TANZANIA HIGHER LEARNING INSTITUTIONS TRADE UNION (THTU)

RE-IMAGINING THE FUTURE OF IMPLEMENTING UNIVERSAL HEALTH COVERAGE IN TANZANIA: EXPERIENCE FROM THE COMMUNITY HEALTH FUND (CHF)

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1.0. Introduction

Since the introduction of the decentralised system, Tanzania embarked on different mechanisms of health financing such that in 2001, the country introduced both the National Health Insurance Fund (NHIF) and Community Health Fund (CHF) schemes to cater for the rural poor. Since then, there has been need for the introduction of Universal Health Coverage (UHC) which seeks to ensure that everyone has access to better healthcare. It is in the same perspective that the government plans to introduce UHC that is envisioned to witness every Tanzanian being ensured and a bill was developed to this effect. The bill that was first read in the parliament on 23rd September 2022 has sparked a lot of interest among Tanzanians; the learned and unlearned. The parliament has offered opportunity for individuals and groups to present their views so that the bill can be further improved before being passed and signed into law.

While it is very important to appreciate the bill and the subsequent arrangements for its implementation by July 2023, many questions still arise, and they will keep emerging until the day of its implementation and beyond. These questions revolve around the following (i) Is it the right time to implement the UHC? (ii) Are Tanzanians ready for its implementation? (iii) What is the government experiences from the present health insurance like community health fund (CHF)? (iv) Will the UHC be sustained and achieve the targeted 44% enrolment by 2030? A critical reflection to these questions is of importance to help sharpen the present bill and the proposed policy guideline and for the ultimate sustainability of the scheme.

2.0. Universal health coverage in Tanzania: Is it the right time for its implementation or not?

All signs portray that timely implementation of UHC is now. This is due to the three main issues (i) Experience from the already implemented community-based health insurance i.e., CHF as well as experience from NHIF. The implementation of these schemes has revealed strengths and weaknesses that should be addressed (this will be addressed in subsequent sections). The study

that was done by NIMR in 2022 established that 73% of citizen expressed their readiness to join the UHC which shows that Tanzanians are now aware with the on-going health insurances. (ii) The global force has also attracted the need to introduce UHC emanating from the sustainable development goals which called for each country to implement the UHC by 2030. Thus, by ratifying to the international agreement puts the country with no option than pooling its efforts to join other countries to implement the UHC. (iii) The increasing population which is project to almost 60 million (waiting for the actual statistics from the NBS). The increased population continues to add pressure for the government in its efforts to improve health service delivery. Thus, for the government to have assurance that its people will enjoy quality health services then pooling mechanism of health financing through UHC is mandatory.

3.0 Community health fund as a yardstick for implementing UHC in Tanzania.

The community health fund (CHF) was introduced in 2001 under the auspice of the decentralised policy, and Igunga district was the centrepiece of the scheme. Initially, the contribution to the scheme was TZS 5,000 which was later raised to TZS 10,000 and was managed at the district level under the Council Health Management Team (CHMT), Council Health Service Board (CHSB) and Health Facility Governing Committee (HFGCs). With two decades of implementing CHF insurmountable challenges emerged (will be discussed later) that prompted the need for further improvement hence, the introduction of the improved Community Health Fund iCHF in 2018. The iCHF premium was raised to TZS 30,000 and extended referral to the district hospital which also allowed patients to be admitted for certain days amongst others. With all its efforts since 2001 to enrol CHF members, the coverage has been as low as 6% national wise. The failure to enrol as many members as possible to the CHF was due to inherent weaknesses including weak management, poor health services, poverty among its staff, overburdened health care workers etc. The lingering question is how will the re-imagined UHC escape from the current challenges faced by the CHF?

3.1 Importance of using CHF as a reference for sustainability of the UHC.

First, the implementation of UHC in Tanzania is context-specific with its distinct conditions. Thus, sheer coping from other successful countries in Africa (Rwanda) and or other LMICs is not by itself satisfactory. Instead, learning the success and unsuccessful stories from the two decades of implementing CHF is much better. Secondly, I have widely researched the

implementation process of CHF in Tanzania drawing from high and low-performing districts. As a result, this can better give a thorough reflection of how the ambitiously UHC can correctly be implemented and its possible sustainability.

4.0 Challenges that faced CHF that may permeate to the UHC.

The present bill on the implementation of UHC follows consultative efforts that the government has made to-date. And given its relevance, one cannot resist agreeing to its formal implementations come July 2023. However, the challenges that have been affecting CHF if not taken with caution may permeate through to the ambitious UHC. This is because the written document by the ministry of health *(andiko la mapendekezo ya kuboresha mfumo wa bima ya afya)* avoided making a critical stock of the actual challenges faced by the CHF, instead, it mentioned a less significant challenges. These include: (i) unfeasible contribution reflecting actual health cost (ii) CHF getting services only within the district or region (iii) CHF insurance services being managed by inexperienced personnel in insurance services (iv) the quest for volunteerism to join the CHF (v) CHF members unable to get services in the private facilities (vi) The structure of CHF does not meet the requirements of the operation of the Fund efficiently, (vii) Limited services in the benefits package provided.

A critical view of the challenges mentioned in the *'write-up',* one realises that while the said challenges are correct, still other pertinent challenges are left perhaps deliberately. Thus, leaving them untouched makes the proposed UHC prone to the same challenges and hence may affect its sustainability. This is because they will not get reasonable attention for being addressed. Without addressing previous and present challenges, several challenges may emerge soon after the implementation of the proposed UHC. Unfortunately, some potential challenges have already started to surface since the first reading of the bill. It is important for the government to know in advance possible challenges and weigh out how to lessen such challenges once they emerge.

4.1. The quest for premium

The amount of money to be contributed by the household to allow them to access health services is so critical for its sustainability. Evidence suggests that since implementation of CHF in 2001, this problem kept emerging especially when the fund rose from TZS 5,000 to TZS 10,000 in

different districts. The situation worsened when the improved community health fund (iCHF) was introduced whose premium rose to TZS 30,000. Coupled with other challenges, the proposed amount persistently affected the sustainability of the scheme. One may be tempted to ask how the proposed TZS 340,000 per household and TZS 84,000 per individual will be accepted at the community level. Many individuals may find an escape route by opting to using the user fee (out of pocket payment). Data have consistently shown how communities' resort to user fees after realising that CHF premium is high, at the expense of unsatisfactory health services.

4.2. Weak management and leadership capacity.

Leadership and management are recognized as important enablers for improving programme performance, strengthening health system capacity, enhancing connections with target populations and increasing the ability of health systems to respond effectively to emerging challenges. Evidence shows that the implementation of CHF largely relied on the effective management of the responsible bodies at the district level namely the Council Health Management Team (CHMT), Council Health Service Board (CHSB) and Health Facility Governing Committee (HFGCs). While diverse research is focused mostly on financial constraints, there is increasing evidence that weak management and leadership capacity is a major obstacle to service delivery in many countries (Joseph & Maluka, 2017). Evidence has revealed that in districts with weak management and leadership among district health managers like what was experienced in Iringa district, the uptake of CHF was acutely very low. There was no sense of creativity to ensure that communities enrol in the CHF. This affected even the sense of financial management as well as community mobilisation. Districts with poor management experienced poor coordination and fragmented health stakeholders. The quest for financial accountability seriously affected the scheme which ultimately distorted communities joining the scheme. In addition, in poorly managed CHF districts did not integrate CHF as one of the key performing indicators among its health district managers, in charge of the facilities as well as ward and village leaders. High performing districts like Iramba in Singida region had well-functioning CHMT, CHGB and HFGCs that facilitated the uptake of CHF to 54% in 2013 (Mpambie, 2017). This is to say that while other variables may be constant, if there is poor

planning, managing, directing and controlling of UHC which depicts management attributes, consequently the scheme may be doomed to fail.

4.3. Level of community sensitisation

One of the failures of CHF to enrol a maximum number of clients was attributed to poor and weak community sensitisation at the grassroots level. The CHMT, CHSB and HFGC in poorly performing districts were not working properly to mobilise the community to enrol in the CHF. In contrast, Iramba district which maintained the top in terms of enrolling households had a different form of mobilising strategy for the community to enrol in the CHF. The district under the then district Commissioner Yahaya Nawanda (currently RC for Simiyu) in collaboration with district health managers developed different slogans like '*Kuku mmoja CHF mwaka mzima kwa kaya'*. This and other strategies were the reasons behind CHF's success in Iramba district. Other districts did not have special enforcement mechanisms to ensure the uptake of CHF. In the top-ranked districts they made enrolment in CHF a permanent agenda in the villages and ward districts.

4.4. Perceived poor quality of health service delivery

The great risk for community members not to enrol in the CHF has been the consistent poor quality of health services in the facilities. When community members realise that the facilities provide low-standard healthcare, they automatically withdraw from the scheme. Researches done considers poor quality of health services to be composed of a shortage of healthcare workers in the facility, long waiting hours, critical shortage of drugs and essential medical supplies (Mpambije, 2017). Other considered issues are failure to renew the scheme, inappropriate diagnosis due to lack of diagnostics equipment particularly laboratory equipment, demotivated healthcare workers, long distance to the location of facility and poor-quality referral system (Mpambije, 2017). For instance, a study by Kapologwe et al. (2020) revealed that by 2019, there were 3821 wards with no health centres and 6005 villages with no dispensaries. Even those facilities that have been constructed in the recent two years critically lack the necessary basic amenities to attract people to join CHF. This is to say, the correlation between the failure of CHF to attract community members to join the scheme and poor-quality standards is very clear. Iramba district in Singida, one of the success stories was so keen and invested heavily in

improving accessibility and affordability to health care, thus, by 2013, 54% CHF beneficiaries had been enrolled. Due to the availability of medical supplies, the district was named as the centre of excellence for health commodity management in 2012 (USAID, 2012). A good number of researches documents how communities failed to re-enrol in the CHF in the following years in districts that were marred with poor medical supplies. Community members went further to discourage their fellow members to join the scheme only because once they go to the facility there is no medical care. Drawing from these past scenarios, the manner in which UHC addresses the quality of health care services, will determine sustainability. This is to say, once community members decide to join the UHC, it is expected that the government will respond by deliberately improving health service delivery especially availability of medical supplies as well as adequate health workers in the facilities.

4.5 The socio-cultural context

In the series of the conducted researches, the poor performance of the community health fund has been connected to the existing diverse socio-cultural context of the area. For instance, the levels of education of the household members have leads to poor uptake of the CHF (Fadllah, et al, 2018). Again, some household members do not accept the pre-paid to access health asserting that it is a way of attracting diseases in their households. More so, different households do not allow women to pay the premium until they get permission from their husbands. For instance, when the husband is out of the family for so long, the wife cannot pay for the premium. All these factors point to lack of awareness at the household level that calls for a quick fix when the UHC will be implemented. Thus, the designed write-up needs to also include how interventions will be designed to ensure that the socio-cultural context of the particular area does not affect in any way the uptake of the scheme.

5.0. Sustainability of the UHC: Lesson Learnt from CHF in Tanzania

Given the global and local context force, it is hoped that the scheme will be introduced and ultimately implemented after undergoing significant changes. The views here focus on how the scheme will realise its goal, attract clients and provide desirable health services over time. This section covers 9 major issues that are not discussed or not adhered to by several schemes including the CHF. If they will not be fully considered, the scheme will be for so long dwarfed.

Using experiences drawn from CHF and iCHF, this section dissects the areas pertinent to forging the sustainability of UHC.

5.1 Constant reviewing amount and timing of paying premium

It has been established that a high amount of paying the premium can lead to a quick dropout of community members into the scheme. Already, this feeling has been felt among community members. The proposed amount of TZS 340,000 for the household and TZS 84,000 for individuals which is said in the government document as 'affordable' still poses an alarm for sustainability. When the amount was raised from TZS 10,000 to TZS 30,000 in the iCHF, one participant in one of the studies argued *'If people cannot afford to pay now, how will they afford to pay if you increase the premium?* (Polet, et al, 2007). Then one is forced to ask how the hefty amount of TZS 340,000 for the household and TZS 84,000 for individuals was reached. Apart from the econometric, that was undertaken, it is important to know if there was another audience that was reached to question the acceptability of this amount. One may remember how the issue of 'tozo' was received by wananchi and its aftermath. I am worried that we may fail before starting to implement the scheme. Given the hefty amount to be incurred by the households, and the need of ensuring the sustainability of the scheme, I wish to offer four suggestions; (i) constant reviewing of the amount scheduled for payment (ii) reviewing the methods of collecting the agreed amount such that it does not sound as do or die, (not corporal like), instead, friendly strategies should be introduced (iii) the time of payment needs thorough consideration in the sense that since the majority of Tanzanian are agriculturalists, then payment should be made during the harvest period (iv) Given the hefty amount suggested, I am of the view that such payments should be made through instalments of at least twice per year to give relief to the households to enjoy the services.

5.2. High community sensitisation

Recalling the fact that the poor performance of CHF and iCHF has been partly associated with weak sensitisation, it is the submission of this presentation that new and more mechanisms be designed to ensure that everyone is sensitised. The r new mechanisms should be fitting each socio-economic context of the region and district. For instance, in each region, the nature of sensitisation will have to reflect its socio-economic context. One may remember how Iramba

benefitted much from using '*Kuku mmoja CHF mwaka mzima kwa kaya.* This was appropriate since Iramba district heavily relies on poultry production. During the sensitisation that is expected to start from the grassroots to the national level, the government should among others, how health services will be improved in the near future. This is to say the content in which sensitisation of the community will be structured will necessary to eventually attract community members to join the scheme. For instance, looking at how sensitisation of the community for the recent concluded census was done if the same will be done to attract joining the scheme, successes will be recorded. It is very important to note that there are some communities in Tanzania who still have misconceptions of health insurance like CHF. In diverse research, that has been undertaken, in Tanzania, citizens still believe that 'paying money for the scheme, is a way of attracting sickness. Others still ask if their contributed money will be refunded in the event after the whole year they will not have fallen sick. These and other questions require intensive sensitisation before and during the implementation of the scheme.

5.3. Improving the management and leadership of the UHC

The success or failure of UHC will largely rely on how the leadership and management of the UHC is structured. As hinted earlier, the highest uptake of CHF and iCHF in Iramba district relied heavily on the district health managers. Though the bill speaks of the presence of TIRA, the leadership structure from the facility level and village to the national level is not well defined. Even how the existing framework at the district level that has led to the success of CHF in Iramba i.e., is still not very clear. It is the submission of this paper that before the formal implementation of the scheme, there is a need to design more creative and diverse strategies to ensure that UHC managers from the national to the grassroots facility level abide by.

In addition, for the scheme to attract more effective leadership and management attention, I am proposing the current 'write-up' to clearly state the role of the regional commissioner and district commissioner for its success. It is thus suggested that the RC should have a contract with the president and or minister responsible on an annual basis to enrol a certain percentage of the population of the scheme. The same contact will have to be served to the regional commissioner with the district commissioner on the same basis. This will therefore be part of the key performance indicator for the RC, DC and other district health managers and will define if they

will maintain their positions or not. For management and leadership purposes, it is further suggested that regions that will perform higher in terms of enrolment to the scheme, will have to be recognised and the strategies used to attract higher enrolment will be adopted by other regions.

5.4. Improve Financial Transparency

By all standards and given the economic status of most Tanzanians, the proposed premium is very high for the individual and households. Renewing subscription in the subsequent years will entirely depend mostly on how their contributed funds will have been spent for improving the health sector. We should be mindful that this bill comes out during which the health sector is implicated so badly as the second most corrupt sector (17.9%) after the police force (45.6%) (URT, 2020). The report produced by the PCCB hinted further that households consider the health sector more corrupt by 25.6% (URT, 2020). Above all, the CAG reports of 2010 to 2013 revealed a total amount Tshs 6,744,015,010 were unspent which smelt of fraudulent activities in the CHF fund (Poncian & Mpambije, 2015). Of recent, information has surfaced on how NHIF is overburdened with debt from public institutions that failed to pay the loaned money. Indeed, if the information of financial malpractice will keep surfacing during the implementation of UHC, automatically it will demoralise those who contribute to the scheme to re- consider withdrawing at any cost.

It is the submission of this paper that more robust designing mechanisms on how the fund will be judicially utilised be made before the actual implementation of the scheme. This is because the amount that is expected to be collected during the implementation is quite high as it is projected to grow from Tsh trilioni 1.84 in 2023 to Tsh Trillion 6.58 in 2030 (URT, 2022). When stringent measures to ensure that no coin will be fraudulently appropriated by the public servants are out in place,sustainability of the scheme may be plausible.

5.5. Deliberate strengthening health services delivery.

Perhaps the most hindrance to the sustainability of the proposed scheme will be the poor quality of services that are offered by the existing facilities. The CHF experience has proven so clearly how the two aspects depend on each other. It is thus important to design very clear measurable and attainable strategies before and during the implementation of the scheme. To start with, first,

continued efforts to construct health facilities in the wards and villages that are still missing need a new impetus to address the distance factor. Secondly, the quest to increase healthcare personnel needs a new strategy. Of recent, for instance, I was doing research in Mbarali district Mbeya, and realised that the district has a shortage of almost 600 out of 1050 medical personnel needed and yet there are unemployed graduates, clinicians and nurses. There should increase in admission of physicians to our universities and colleges. Thirdly, a deliberate effort to provide incentives to healthcare workers both financial and non-financial should be made so as to motivate them to work diligently. Fourthly, conducting a quick renovation and rehabilitation of the facilities that were constructed almost 20 years ago and ensuring that all necessary amenities are present is vital. In the study by Kapologwe (2020) found that out of 115 heath centres, only 17.4% had facilities for offering blood transfusion, whereas only 33% of 1673 health facilities had piped water. Fifth, ensuring the shortage of medical supplies is curbed is of significant importance. When all these efforts are made before and during the implementation of the scheme, it will restore trust in the community using health services to opt for not only joining but also renewing membership in the scheme.

5.6 Integrating UHC and poverty reduction strategy

Universal health care is positioned to solve most health-related financing mechanisms and so ensuring people's access to quality health care. Regardless of its embedded positive attributes, if poorly interpreted by the community, it may sound like a mechanism designed to impoverish them before they get sick. This is because households will be required to dig deep into their pockets to contribute to the scheme. If not taken with caution, community members will translate that all their earned money will only be used to contribute to the scheme annually. As such no other household investments will have to be done and hence postponed. To avoid this trap, it is the view of this paper, for the ministry of health to design mechanisms that will not sound like a punishment to the community members to impoverish them. This was done in Iramba when the slogan '*Kuku mmoja CHF mwaka mzima kwa kaya'* was designed. Through this slogan, the contribution was thus made without much contestation.

Another trick is for the government to identify poor families that will have to benefit with the new scheme. Though this effort has already been done, in the long run, it will not be feasible as

many community members will present themselves as poor and deserving to partake in the exemption. While the government's efforts are appreciated, l its sustainability is not guaranteed. This is because on annual basis, new households will force to join the scheme under the window of the exemption policy; in the long run, it will overburden the government. It is in this context that this paper posts to the government to design other ways of poverty reduction for community members so that they are able to contribute to the scheme from their own earned money. I have termed this as integrating UHC and the poverty reduction strategy.

5.7. Extensive stakeholders' engagement

Effective involvement of all key stakeholders before and during the implementation of the UHC is of utmost importance for both healthcare p and non-healthcare professionals. This is expected from the designing stage to the implementation to forge 'buy -in' the and ownership of the scheme. Extensive evidence has depicted how CHF failed in poor-performing districts due to low involvement of the district health managers, and other key personnel. It is important to note that the UHC is a huge thing, worth TZS 6.5 trillion in 8 years to come. This then requires many individuals and groups to have their stake in it. This will ensure community participation and ultimate ownership of the entire scheme. For instance, one may ask, how the proposed premium of TZS 34,0000 for the household, and TZS 86,000 for the individuals was reached. Was it reached by only computing the actuarial mathematics and projection in the highly intensive academic setting? We may recall witnessing the improvement of the curriculum from primary to secondary level being ensured by conducting involving different stakeholders' meetings at the national and regional levels. Can the same be done before the actual implementation of the scheme? It is the submission of this paper that a thorough stakeholder analysis is done to draw stakeholders on board so that they may air out their views for improving the policy document and stakeholder ownership.

5.8. Undertaking consistent research for evidence-based data.

The implementation and ultimate sustainability of the UHC will entirely depend on how evidence- based data will be collected and analysed consistently over time. It is important that after a certain period of time, changes over how the UHC will be implemented. Such change will

be meaningful if they will be supported with evidence-based data that might have been collected from the early implementation of the scheme. It is anticipated that such data will cover amongst other things the premium costs, timing of payment, number of beneficiaries, those who are insured by the government etc. To get this done with its effectiveness, it is strongly suggested that from the onset of the implementation of the UHC, research should be conducted. It is the view of this paper that a special task force is formed for constant reviewing the implementation of the scheme. It has come to the attention of public scholars that the changes from CHF to iCHF were fully informed by inadequate research and it is no wonder that the same problems persisted. This is perhaps because no constant research as undertaken to make thorough follow-up. Most research done was mostly funded by international organisations and or voluntary research done by universities that questioned the whole course of the implementation process. It is high time with the premium that will be collected; a certain percentage is allocated for undertaking research to avoid getting rushed and unreliable data.

5.9. The quest for co-existence of universal health coverage with user fee

Reading from the bill, there are issues that need quick fixes. For instance, as the UHC aspires for 44% of the population to be enrolled by 2030, the bill is silent on how the status of user fees will be handled. It is expected that specific guidelines will be designed to lead district health managers on how to run the user fee. Properly designed mechanisms for implementing user fees will have an impact on the new scheme. Experience from CHF revealed that in high-performing districts like Iramba in Singida, one of the strategies used was to fix the user fee a little bit higher so as to discourage community members to rely on the user fee (Joseph & Maluka, 2017). Again, there was a plan among those in charge of the facility to discourage user fees, instead, they worked closely with CHF coordinators to ensure that each member is registered under CHF. It is my submission that a clear design of how the co-existence of the two will be done during the transition period. Failure to concretely analyse how the two will coexist may lead to many community members opting for user fees hence impeding the uptake of UHC and its ultimate sustainability.

6.0 Conclusion

Implementation of universal health coverage in Tanzania is a timely agenda as spearheaded by the global forces as well as the local context. Again, efforts that have already been made by the government to date are commendable. This is because of the first bill and other subsequent write-ups that have already been made. However, its actual implementation in 2023 will require a little more concerted coordination from diverse stakeholders. Again, as the scheme sounds among community members it is like a corporal taskith no sense of humanity, especially during the collection of the premiums. Let us not quickly forget Mwalimu Nyererere's view point of development with a human face. It is strongly suggested that even if there is sense of necessity in the collection of premiums, creating a friendly environment should be prioritised. This requires intensive sensitisation initiatives. Above all, as a huge programme that within 8 years will collect Tsh 6.5 trillion, effective management and financial transparency is the impetus to sustainability of e the scheme. It is my wish and hope that after some years of implementation, other countries will come to study the Tanzania success story. As a scholar, I am looking forward to how this rolls out and becomes a point of reference not only for scholars, but also policy makers and development practitioners.

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