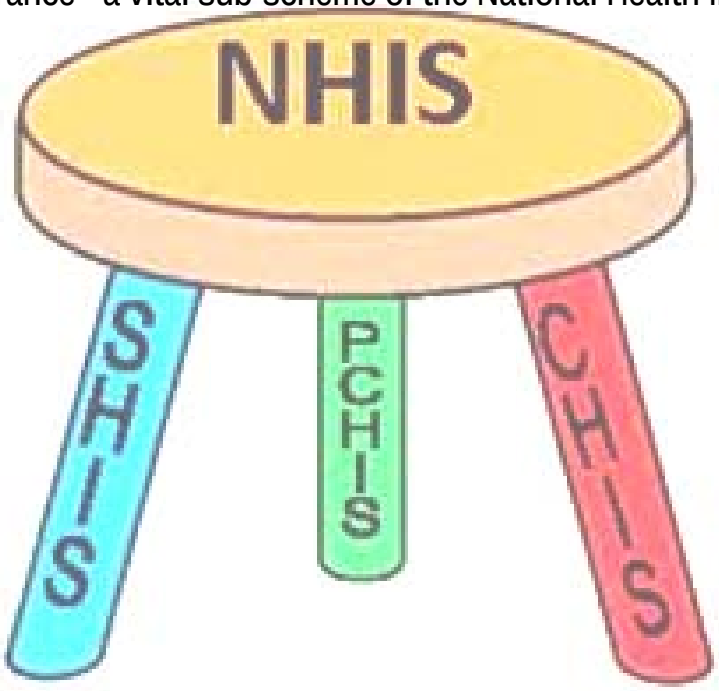
Community Health Insurance - a vital sub-scheme of the National Health Insurance Scheme



Position Paper presented to the Ministry of Health, Kampala

By

UCBHFA
PATH TO BETTER HEALTH

SAVE FOR HEALTH UGANDA

KABALE DIOCESE COMMUNITY HEALTH INSURANCE SCHEME
KDCHIS
CONCERN FOR HEALTH

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Acronyms

CBHI	:	Community Based Health Insurance
CHF	:	Community Health Fund
CHI	:	Community Health Insurance
CHIS	:	Community Health Insurance Scheme
EAC	:	East African Community
GIZ	:	German International Cooperation
HCS		Health Card Scheme
HPU	:	Health Partners Uganda
IHSU		International Health Sciences University
KDHIS	:	Kabale Diocese Community Health Insurance Scheme
MHO	:	Mutual Health Organization
MMI		Medical Military Insurance
MOH	:	Ministry of Health
MWS		Medical Welfare Scheme
NHIF	:	National Health Insurance Fund
NHIS	:	National Health Insurance Scheme
PCHIS	:	Private Commercial Health Insurance Scheme
RSSB	:	Rwanda Social Security Bureau
SHIB	:	Social Health Insurance Benefits
SHIS	:	Social Health Insurance Scheme
SHU	:	Save for Health Uganda
TIKA	:	Tiba kwa Kadi
UCBHFA	:	Uganda Community Based Health Financing Association
UCMB	:	Uganda Catholic Medical Bureau
UCS	:	Universal Coverage Scheme
UMU		Uganda Martyrs University
UOMB	:	Uganda Orthodox Medical Bureau
UPMB	:	Uganda Protestant Medical Bureau
USAID	:	United States Aid for International Development
VAT	:	Value Added Tax
WHO	:	World Health Organization

1.0 Background

Uganda is developing a law for National Health Insurance Scheme (NHIS) based on pre-payment and financial risk pooling aimed at universal coverage and social health protection (MoH, 2010). However, the NHIS bill of December 2012 only provides for Social Health Insurance Scheme (SHIS) that covers public servants and formal employees in the private sector. The Private Commercial Insurance scheme (PCIS) and Community Health Insurance Scheme (CHIS) are presented as other schemes outside NHIS (MoH, 2012). Consequently, no specific provisions were made for CHI throughout the entire NHIS Bill of December 2012.

The Community Health Insurance (CHI) that started wayback in 1996 at Kisiizi hospital, Rukungiri district, has grown to 22 schemes covering 150,000 beneficiaries in western and central regions of Uganda. Anecdotal evidence shows that on average CHI schemes coverage is 40% of the target population in their areas of operation. The schemes are coordinated and promoted by Uganda Community Based Health Financing Association (UCBHFA) a Non-Governmental Organisation established in 1999. UCBHFA works closely with Save for Health Uganda (SHU), Kabale Diocese Community Health Insurance Scheme (KDCHIS), Health Partners Uganda (HPU) that offer operational and technical support to the CHISs. Others are the provider managed Kisizi Health Insurance Scheme of Kisizi Hospital and e-Quality scheme of Bwindi Community Hospital. The Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB) and Uganda Orthodox Medical Bureau (UOMB) provide key health service points for the CHISs beneficiaries while CORDAID and USAID have been key funders of the schemes (UCBHFA, 2014). (*Also see informative Annex 1 for details on CHIS in Uganda).*

Presenting Community Health Insurance as scheme outside the NHIS and the subsequent absence of relevant legal provisions in the entire bill is quite defective. Section 4.0 of this paper presents positions taken by CHI key stakeholders on the draft NHIS Bill to support development of a law that provides for CHIS as a vital sub-scheme of NHIS

2.0 Development process for the position paper

The development of the paper took participatory and interactive processes. Consultations held with representatives of UCBHFA, SHU, UCMB, UPMB and World Health Organisation (WHO) raised key concerns with the NHIS bill and informed the purpose as well as the focus of the paper. Consultations with a number of CHI scheme managers at a half-day meeting in Ishaka, Busheyi district provided insight into the best practices, lessons learned and challenges facing the schemes.

Representatives of several organisations listed in the acknowledgement took a two day non-residential retreat where they raised key issues and generate ideas for the position paper. Review of official documents and reports from various sources such as offices of key stakeholders and internet provided both local and global CHI experiences.

The consultant facilitated the entire development process of the position paper with financial support from SHU.

3.0 Purpose of the position paper

The purpose of this position paper is twofold:

- To provide information on the relevance of Community Health Insurance in Uganda and selected low income countries.
- To provide guidance on provisions of CHI as a sub-scheme of NHIS in scaling-up health insurance coverage.

4.0 Our Positions on CHI provisions in NHIS

The positions set out in this paper are in reponse to the substantial omissions in the NHIS Bill of December 2012 with respect to Community Health Insurance Scheme. The paper has benefited from CHI stakeholders' consultations and dialogue covering key concerns with the draft NHIS Bill of December, 2012, purpose and main focus of the paper.

The paper also draws evidence from review of CHI experiences in Ghana, Rwanda and Tanzania presented in Table 1. These countries were selected because each has had at least 10 years track record of CHI implementation arrangements and like Uganda, they are low income countries in Sub-Saharan Africa. The review covered best practices, achievements, lessons learned and challenges with CHI. Details of the literature review for Ghana, Rwanda, Tanzania and Uganda are presented in *informative Annex 2.*

Tables 1 and 2 present our positions on specific issues and provisions for NHIS Bill.

Position 1: Mainstreaming CHIS in NHIS

The position paper central argument is that NHIS be composed of SHIS, PCHIS and CHIS in order to form a rational social protection system for the population. As clearly stated (MoH and GIZ, 2013); *'Community based health insurance does not principally differ from other insurances except for its scale, voluntarism and use of flat rates'*. In order to mainstream CHIS in NHIS, a number of key issues need to be explicitly addressed by relevant provisions in all the parts and sections of the NHIS bill. They include but not limited to: CHI relationship with other sub-schemes, governance, CHI structures, target population, financing mechanisms, compulsory enrolment, health care benefits and evidence based policy and planning as presented in Table 1

Table 1: Key position issues and related provisions for mainstreaming CHI in NHIS

Key Issues	CHI provisions in NHIS	Justification	Related experiences
i) CHI relationship with other sub-schemes	CHI is one of the three sub-schemes The other two are SHIS and PCHIS	• CHI compliments SHI and PCHI • CHI targets about 80% of Uganda's population which is in the informal sector	• Ghana's District Mutual Insurance is a sub-scheme of NHIS targeting residents of a given district, majority of whom are in the informal sector (NHI, Act 2003) • CBHI compliments Rwanda Social Security Board (RSSB) and Medical Military Insurance (MMI) by covering the informal sector (MoH, 2010(a) • CHFand urban equivalent TIKA focusing on the informal sector is part of a three tier (other two being NHIF&SHIB) insurance system in Tanzania (EAC, 2014).
ii) Governance	Representation on the NHIS Board, Regional and district levels	• Promotes interests of the majority of beneficiaries • Promotes CHI best practices	• Ghana's NHI Act., 2003 provides for representatives of Mutual Insurance scheme and consumers on NHI governing council (NHI Act, 2003) • In Tanzania Non-profit voluntary agencies and consumers are represented on the Council Health Services Board of CHF (CHF Act, 2001)
iii) CHI structures	• National umbrella organization for CHISs • District level organs for CHI	• Ensure effective coordination and mobilization of beneficiaries and resources • Promote partnerships and synergies among CHI stakeholders	• In Uganda UCBHFA coordinates and promotes CHISs (UCBHFA, 2014) • In Ghana a mutual health insurance scheme was established for residents in each of the districts (NHI Act, 2003) • In Tanzania management and administration of the CHF/TIKA shall vest at the district level (CHF, Act, 2001) • In Rwanda CBHI are coordinated at the district level by *Fonds de Mutuelle de sante* (MoH, 2010(a)

Table 1: Key position issues and related provisions for mainstreaming CHI in NHIS			
Key Issues	CHI provisions in NHIS	Justification	Related experiences
iv) Target population	• Adults not formally employed • Indigent • The vulnerable	• Not eligible for SHI • Unable to afford PCHI due to low and seasonal income • Vulnerable that require social support and protection	• The Ghana district-wide scheme provides opportunity for majority in the informal sector (Blanchet and Acheampong, 2013) • Rwanda CBHI focuses mostly on people in the non-public sector (MoH, 2010(a) • The Tanzania CHF/TIKA is designed to cover the informal sector (EAC, 2014)
v) Financing mechanism	Subsidized regime	• A significant population is poor and unable to pay full premiums • Indigents and vulnerable persons to be fully subsidized	• In Ghana, NHIS operates a single national fund whose 90% of its revenues are from dedicated taxes (portions of VAT and payroll) (Blanchet and Acheampong, 2013) • In Rwanda households finance 70% of mutuelles, subsidized by donors (13%) and government (9%) (MoH, 2008) • In Tanzania the government provides a matching grant of equal amount (100%) as subsidies upon request by CHF schemes in respective districts (J. Bultman et al., 2012) • In Thailand tax funding offered coverage to vulnerable groups (e.g. the poor, elderly and monks), providing access to health for the self-employed on payment of a flat-rate fee per household (Dutta and Hongoro, 2013)
vi) Compulsory enrollment	Compel every adult Ugandan to enroll in at least one of sub-schemes of NHIS	• Promtes equity and social protection • Increases financial risk pooling and sustainability • Eliminates household catastrophic health expenditure • Streamlines management of subsidies	• Ghana's NHIS Act, 2003 compels all citizens to make contributions into a fund to receive affordable healthcare under one of the three sub-schemes of NHIS. There are no-copayments and other fees at points of service • Article 33 of Law No. 62/2007 dated 30/12/2007 compels all Rwandans and foreigners living in Rwanda for more than fifteen (15) days to possess a health insurance card.
vii) Health care benefits and premiums	• Costed minimum healthcare package for all contributors • Additional packages (optional)	• Minimum package promotes universal access to health insurance • Improve access and eqiuty to healthcare • Promotes health benefits	• Ghana has a minimum benefit package that covers about 95% of diseases in the country which every district-wide scheme must cover; with an option to organise their schemes to cover additional service, provided it is approved by the National Health Insurance Council (NHI Act, 2003) • Rwanda under CBHI covers services at health Centres, District and Referral hospitals with co-payments at points of service by enrolled members (MoH, 2010a) • Thialand Universal Coverage Scheme (UCS) covers a comprehensive benefit package with outpatient, inpatient, and preventive care (health education and immunization) (Dutta and Hongoro, 2013)
viii) Evidence based policy and planning	Research and knowledge management frameworks	• Account for social and economic dynamics • Evidence for equity and social protection • Identification of implementation challenges	• In Rwanda various studies demonstrated the viability of CBHI in health financing and consequently led to community stratification using '*Ubudehe'*[1] criteria (EAC, 2014) • In Thailand study tours and research on the Medical Welfare Scheme (MWS) and Health Card Scheme (HCS) a nationwide voluntary insurance scheme to cover the non-poor who were ineligible for the MWS informed universal health coverage (Dutta and Hongoro, 2013)

[1] Ubudehe is a community-based targeting mechanism that categorises the Rwandan population according to their income and vulnerability

Position 2: Revision of some interpretations and provisions in the NHIS Bill

In the event that CHI is a sub-scheme of NHIS, we have considered revision of related interpretations and provisions in the NHIS bill as presented in Table 2.

Table 2: Revised Interpretations and Provisions in the Draft NHIS Bill, December, 2012

Interpretations in the draft NHIS Bill Dec. 2012		Provided/Revised	Justification for revision
i) "Membership of the scheme" – *No interpretation is provided in draft NHIS bill, Dec., 2012*		• "Membership of the scheme" means Social Health Insurance, Private Commercial Insurance and Community Health Insurance as sub-schemes of NHIS	• NHIS is to be made up of three sub-schemes
ii) "Contributor" means a public servant		• Contributor" means a registered member who pays premiums under any of the three sub-schemes	• Every Ugandan is expected to pay a health insurance premium • Subsidies and exemptions will only be addressing vulnerability
NHIS Bill no.	**Provision in NHIS Bill Dec. 2012**	**Revised Provisions**	**Justification for revision**
4 (1)	The following categories of employees shall be members of the scheme	The following sub-schemes shall form the membership of the Scheme	SHIS, PCHIS and CHI <u>not</u> categories of contributors form the NHIS
4(1)	a) Public servants b) Employees in firms with five or more employees	Social Health Insurance Scheme (SHIS)	It is SHIS that is a member of the Scheme but <u>not</u> Public servants and employees in firms with five or more employees
4(1)c	No provision in the Bill	Community Health Insurance Scheme (CHIS)	Second member of NHIS
4(1)d	No provision in the Bill	Private Commercial Health Insurance Scheme (PCHIS)	Third member of the scheme
38(b)	Private health care provider registered in accordance with the Medical and Dental Practitioners Act	The health care providers registered in accordance with the laws of Uganda	Health care providers come from public and private sectors in a scaled-up health insurance coverage
44(3)	an accredited service provider is paid within 60 days of submitting the claim to a regional office	an accredited service provider is paid within 30 working days of submitting the claim to a NHIS regional office	60 days is considered a long time given that providers need operational funds to maitain or increase service levels
63(3)	…the Board shall suspend …..	the accreditation of the health provider for a period not exceeding one calendar year	Setting time limit for the penalty makes it known to offender and provides the Board with timeframe for its decisions

6.0 Conclusion

This paper has argued that the NHIS need to establish a coherent social protection system in order to attain high levels of universal health insurance coverage. This is important not only in context of legal provisions in the event that Community Health Insurance is a sub-scheme of NHIS but also the integration of informal and formal sectors under NHIS to permit greater involvement of beneficiaries in scheme design, management as well as improvements in communication and education.

While there are daunting challenges affecting CHISs, there is equally a growing body of evidence on integrating, regulating and financing CHI globally that Uganda can advantegeously exploit. The experiences of Ghana, Rwanda and Tanzania reveal that community health insurance initiatives provided a fertile ground for mobilisation and tested models for implementation of NHIS. In Uganda alone the existence and contribution of the CHISs to social protection and the varied support of CHI stakeholders is a practical demonstration that CHIS forms a vital component of NHIS. Therefore mainistreaming CHIS in NHIS is a critical strategy that serves to address key challenges facing the current stand alone CHI schemes and harnessing opportunities that come along with the science, human resources and beneficiaries of community health insurance.

The paper suggests that CHIS as a component of NHIS will go along way to improve access and equity in health insurance services in Uganda. However, CHI schemes currently face severe limitations in terms of financial sustainability and managerial capacity due to size, voluntarism and low premiums. These weaknesses point to a need for substantial support from government and development partners if CHI is to contribute to social objectives across these dimensions.

This paper further demonstrates lessons and initiatives from various countries regarding financial support from government and development partners to mobilise communities, invest and set-up infrastructure for health insurance. Therefore one of the key pre-ocuppations of NHIS should be that of initiating financing reforms to support CHIS operational costs and modalities for subsidy to CHI contributors to cover their premiums for the minimum package.

Strong political will has been cited in Ghana, Rwanda and Tanzania as key catalyst that directed appropriate policy and legislative frameworks with matching financing mechanisms based on the principle of universal coverage. For example, the political commitment in Ghana enabled the fast tracking of the enactment of NHIS Act, 2003 which guarantees 90% funding to NHIS. While in Rwanda, unprecedented political will led to the development and implementation of the Community Based Health Insurance policy 2010 raising health insurance coverage to over 95% of population. In a related spirit, CHI stakeholders appeals for political commitment to CHI from the highest political offfice in Uganda in order to prioritize the health needs of the poor and vulnerable.

7.0 References

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10. Ministry of Health (July 2008), National Health Accounts Rwanda 2006, with HIV/AIDS, Malaria and Reproductive Health Sub-accounts, Kigali, Rwanda
11. Uganda Community Based Health Financing Association, Strategic Plan 2013/14-2017/18 , 2014, Kampala
12. United Republic of Tanzania, The Community Health Fund Act, 2001

Annex 1: History and Experience of Community Health Insurance (CHI) in Uganda

The first Community Based Health Insurance Scheme in Uganda was set up in 1996 in Kisiizi hospital, Rukungiri district. Following a successful piloting of the scheme in Kisiizi hospital other schemes were started at Mutolere, Nyakibale, Ishaka, Comboni, Kitovu, eQuality Bwindi Health facilities among others. Majority of these schemes were (until recently) hospital based and were started jointly with MoH and various donors.

Community Health Insurance Schemes in Uganda are essentially community initiatives. Community Health Insurance targets over 80% Uganda's population that are hard to organise including the most vulnerable especially women and children to access quality health care. The individual schemes target household heads or families and others use the existing community groups. Each scheme has its own constitution, rules, regulations and leadership. Each scheme also collects and manages its premiums. The individual schemes select their health providers while supporting agency such as Kabale Diocese Community Health Insurance Scheme (KDCHIS), Save for Health Uganda (SHU), Health Partners Uganda (HPU) provides technical support in formalising the scheme and provider relationship. The CHIS may be community-based or provider-based with regard to operationalising the premiums. The community-based model is where premiums are collected and managed by community itself with provider billing the scheme after service delivery. The provider-based model is where the CHI is initiated by the provider who collects the premiums and pays oneself.

Uganda Community Based Health Financing Association (UCBHFA) a Non-Governmental Organisation was established in 1999 to coordinate and promote community based health financing (CBHF). UCBHFA is the umbrella organization for all CHI initiatives in Uganda. UCBHFA core activities are coordination of CHI initiatives, capacity building, technical support and advocacy on community health insurance. Others are research, supporting education and information sharing with CHIS and the members. The association works closely with local and international stakeholders in promoting and supporting the initiatives. Key among these are Save for Health Uganda (SHU), CORDAID, Health Partners, Kabale Diocese, Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), Uganda Martyrs University (UMU), , Ministry of Health (MoH), International Health Sciences University (IHSU).

The achievements include UCBHFA active member organisations currently at 22 compared 5 in 1999 and 111 schemes with over 150,000 beneficiaries. The association works closely with Save for Health Uganda (SHU) and Health Partners Uganda (HPU) and KDCHIS that offer operational and technical support at total of 90 schemes. Others are Kisizi Health Insurance Scheme of Kisizi Hospital, e-Quality scheme at Bwindi Community Hospital. The key service providers are health facilities of Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB) and Uganda Orthodox Medical Bureau (UOMB); and Bwindi Community hospital. CHISs currently cover parts of South Western and central regions limiting coverage with regard to universal coverage and notably excluding the Eastern and Northern regions of the country.

While the existing CHISs provide alternative means to health care financing there are daunting challenges:

- The absence of a supportive environment due to lack of policy and legal framework for CHIS which undermines the roles of CHI stakeholders of lobbying for reforms, mobilising communities and resources. Scheme beneficiaries are not protected in absence of professional accreditation body, quality assurance and legal redress mechanisms. Equity, efficiency and the social objectives of health insurance are equally undermined
- Low support to CHI initiatives by government leads to poor utilisation of social capital and local innovations.
- Poor resource base undermines the quality of services accessible to the beneficiaries, limits coverage and sustainability.
- Lack of information about health insurance among the population requires considerable resources (human and financial) to mobilise, recruit and retain beneficiaries in the schemes.

A number of lessons can be drawn from the implementation of the CHIS since 1999:

- In the absence of public sector free and quality health services, the schemes provide alternative health care financing mechanisms that enabled members to access quality care within their proximity.

- The CHI initiatives have over time evolved into unique management and operational models. The community based and provider-based span various ownership, management and insurance categories as well different community groupings. They provide valuable information for benchmarking development of CHIS, community dialogue and effective participation of the affected communities.

- The existence and spread of the CHIS means that there are sections of Uganda's community that embrace health insurance as a mechanism for health financing. They have developed local accreditation criteria and contract management systems upon which the NHIs can draw inference and forge an acceptable CHI model responsive to the local context.

- The implementation of CHI in Uganda had drawn on involvement and support of local and international stakeholders such as UCBHFA, SHU, HPU, Medical Bureaus, CORDAID and MoH. In furthering the efforts of communities, the stakeholders have marshaled synergies in areas of coordination, technical guidance, advocacy and financial support. The support is a practical demonstration that CHI has captured the attention of local, national and international stakeholders as one of key health financing mechanisims. Uganda will no doubt benefit from support, wisdom and experience of CHI stakeholders and communities in promoting CHI for universal health coverage.

Annex 2: Informative Annexes on Experiences of CHI in Uganda, Ghana, Rwanda and Tanzania

Annex 2a: UGANDA

Policy framework	Legal framework	Financing mechanism	Implementation arrangements	Achievements	Challenges	Lessons learned
There is no explicit policy framework on Community Health Insurance (CHI)	•NHIS Bill December 2012 provides for mainly Social Health Insurance (SHI) •Community Health Insurance (CHI) and Private Commercial Health Insurance (PCHI) are given as other categories of NHIS NHIS Bill does not have provisions for CHI as a sub-scheme of NHIS notebly •Premiums •Basic package •Financing mechanism	•CHI premiums and copayments at point of service [3]	<u>CBHFA</u> •Coordinates 22 CHI initiatives in the areas of capacity building, Advocacy and networking <u>SHU, HPU</u> •Promotion of CHIs •Capacity building •Advocacy <u>Medical Bureaus and PFPs</u> •Providers of services to Communities and beneficiaries •Payment of premiums <u>Donors - CORDIAD</u> Financial and technical support	•Over 22 CHI initiatives are operational mainly in South Western and part of central Uganda •Over 150,000 people are CHI beneficiaries •There is a critical mass of human resources in CHI initiatives •CHI initiatives have a rich knowledge base on CHI	•Lack of policy and legal framework to support CHI •Communities do not have information about CHI •CHI members over depend on income from unstable agricultural outputs •Lack of resources to support CHI operations and other costs	•A section of Uganda's community embracing CHI and varied support of stakeholders demonstrate CHI scale-up viability •CHI schemes rely on voluntary engagement of scheme representatives and group leaders for other key functions (marketing, sensitization, premium collection from individuals and distribution of membership cards). •Many people feel they can get free health services from government health facilities - adversely affects retention of membership and enrolment[4] •CHISs face a problem of adverse selection at enrolment (insurance attracts more elderly and people with chronic diseases)[3] •CHISs are not financially sustainable but still efficient due use of lean staff and voluntary human resource services[3] There is no pooling among existing CHISs[3]

Source: (1) Ministry of Health, Health Strategic and Investment Plan 2010/11-2014/15, Kampala
(2) WHO Health Statistics 2010.
(3) Kabale Diocese Community Insurance Office, Evaluation Report, Phase 2, 2010-2013, Kabale, Uganda
(4)Consultations with CHI Scheme Managers, Ishaka Municipality, Busenyi District, September 2014
(5) Ministry of Health, The Second Health Policy, July 2010, Kampala

Annex 2b: GHANA

Policy framework	Legal framework	Financing mechanism	Implementation arrangements	Achievements	Challenges	Lessons learned
NHI policy ensures access to basic healthcare services to all residents[1]	•District mutual health insurance scheme covering all residents of a district[1] •Private mutual insurance scheme (Group of individuals registered by guarantee[1] •Private Commercial Health Insurance Scheme – A limited liability company)[1] •Exemption: those under 18 and above 70 years, pregnant women and the poor are exempt from premium payments[2] •Individual NHIS enrolment is mandatory[2]	NHIS is funded at National level: •VAT of 2.5% on most goods and servives contributes 75% of NHIF revenue[2] •2.5% carve-out of social security payroll tax[2] •5% of revenues from informal sector members' premimium payments •Investment income from NHIF[2] •Single national funding risk pool[2] •NHIA controls the budget and works with parliament to pass budget[2]	<u>Central government</u> •Financing NHIS •Management and Administration •Policy making •Accreditation to healthcare providers and monitor their performance[1] <u>District local governments</u> •Registration of members •Examine claims before paying the providers of services[2] <u>Development partners</u> •Technical support[2]	•Prepaid insurance has been possible for large rural and informal sector[2] •Single pool of prepaid funding in NHIF[1&2] •Out of pocket expenditure at 29% is lower than Sub-Saharan Africa average of 32% and lower than pre-NHIS – period 2011[2]	•Expenditure on claims are growing faster than revenues •Scaling-up diminished community ownership of the scheme	•Competitive democratic politics in response to public backlash against user fees fast-tracked enactment of the National Health Insurance Act 2003; and mplementation of NHIS in 2004 [1] •Earmarking Ghana's VAT to finance the NHIS is a major part of the MHO-to-NHIS transition [1] •The current NHIS was from experiences of MHOs that preceded it: Previous MHOs offered field templates which were used supported district-wide system in the scale up[1] •Hiring of the critical mass of experts in MHOs; initialy helped to implement and scale-up NHIS [1]

Source: 1. Republic of Ghana, National Insurance Act, 2003, Accra
2..Blanchet Nathan J. and Acheampong Osei B. (2013), Building on Community-Based Health Insurance to Expand National Coverage: The Case of Ghana, New York, USA

Annex 2c: RWANDA

Policy framework	Legal framework	Financing mechanism	Implementation arrangements	Achievements	Challenges	Lessons learned
There is a specific policy on CHI with the Goal: •Provide universal and equitable access to health services by complementing other health insurance schemes(1)	Community Based Health Insurance (CBHI) (1) •CBHI Act, 2007 is under revision to transfer the management of CBHI from the Ministry of Health to Rwanda Social Security Bureau (RSSB) - a body under the Ministry of Finance and Economic Planning(3)	Three types of funding sources for the primary, hospital and referral levels(1) •Annual membership premiums which are subsidized by government(3) •Development partners and government pay fees for people who cannot afford any level of coverage (25% of the population is fully subsidized)(3)	Community •Ownership and management •Paying premiums Government •Financing and administration Development Partners •Financial and technical support(1)	•Significant reduction in household health related consumption shocks •Coverage by CBHI is 90.7% of population by 2012 •Increased utilization of health facilities (increase from 0.31% outpatient visits in 2003 to 0.95% in 2010, per capita)(4)	•Majority of the people are in the informal sector, poor and hard to identify(5) •Insufficient funds at national and district levels •Abuse of the scheme by beneficiaries and providers	•Strong sense of community has been critical in building CBHI schemes and scale up to national level such as use of traditional concepts that are more familiar and acceptable to the population – for sensitization and collection of premiums(3) •Direct government financing of health facilities and subsidies for mutuelles(3) •Strong political will in policy development, implementation and monitoring success/progress(3)

Source: (1) Republic of Rwanda, Rwanda Community Based Insurance Policy April, 2010, Kigali
(2)Abebe Shimeles (Dec. 2010), Community Based Health Insurance Schemes in Africa: the Case of Rwanda; Working Paper Series No. 120, Tunis, African Development Bank Group
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Annex 2d: TANZANIA

Policy framework	Legal framework	Financing mechanism	Implementation arrangements	Achievements	Challenges	Lessons learned
Vision of the National Policy is to improve the health and well being of all Tanzanians with focus on those who are at risk and encourage the health system to be more responsive to needs of the poor[2].	•Community Health Funds (CHF) established by the CHF Act 2001[1] •NHIF administers CHF through an MOU (provision of technical and managerial support)[3] •Exemption and waivers benefit vulnerable groups[1]	•Households in a district agree on a uniform premium to finance basic package of curative health services[1] •Government provides a matching grant of equal amount (100%) as subsidies to CHF schemes in respective districts[1] •Grants from organizations/donors •Districts Councils fully subsidize the CHF membership fees of people given exemptions and waivers[1] •Government finances health development activities, essential drugs, medical supplies and vaccines[1]	<u>Line Ministries/Government</u> •Provide advice and technical support to the Fund[2] •Monitor and evaluate the activities of the Fund. •Contribute funds to CHF[2] <u>District (Council Health Services Board)</u> •Determine level of premium[1] •Provide operational and managerial guidelines for health activities[1] •Make, by-laws for the Community Health Fund •Mobilize and administer funds[2] •Set exemption criteria for users of services[2] <u>Ward Health Committee</u> •Mobilize the community to be members of the Fund[2] •Supervise collection of annual premiums •Review CHF operations, make recommendations and take remedial actions[2] •Issue exemptions to payment CHF contributions by vulnerable groups (pregnant mothers, under 18 and above 70 year olds) [2] <u>Donors</u> Technical and financial support[3]	•Rolled out CHF in 112 out a total of 169 districts •8.6% of the population is covered by CHF[6] •Reduced drug stock-outs in hospitals[2] •Increased utilization of health services[2]	•Expensive hospital care is not covered under the CHF •Fluctuation of CHF revenue due to members' over dependency on income from agricultural harvests which vary annually[2] •Lack of clear criteria for application of waivers and exemptions from payment of contributions by the poor[2] •District Councils have weak knowledge on financial management[2] •No equal access to health care due to (differentiation of premiums across[5] districts - ranging from 5,000 – 20,000 TZs[4,5] •Communities' poor understanding of the concept of insurance[5]	•Reaching the informal sector and poor households requires building on existing community structures[6] •Restriction of CHF schemes to district level undermines portability of health services and ability to pool the risks more widely[6] •Identification of the poor for waivers and exemptions from contributions is difficult[6] •User fees set below the CHF premiums discourage enrolment to CHF[2]

Source: (1). United Republic of Tanzania, The Community Health Fund Act, 2001.
(2) Gemini Mtei and Jo-Ann Mulligan (Jan., 2007), Community Health Funds in Tanzania: A literature Review, Dar es Salaam, Ifakara Health Institute
(3) National Health Insurance Fund (Oct. 2010), National Health Insurance Fund Actuarial and Statistical Bulletin as of 30 June, 2009, Issue No.6.
(4) National Health Insurance Fund (2013), Fact Sheet Inside NHIF 2001/02 to 30 June 2013.
(5) Bultman J., et al. (March 2012), Tanzania Health Insurance Regulatory Framework Review, Final Report, Dar es Salaam, Ministry of Health and Social Welfare and Social Security Regulatory Authority
(6) Jan Bultman and Anselmi Mushy, (June 2013), Options for Health Insurance Market Structuring For: the Tanzania Health Financing Strategy, Final Report, Dar es Salaam, Ministry of Health and Social Welfare and German Development Cooperation

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