependants other than spouse and children is not allowed. This means that those members with other dependants (27 percent) still have to carry an additional burden of treatment costs for those dependants. According to the survey done in April 1999, 4.5 percent of the titular members indicated that they paid for health care for the non-members in their household during the previous three months.

As the scheme is still young, it might be too early to establish trends in utilization patterns of services between members and non-members. During the period from July 1, 1998 to March 31,

1999, 19 members made use of the facilities of the Harlem Agape dispensary. A survey done showed that over a period of three months, 9 percent of the members incurred additional expenses for health care at other dispensaries.

The members of the Mburahati Health Trust Fund are working in the informal sector and are not covered by any other social protection systems. With an average yearly household income of Tsh. 1,072,872 (US\$ 1,533),¹ which is below the GDP per capita (US\$ 2,989 for the average household size²). The scheme has no provisions for charity or exemptions: all members are expected to pay their contributions and so far, the scheme is not aiming at covering non-cooperative members.

1.2.4 Quality

From the April 1999 survey of scheme members, it could be concluded that all members were satisfied with the services provided by the Harlem Agape Dispensary. Their perceptions on the quality of the dispensary are shown in the following table.

Table E-2. Perceptions of Dispensary Quality

Quality Indicator	Number	Percent
<i>Quality of medical treatment</i>		
Good	19	86.4
Average	3	13.6
Low	—	—
<i>Attitude of staff</i>		
Good	16	72.7
Average	3	13.6
Negative	—	—
Don't know	3	13.6
<i>Waiting times</i>		
Short	14	63.6
Average	5	22.7
Long	—	—
Don't know	3	13.6
<i>Availability of medicines</i>		
Always available	20	90.9
Not always available	1	4.5
Don't know	1	4.5
<i>Prices</i>		
High	—	—
Average	18	81.8
Low	1	4.6
Don't know	3	13.6
<i>Cleanliness</i>		
Clean	19	86.4
Average	—	—
Dirty	—	—
Don't know	3	13.6

¹ Based on income as indicated by members in a survey done in April 1999.

² GDP per capita according to UNDP Human Development Report 1998.

Of the members interviewed, 95.5 percent want the scheme to continue using the Harlem Agape Dispensary.

When the scheme entered into an agreement with the health care provider in June 1998, payment was based on fee-for-service. Prices were pegged on the essential and generic drugs. As part of its collaboration with the scheme, the TEC Medical Department has assisted by reviewing the use of the treatment reports. They identified various weaknesses including:

- ▲ The titular member's name was used on the treatment report instead of the patient's name. This was because of an unclear definition of the term in the treatment report.
- ▲ Consultation fees were included in the total fees, while it had been agreed in the contract that they would be waived.
- ▲ In some treatment reports:
 - △ The diagnosis was not indicated or not clearly described;
 - △ The services were not clearly described (e.g., type of laboratory tests, type of medicine) The dispensary staff indicated that this was because there was not sufficient space on the forms to fill the required information; and,
 - △ The calculations of the prices for the services, mainly for medicines, were incorrect.

These issues have been taken up with the dispensary and the format of the treatment reports was modified. It is clear that there is a need for close monitoring to ensure compliance with reporting instructions. The scheme, in collaboration with the TEC, is presently in the process of introducing the use of treatment guidelines for the most common diseases (for adults and for children). The treatment guidelines will be the basis of improved monitoring of the quality and cost-effectiveness of health care.

1.2.5 Management

Three people—the chairman, secretary and treasurer—form the scheme's Health Committee. They work on a voluntary basis. All three have attended the workshop on the establishment and management of mutual health insurance schemes. They have also received on-the-job training during the regular follow-up visits by the SSMECA Project. The treasurer has particularly been trained (in house) on the preparation of daily, monthly, and annual financial reports of the scheme.

Before starting the scheme, the cooperative leaders participated in several workshops on leadership and group management organized by a SIDO/GTZ project. This training greatly contributed to the democratic decision making and financial transparency within their organization.

The April 1999 survey of members sheds light on the question of accountability/transparency:

- ▲ 95.5 percent of the members get regular information on the progress of the scheme during their monthly meetings; and,
- ▲ 86.4 percent of the members feel the scheme has no management problems. The problem identified by the remaining 13.6 percent is delay by members in making contributions.

The responsibilities of the leaders are clearly defined in the constitution. Problems are discussed with members during the regular meetings. Solutions and decisions are made in a democratic manner.

1.2.6 Community Participation

The level of community participation within the scheme is very high. All members were fully involved in the whole design of the scheme. Jointly the members took decisions on features of the scheme, e.g., with regard to membership, benefit package, contribution rate and frequency, management structure, choice of health care provider, provider payment system and probation period. They manage the scheme on their own. The SSMECA Project and the TEC medical adviser have only been providing technical assistance.

1.2.7 Solution Strategies

The scheme is still young and has limited experience with problem solving strategies. The fact that it is small (23 members), all members have known each other for many years, live nearby, and are in one way or another related, gives the scheme a strong sense of solidarity.

1.2.8 Sustainability and Replicability

Financial Performance

It is still too early to assess the financial performance of the scheme. So far, the financial performance indicators are as follows:

- ▲ The ratio of administrative costs to income is 12.4 percent (70 percent of the administrative costs were related to start-up of the scheme); and,
- ▲ Net surplus for the year was Tsh. 363,750.

Institutional Issues

As the scheme is an activity of the Mburahati Metal Works & Carpentry Cooperative, its sustainability also depends on the activities and sustainability of this cooperative.

The scheme is independent from the health care provider and is therefore able to represent its members' interests effectively. This is illustrated by the drawing up of a contract between the scheme and the dispensary, and the preceding negotiations. However, for monitoring quality of the health services, the scheme will most probably rely on collaboration with an external organization. The TEC Medical Department has so far taken up this responsibility. If they were to withdraw, it might not be easy to find another organization/person to take over this important task, due to the high costs that might be involved.

The scheme has a clearly defined organizational structure, with well-defined tasks and responsibilities of leaders. The leaders report to the members in the regular meetings. All members are involved in the decision making process.

Administrative and Managerial Capacities

The leaders of the scheme have been trained by the SSMECA Project. SSMECA project has been promoting the establishment and management of mutual health insurance schemes for the informal sector as a pilot activity. This type of support has not yet been institutionalized in a local organization. It is clear that for replicability of such schemes there would be a need for capable support organizations, which should have adequate resources. As mentioned above, the scheme's leadership does not have enough medical background to check the quality of the health care provided.

The tools that are used for control of abuse and for record keeping and preparation of financial statements are simple and adapted to the members' context.

External Factors

Health insurance is a relatively new concept in Tanzania. So far, only a few initiatives have been developed that were targeted to extension of social protection to the informal sector. These could be either provider-based or community-based (mutual) schemes. Most of these schemes are in a pilot phase. As the need for social protection in this sector is high, it is unlikely that the other schemes will undermine the Mburahati Health Trust Fund.

The Ministry of Health's reaction to the new initiatives is positive. They have indicated that they want to learn from the ongoing experiences before developing guidelines or legislation for community-based health insurance. It is recommended that the stakeholders participate in development of such guidelines/legislation.

As indicated before, the scheme's sustainability depends on the sustainability of the main cooperative. This, in turn, depends on external factors related to the environment for self-help organizations of micro-manufacturers and petty traders. Among the issues are access to workplaces, business support services and micro-finance services.

2. Key Lessons Learned

2.1 General

- ▲ The establishment of mutual health insurance schemes for micro-entrepreneurs in Tanzania is relatively new. There are very few successful examples. They are not well publicized and therefore remain unknown.
- ▲ Many micro-entrepreneurs have identified ill health as a major problem, which is also affecting their business. Most are willing to establish their own health insurance schemes but lack the know-how.

2.2 Case Specific

- ▲ The Mburahati Health Trust Fund is the first successful urban mutual health insurance scheme in Tanzania, which is fully designed and managed by its members (full participation). It is relatively new (ten months, at the time this was written) and its membership is small—23 titular members, covering 78 members). The members have known each other for long periods and are closely related.
- ▲ The Health Scheme Committee has received training that is specific on mutual health insurance schemes.
- ▲ The group has signed a contract with a private dispensary, which provides curative and preventive care. So far, treatment has been curative. There is a strong need to address the aspect of preventive care through health education.
- ▲ Members work in the same work place and usually meet to exchange information on the progress of their scheme. This contributes to the social control factor to limit the risk of moral hazard and abuse.
- ▲ Until now, the scheme has not experienced high administrative or medical costs. There are adequate reserves. Although this is the case, commitment to the scheme and payment of regular contributions are the key indicators for its future success.
- ▲ There is an external audit of the treatment forms to check the quality of health care given by the provider.

3. Conclusions and Recommendations

3.1 Conclusions

3.1.1 General

- ▲ There is need to further market the concept of mutual health insurance schemes for micro-entrepreneurs. This is expected to lead to the establishment of more schemes. This means that SSMECA and other similar organizations should be ready to provide the necessary technical assistance.
- ▲ Scientific data on the cost of medical care in Tanzania is not readily available. This needs to be established.

3.1.2 Specific Conclusions Related to Assessment Criteria

Resource Mobilization

For the time being, the scheme is not contributing significantly to the income of the health care provider.

Efficiency

The design of the scheme is based on PHC at a dispensary level. Special features were designed to control abuse, cost escalation, moral hazard and adverse selection.

In the case of referrals, the scheme pays 10 percent of the hospital costs in a designated government hospital.

Quality

Quality is promoted through:

- ▲ The use of essential and generic drugs;
- ▲ Regular monitoring from the Medical Department of the Tanzania Episcopal Church; and,
- ▲ The contractual agreement with the provider.

Management

The scheme is managed by the Health Committee of the scheme. Committee members have been provided with specific training on mutual health insurance schemes.

Community Participation

The whole group was involved in the design process of the scheme. They fully own it.

Sustainability and Replicability

The sustainability of the scheme depends on the sustainability of the main cooperative and the commitment of its members.

3.2 Recommendations

3.2.1 General Recommendations

- ▲ There is a need to establish a network of projects, associations, non-government organizations, etc. that are involved in the promotion of mutual health insurance schemes (rural and urban).
- ▲ Undoubtedly, the various groups/projects use different methodological approaches. These should be synchronized (exchanges, methodology development). Consensus should be sought on:
 - △ The degree of community involvement in the design of the schemes (ownership);
 - △ Information dissemination between group members and between the proposed networking organizations; and,
 - △ Monitoring and evaluation of schemes.
- ▲ The proposed network of organizations should create awareness and market the concept and provide training (workshops, study tours, etc.) which is specific to the establishment of mutual health insurance schemes. The focus of the training should be to empower groups to design and own their individual schemes.
- ▲ The network should sensitize private/public health providers on the concept and seek their active participation.
- ▲ The network should document, publish, and publicize the best case studies through the different media.

3.2.2 Specific Recommendations

- ▲ Conduct regular participatory workshops with all the members (titular and dependants) in order to identify the strengths and weaknesses of the scheme.
- ▲ Together with the Harlem Agape Dispensary, establish ways of introducing health education to its members.
- ▲ The TEC should continue to audit the treatment forms.
- ▲ Analyze treatment costs with the dispensary and periodically review contract and prices. Introduce treatment guidelines as soon as possible.
- ▲ The government, especially the local government (city, municipal and town councils) should be informed of what is taking place through regular progress reports and workshops.

- ▲ Ensure that members meet regularly to assess the performance of the scheme (SSMECA).

Many of these qualities can be attributed to the small size of the group and the solidarity among its members, and the technical assistance provided by SSMECA Project.

3.2.3 Specific Recommendations for Government Policy

- ▲ The local government should be encouraged to market the concept of community-based health insurance/mutual health organizations in selected wards where the prospects of establishing successful schemes are high.
- ▲ The ongoing initiatives should be monitored and documented. In the long run, these case studies will provide important insights and guidelines on policy formulation.

3.2.4 Specific Recommendations for Donors

- ▲ Donors have a major role to play in providing the necessary funds for awareness creation, training, and capacity development of the groups.
- ▲ The community empowerment approach being promoted by the SSMECA project is time-consuming and new in Tanzania. It puts more emphasis on the process of empowerment rather than the final product. Both aspects are important components of a sustainable project.